Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Pinetree Court

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Pinetree Court as part of its programme of assurance work. Pinetree Court is owned by Pinetree Care Services Ltd, and provides care for up to 29 patients over the age of 18, with learning disabilities, behaviours that challenge, and/or mental illness.

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 are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. Information on our approach to inspections can be found here.

We spoke to the registered manager, who is also the hospital manager, on 18 January 2021, 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?

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 very few changes have had to be made to the environment due to COVID-19. This was due in the main to very low instances of diagnosed or suspected COVID-19 infection amongst the patient and staff group.

We were told that the activities programme was reviewed and amended to provide more on site activities and that individual patients' likes and dislikes have been taken into account when drawing up activity planners. Additional activities include local walks, dance sessions, music therapy, outdoor gym/circuit training, music quizzes, bingo, fitness sessions and yoga. In the event of patients having to isolate, then bedroom based activities would be provided for patients together with access to external spaces.

Patients have been supported to deal with the change through the social stories[1] approach and regular unit meetings to ensure they understand changes to rules and regulations. Easy read guides have been provided for the patients in order to ensure that they understand any changes and to reduce anxiety levels as much as possible. Increased virtual contact with their families has also been enabled to assist patients in adjusting to the changes.

We were provided with copies of monthly environmental audits for November 2020, December 2020 and January 2021, together with ligature risk assessments for November 2020. These show that the organisation is making every effort to ensure the health and safety of patients, staff and visitors through robust and comprehensive audits and risk assessments.

We were provided with copies of clinical governance meeting minutes for October, November and December 2020, which show that incidents are recorded and reported on appropriately. We were also provided with a copy of the most recent quarterly thematic review of restrictive interventions applied to manage certain behaviours that challenge. This shows that such interventions are managed appropriately and that the organisation has very robust recording, reporting and reviewing processes in place. It also shows that information is presented, in a formal way, to senior managers on a regular basis.

[1] Social Stories are a social learning tool that supports the safe and meaningful exchange of information between professionals and people with autism of all ages.

No improvements were identified.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. 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. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were told that there were no current, confirmed cases of COVID-19, within the staff or patient group.

We were provided with copies of the policies and procedures in place for the prevention and control of infection, which included specific COVID-19 policies and guidance. These were seem to be comprehensive and reflective of current COVID-19 national guidance.

We saw from the documents submitted and from discussions with the hospital director that any patient diagnosed with an infectious disease would be managed appropriately. Should a patient have to isolate due to suspected or diagnosed COVID-19, then they would be cared for in their bedroom to limit any risk of cross-infection.

Monthly infection control audits are undertaken across the three units within the hospital. We were provided with copies of the most recent audit reports conducted in December 2020. These showed very high infection prevention and control compliance. The audits are comprehensive and any issues requiring attention are highlighted and actioned.

We were told the hospital has sufficient PPE for staff, patients and visitors, which is regularly audited to ensure adequate stock levels are maintained.

The hospital has Standard Operating Guidelines in place which reflect the up to date COVID-19 guidance. The guidelines are circulated to all staff following any amendments. There is also a COVID-19 communication board in the staff room, which is used to display regular communication from the Board of Directors and also to share any information from the twice weekly COVID-19 Committee meetings that take place. The information is also e-mailed direct to all staff.

We were told that staff, patients and visitors to the hospital are continuously reminded of the need to wash their hands and to maintain social distancing. During shift handover sessions and daily meetings, staff are reminded of the need to use PPE and to undertake

regular temperature checks. The unit managers, clinical lead and hospital director conduct regular spot checks to ensure adherence to cleaning schedules, use of PPE and temperature checking. The hospital director also holds twice weekly COVID-19 monitoring calls with other senior managers within the organisation, to discuss any non-compliance issues, concerns or support requirements.

We were told that, if staff did not comply with the guidance, then this would be formally addressed during one to one supervision sessions which are conducted every six to eight weeks. Persistent non-compliance would be dealt with under the organisational disciplinary policy.

No improvements 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:

Discussions with the hospital director and clinical lead highlighted a good understanding of their responsibilities and the hospital's escalation and reporting processes. The hospital director told us that they are well supported by the wider organisation's senior management team and have access to advice and guidance when required.

We were told that agency staff are used to cover staffing shortfalls. We were also told that every effort is made to ensure that the same agency staff are secured to provide cover. This provides a level of continuity in the care provided and ensures that the agency staff are familiar with the hospital layout and working practices, and are familiar with the patients' individual care needs.

At the time of the call, we were told that staff recruitment was on-going with interviews currently being held for a number of vacant support worker posts.

We were told that patient dependency levels are assessed regularly and additional staff brought in to cover any increase in demand. We were also told that the agencies used were very responsive and accommodating in ensuring that sufficient staff were available to cover shifts at short notice.

We were provided with training statistics and saw a high compliance rate for mandatory training.

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. Where face to face meetings have not been possible, telephone 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 in accordance with government guidelines. However, as restrictions were lifted, patients' leave status has been reviewed and amended to reflect the changes. Where appropriate, 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.

No improvements were identified.

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: Pinetree Court

Date of activity: 18 January 2021

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
	No Improvements Needed				

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: