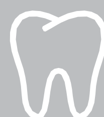
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Tier 1: Quality Check Summary

Redwood Suite step down facility, Rhymney

Activity date: 16 September 2020

Publication date: 14 October 2020



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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 978-1-80082-339-6

WG41024 © Crown copyright 2020

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Redwood Suite step down facility, Rhymney 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 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 (IPC); and governance. More information on our approach to inspections can be found here.

We spoke to the Ward Manager and Quality and Patient Safety Manager on 16 September 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

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. All staff, including bank and agency staff, had access to the health board intranet which had a specific designated area for a COVID-19 clinical hub.

The hub included the latest guidance for infection control hygiene, hand hygiene and links to a training video for donning and doffing PPE. We were told that staff were also kept informed of up to date guidelines through information placed on staff notice boards and daily emails.

We were told that daily cleaning schedules are completed for all clinical and non-clinical areas which are audited by the nurse in charge at the end of the month to establish the ward's compliance and any action required. In addition, increased cleaning of non-clinical areas and regular touch surfaces such as doors and handrails is being undertaken. The ward manager told us they complete a monthly infection control audit which includes a walk-around of the service area to observe cleanliness and equipment. An IPC lead nurse also carries out a three monthly review. We were told of an annual cleaning audit of the service which is completed by the lead facilities team. It was explained to us that any shortfalls identified are recorded on the health board's incident recording database with remedial action implemented within 48 hours.

We were told the service had not had any issues with access to PPE. The provision of PPE formed part of the health board's daily risk assessment and the service reported continuous prompt deliveries from the PPE distribution centre. We were also informed that full PPE was available throughout the ward for use by staff and visitors who attended the service to visit relatives receiving end of life care.

We were told that the service had implemented testing procedures for staff and patients. This included patients admitted from a home environment being tested for COVID-19 upon admission and a requirement to self-isolate within their en-suite room until a negative result has been obtained.

We were told that staff requiring shielding had been identified at an early stage and that arrangements had been made for them to work from home and maintain regular virtual contact with staff at the service. The ward manager said that this had worked well.

We saw evidence of documents which are used by the health board to inform pandemic preparation in the workplace. These included the guidance for infection prevention and control in healthcare settings and the World Health Organization hospital readiness checklist. We were also told that the head of emergency planning is in the process of rewriting the health board's overall pandemic plan to reflect the learning to date. This is due to be completed by the end of October 2020.

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 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:
We saw evidence that an annual environmental risk assessment was completed on 24 August 2020 and actions had been taken to reduce risk where appropriate. The service also has additional monthly audits to further support patient safety which include audits on falls and pressure and tissue damage. We reviewed a sample of these and found the service to have scored positively. We were also informed that all staff have a responsibility and accountability for maintaining a safe environment and protecting patients from harm.
We were told the service benefits from all single en-suite rooms for patients. We were also told that patient care is undertaken with the room door closed and a 'do not disturb' notice placed on the door to inform that care is being administered. This ensures that patients' dignity is maintained. We were also told that call bells are available in each room. It was explained that consideration and assessment of clinical need and risk, such as risk of falls, is reflected in relation to the allocated room on the ward.

It was explained to us that patients have been supported to maintain contact with families and friends during the pandemic through telephone calls and the use of electronic devices. In line with Welsh Government guidelines, we were told the ward is currently operating restricted visiting to reduce the risk of the spread of COVID-19 between patients, relatives and staff. We were also told the service recognises the impact of this on both patients and families, and every effort is made to balance the risks with consideration of patients and families individual circumstances. The service has processes in place for visitors supporting patients receiving end of life care. This included only one visitor permitted at a time, visitors being logged in upon arrival at the service, details being taken in line with test, track and protect procedures and provision of PPE and sanitising hand gel for visitors use.

We were told that the unit is secure and staff have to swipe in to gain access. This limits any unnecessary footfall within the unit. We were told of measures which had been introduced to ensure that staff, patients and relatives are protected. Social distancing had been introduced within the service and all multi-disciplinary team meetings take place in the largest room available within the unit. It was explained that staff from the health and safety unit within the health board had attended the service and were satisfied that risks within the unit are minimal. We were told that the reception desk has been fitted with a perspex screen for the protection of clerical staff.

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 a health board IPC specific policy as well as 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 health board also has a COVID-19 clinical hub on the intranet which is referred to earlier in this report.

It was explained to us that the facility had a designated IPC link nurse. Their role includes the appropriate use of PPE by staff, in line with current health board and Welsh Government guidance for patient care. They also monitor stock levels of PPE for staff and patient use when required. We were told that visual and written notices relating to IPC are available within the ward for staff, patients and relatives.

We were informed that mandatory on-line training relating to infection control and COVID-19 is provided to staff. A recommendation in relation to training compliance is made later in this report.
We were told the facility has had no reported cases of COVID-19 and a process is in place for the ward manager to report daily to the health board's business and performance team. If any positive cases were identified, we were told they would be reported to Public Health Wales. In addition, we were informed that all incidents of healthcare acquired infection are reviewed by the health board's IPC team. Any learning and actions would be fed back to the ward and shared more widely for assurance of learning and improvements.
No areas for improvement were identified.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

We were told that the ward manager ensures that the staffing levels meet the agreed

establishment. Processes for addressing staffing deficits were explained to us which are escalated in a timely manner allowing arrangement of appropriate cover through the nurse bank or agency staff. We were also told there is an escalation plan available in the event of unexpected staff absence and a weekend divisional plan is formulated to ensure any staffing deficits are highlighted to the senior nurses on call, with a contingency plan attached.

We saw that annual personal appraisal development reviews (PADR) are undertaken to ensure that staff development is enhanced and opportunities created in relation to professional development, leadership and clinical skills. We saw figures which reflected that the majority of staff had completed their PADR and were told by the ward manager that plans were in place to ensure the remainder are completed in a timely manner. We were informed that a training skills analysis has recently been undertaken to identify any deficits in staff training and to scope further development opportunities.

The service told us that they were currently carrying one full time registered nurse vacancy as well as a part time vacancy. Efforts were being made to fill the posts, and we were told the full time position had been advertised on three occasions but had not yet been filled. It was explained that the staff shortfall was being managed through the use of bank staff and consistency is provided through the use of the same bank staff.

The ward manager told us they are located on the ward and are visible and easily accessible to staff. We were also told that senior management have been supportive throughout the pandemic and regular virtual meetings have taken place. The service also described to us a number of arrangements in place to provide support to staff. This included the availability of occupational health and well-being services. Telephone numbers for these services are available within the unit and staff can access them directly, or be referred by the ward manager. In addition, we were told that links to additional support services including mental health and psychology services are available on the health board's intranet.

The following areas for improvement were identified:

We saw evidence that the ward manager records and monitors the training compliance of staff and highlights any low compliance figures to staff on a monthly basis. Whilst overall training compliance was high, some staff members' compliance figures were between 60 and 70 per cent. We discussed this with the ward manager who explained that a few part-time staff members were trailing with their compliance. It was also explained to us that there is a practical, face to face element to complete with manual handling training which had been delayed due to the pandemic. We recommend a review of all mandatory training compliance figures and action be taken to ensure high compliance rates by all staff.

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: Redwood Suite, Rhymney

Ward (delete as appropriate): Step-down facility

Date of activity: 16 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 recommend a review of all mandatory training compliance figures and action be taken to ensure high compliance rates by all staff.	7.1 Workforce	The Ward Manager will introduce monthly formal monitoring of mandatory and statutory training compliance and develop an improvement trajectory. Action will be initiated where the trajectory is not met, with escalation as required.	Alex Price Redwood Ward Manager	Immediate introduction of monthly reviews commencing October 2020

Name: Jo Webber, Head of Nursing

Date: 06/10/2020