Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Bryngolau Ward, Prince Philip Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Bryngolau Ward, Prince Philip Hospital, 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; and governance. More information on our approach to inspections can be found here.

We spoke to the Service Manager on 6 October 2020 who provided us with information and evidence about the setting, both deputy ward managers were also in attendance. 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:

Bryngolau Ward was a 15 bed, older adult mental health assessment unit. We were told that a number of changes had been made to the ward environment as a result of the pandemic. The ward was divided into amber and green areas. All new admissions were isolated in their en-suite bedrooms, swabbed for COVID-19 and remained in rooms until a negative result was provided. This caused challenges, due to the mental ill-health and level of understanding of the patients admitted to the ward.

Advice and guidance was received from the infection control team to ratify best practice. A one way system was introduced onto the ward, social distancing measures were maintained and there was an increase in use of PPE. There was also an increase in the reliance of Information Technology (IT), with virtual meetings held with outside professionals and agencies.

Due to the increased risks posed by COVID-19, we were told that patients had not been granted leave, to ensure safety. This was in line with health board guidelines. Where patients were discharged to care homes, they would be tested for COVID-19 prior to leaving the ward and if the result was negative, they would be required to isolate in the home. Patients would not be sent to a care home where there had been a positive case of COVID-19 at the care home, within the previous 28 days.

Visitors were not allowed on the ward, again, in line with health board policy, except for families of palliative care patients. The process used was described and this followed advice and guidance from Infection Prevention and Control (IPC) teams, with strict PPE controls in place. Alternative means of communication were used between the patients and their families, using virtual meetings, in addition to emails with photographs attached and using the ward telephone with advocate support.

We were told that whilst there were virtual ward rounds, the ward received support from an advance nurse practitioner and a consultant psychiatrist. Meal times were rearranged to ensure social distancing, as opposed to a group mealtime previously. Staff provided support where required. The ward had recently received a delivery of clear masks, which it was hoped would improve communication on the ward.

We were also told that patients were supported to engage in activities on the ward and that these routines had not changed. There were social groups and singing groups, facilitated by the Occupational Therapists (OTs). These were designed to promote independence, maintain skills and combat boredom, as well as assessing a patient's ability in the activities of daily living.

Throughout the quality check, the Service Manager expressed his pride of the staff and their achievements during the pandemic.

We were provided with evidence of a number of policies and procedures specific to COVID-19, including a patient pathway, IPC guidance and risk assessments. We were told that there were sufficient supplies of PPE for staff and patients. Staff had received training on the correct donning and doffing of PPE and fit testing of masks. Staff were also encouraged to check each other to ensure both their safety and the safety of their patients.

The systems in place to ensure the prompt identification of people who were at risk of developing COVID-19, or other infections, and who displayed symptoms were described. Posters were on the walls listing the symptoms and where staff had concerns with the patients, they were isolated. The advance nurse practitioner would conduct the physical checks and would request a COVID-19 test, as necessary.

The self-assessment provided, stated that the ward team had to adjust their ways of working through this difficult period. This resulted in the team growing in resilience and adapting accordingly in line with changes to guidelines and policies. Psychological support for staff well-being had been introduced, including external sources of support offered with increased supervisions, free counselling services and peer support.

Redeployed staff had shown great support to the team, they adapted and integrated quickly and well. In turn, when the staff returned to their original role, we were told that feedback was very positive, in that they felt supported, safe and a valued member of the team. There were also informal arrangements between staff, with individuals identifying those that appeared to require support and helping them accordingly. We were also told of the reflective sessions during meetings and how to share best practice between staff and wards. Both the service manager and the deputy ward managers said that their door was always open for staff to discuss anything.

The following areas for improvement were identified:

We were provided with evidence relating to mandatory training, which showed the compliance with the majority of mandatory training was over 80%. However, the online All Wales COVID-19 Workforce Risk Assessment compliance, on the evidence provided, was nil, we were told that this has now risen to 70% compliance. Other compliance rates for face to face training were low, for example Fire Safety Level 2 (5%), Resuscitation Level 2 (59%), Level 3 (44%) and information governance under 50%. The All Wales COVID-19 Workforce Risk Assessment Tool aimed to identify vulnerable and at risk staff who needed to be redeployed from front line patient facing roles. The health board must ensure that all staff have completed training in all mandatory subjects.

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 saw evidence of various risk assessments that had been carried out including, ligature point risk assessments and fire risk assessments. The manager described the process of the daily checks of the environment, the monthly assurance checklist used by the service manager and the annual points of ligature audits, due by the end of month. The manager also described specific adaptations that had been made on the ward, such as special shower heads, rails and anti-ligature beds.

The service manager described how patients' rights were safeguarded through a number of methods. These included patient advocacy that continued throughout the pandemic, through virtual means, and patients continued to have access to the consultant psychiatrist.. Mental Health Act[1] 1983 reviews had continued, including the reviewing of patients on any sections of the act, by virtual methods. There was a clinical advisory group, where patient care was reviewed as a multi-disciplinary team (MDT) and the ward manager had recommenced reviewing delayed transfers of care[2]. Individual patient care was discussed daily in board meetings with the MDT on the ward. There were weekly virtual reviews with the MDT, Community Psychiatric Nurse, advocates, OTs, families and patients.

We were told that when patients were admitted to the ward they were placed on 15 minute observations, unless the level of risk was increased and one to one support was considered. Over a period of time the patient risk level was assessed and level of observations reviewed, generally reducing to 30 minute observations to hourly observations. Every patient’s level of observations was reviewed on a shift by shift basis. Patient acuity fluctuated with no predictable pattern, due to this, the staffing levels and requirements were reviewed on a daily basis in order to support the team in providing safe and efficient care.

We were provided with evidence of the health board results of clinical practice in relation

[1] The Mental Health Act (MHA) 1983 is the law in England and Wales which was updated in 2007. It tells people with mental health problems what their rights are regarding; assessment and treatment in hospital; treatment in the community; and pathways into hospital, which can be civil or criminal. Many people who receive inpatient treatment on psychiatric wards have agreed to go into hospital as informal patients (also known as voluntary patients). However, over half are in hospital without their agreement as formal patients. This is because they have been detained under the Mental Health Act (often called being sectioned).
[2] A delayed transfer of care (DToC) occurs when a person is ready for discharge from acute or non-acute care (including mental health) but is still occupying a bed designated for such care.

to restrictive physical interventions[3] in mental health settings for the six months up to 30 June 2020. This showed that there had only been one incident of a restraint being used on the ward in this period. This also showed that the ward had worked with the team involved in reducing restrictive practice to facilitate training in a new format for their staff team. The service manager stated that the incidents were not directly linked to changes in ward routines as a result of COVID-19, but were reflective of the general care needs of the patient group. The limitations with Datix, the system used to record incidents, were also described. The above report also reflected that the health board were reviewing the reporting in Datix to ensure it "enabled the capture of the pertinent data required to report progress outcomes".

The following areas for improvement were identified:

We were provided with evidence of the last ligature risk assessment dated January 2019, this included a number of areas that required remedial work to reduce the ligature risks. We were told that a further ligature risk assessment was due to be completed by the end of October 2020, which is a gap of 21 months. Additionally, we were told that some issues were still outstanding, such as windows had not been changed, that involved a large capital cost. However, the highest risks had been prioritised, identified and completed. A number of the actions sat with the estates department, who completed the assessments alongside the ward staff. We were told that patients at a high risk of self-harm were risk assessed with increased observations and they were nursed in the two identified anti-ligature rooms on the ward. The above actions were not documented on the risk assessment provided.

The health board must ensure that these risk assessments are completed annually, the risk assessment is updated with the actions taken and the responsibility for completing these actions, on a regular basis. The mitigation taken should continue to be documented in the patient notes.

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 provided with the policies and procedures in place for the prevention and control of infection. These included both the standard IPC precautions and the further guidance issued relating to COVID-19. These were reviewed and updated regularly and we were told

[3] The purpose of restrictive physical intervention is firstly to take immediate control of a serious, significant or dangerous situation and secondly to contain or limit the person's freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around.

that staff were informed of any updates.

We saw evidence of the regular audits undertaken to assess and manage the risk of infection. The most recent quarterly infection control by the infection prevention team was completed in August 2020, the report was mainly positive. The audit included checks of the environment, nursing cleaning schedules, hand-hygiene and equipment cleanliness. We also saw the action plan that had been completed and closed by the ward, for the two issues noted.

The systems in place to ensure that all staff were aware of and discharged their responsibilities for preventing and controlling infection were described. These included the ward induction with new members of staff, which would highlight safety aspects and PPE donning and doffing training. This was reflected in the fact that current infection rates for Clostridium Difficile[4] and Norovirus[5] were nil.

We were told of the process to inform patients about the importance of good hygiene, with patients being encouraged to wash their hands, particularly before food. Additionally, patients were provided with alcohol wipes before and after food. Patients did not have access to hand gel, other than when the gel was provided by a member of staff who supervised the use by the patient.

No areas for improvement 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:

The service manager stated that the ward establishment had been increased by one qualified member of staff per shift, during the pandemic. The staff roster was agreed monthly, in advance, and was reviewed daily prior to each shift. Any deficiencies were filled with bank staff normally, or through ward staff extending their shift. The service manager also referred to additional staff being recruited recently, including through short terms contracts. The

[4] Clostridium difficile, also known C. diff, is bacteria that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics.
[5] Norovirus, also called the "winter vomiting bug", is a stomach bug that causes vomiting and diarrhoea. It can be very unpleasant, but usually goes away in about 2 days.

deputy ward managers were supernumerary staff, who also assisted on the ward on a regular basis.

We saw evidence that the ward currently had two registered mental nurse vacancies and one on long term sick leave. Additionally, there was one unqualified vacancy and one long term absence. The service manager stated that the vacancies were being advertised, and they had established links with Swansea University for student placements as well as recruitment fairs. The ward were hoping to recruit two student nurses, qualifying currently, and they stated that the health board were proactive in trying to fill the vacant posts. As a result of the steps taken by the service, this area has not been identified as a formal area for improvement, but the health board is advised to be vigilant of this matter.

We were told that training days, which were put on hold previously, had now started to return, but with limited numbers. The service manager stated that a number of staff had a speciality in certain areas of nursing care and had given training sessions on these subjects, as time allowed. Staff had also been encouraged to take short term secondments in other similar wards and hospitals throughout the health board, to share learning and to bring any best practice back to the ward.

We were told that there was regular supervision from line management, including daily conversations. The service manager also attended the ward at least one day per week. A ward manager from another ward also mentored the deputy ward managers. The deputies also regularly supervised the nursing staff both formally and informally, with an open door policy in place. The service manager was also very complimentary about the ward staff and the work that they had accomplished during the pandemic.

The evidence provided for performance appraisal and development reviews[6] showed a 100% compliance. This showed the commitment by management to staff in reviewing and setting objectives and in ensuring that staff and professional development was enhanced.

We were provided with in date copies of the escalation policies for staffing shortfalls. This policy supported the calculation and maintenance of nursing staffing levels in adult acute services, and the actions that were taken to review, report and escalate, where nurse staffing levels were not maintained.

The daily handover was used to disseminate information to ward staff, as well as all staff emails and the regular ward meetings. We were provided with a sample of the minutes of the ward meetings that confirmed this passage of information. The minutes included thanking staff for adapting their ways of working and personal lives to accommodate the changes that were made and continued to be in effect at present. Additionally, we saw minutes of the monthly ward managers' forum, where reports were discussed, in addition to falls reporting, Datix issues, medication management and Mental Health Act administration and compliance.

[6] Undertaken to ensure that staff development was enhanced and opportunities created in relation to professional development, leadership and clinical skills.

No areas for improvement 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: Prince Philip Hospital

Ward Bryngolau Ward

Date of activity: 6 October 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 last ligature risk assessment was dated January 2019 and included a number of areas that required remedial work to reduce the ligature risks. We were told that some issues were still outstanding such as windows had not been changed, that involved a large capital cost. Actions taken as a result of the assessment were not documented on the risk assessment	Standard 2.1 - Managing Risk and Promoting Health and Safety	The Ward Manager Forum will become the owning group responsible for the management of the annual ligature risk assessment cycle across all inpatient services within the MH/LD Directorate. Bryngolau ligature risk assessment will be undertaken jointly with clinical staff and estates staff. Following completion of the risk	Chairs of the Ward Manager Forum Service Manager Service	22nd October 2020 30th November 2020 14th

	provided. The health board must ensure that these risk assessments are completed annually, the risk assessment is updated with the actions taken and the responsibility for completing these actions, on a regular basis.		assessment a joint action plan will be developed with estates, captured within the agreed template which identifies leads for each action. Progress against actions will be reported to MH/LD Quality Safety Assurance Improvement Group via the ward manager forum report.	Manager / Estates Lead. Chairs of the Ward Manager Forum	December 2020 31st January 2021
2	Compliance was low for the online training called the All Wales COVID-19 Workforce Risk Assessment compliance and the face to face training relating to Fire Safety Level 2, Resuscitation Level 2 and Level 3, and information governance. The health board must ensure that all staff have completed training in all mandatory subjects.	Standard 7.1 – Workforce	Training compliance to be scrutinised and a position statement completed. Where there is poor compliance identified, improvement plan will be produced. Compliance against the improvement plan will be monitored and scrutinised via the Older Adult Mental Health Dashboard Meeting which reports to the MH/LD Business Planning and Performance Group.	Ward Manager Ward Manager Service Manager	31st October 2020 14th November 2020 31st December 2020

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: Sara Rees - Interim Head of Nursing, Mental Health & Learning Disabilities

Date: 22 October 2020