Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Bryn Y Neuadd Hospital – Carreg Fawr Unit

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Carreg Fawr Unit within Bryn Y Neuadd Hospital, as part of its programme of assurance work. Carreg Fawr is an eight bedded Mental Health Rehabilitation Unit, part of Betsi Cadwaladr University Health Board.

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 ward manager on 29 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:

A unit specific COVID-19 plan was developed setting out the main challenges and action taken by the service, to support staff to maintain a safe environment for themselves and the patients during the pandemic.

The ward manager confirmed that the unit has a good supply of PPE equipment available and local stock is available on the main hospital site. Additionally, a daily stock check for the unit is completed by the ward manager, to monitor the available equipment.

To allow staff to safely put on the required PPE equipment, the ward manager told us that a 'don and doffing' room has been set up within the unit. Additionally a designated PPE station has been set up at the main entrance. On entering the unit, we were informed that staff must immediately put on a surgical face mask and proceed directly to the staff room to change in to clean uniform prior to entering the ward area.

We were informed that all staff have received training in regards to PPE and there are also posters displayed in relevant areas of the unit. At the entrance to the unit there is also a visitors sign-in book which is can be used as part of 'Track and Trace' if necessary.

The ward manager confirmed that daily safety huddles are held to ensure staff are routinely kept up to date with the relevant guidance and to discuss required changes to care provision. Daily update discussions are also held with patients to ensure that they are provided with relevant information relating to the latest guidance and restrictions. These discussions provide staff and patients with the opportunity to raise any queries, concerns and suggestions with the arrangements in place.

No improvements 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 the care and treatment according to their needs.

The following positive evidence was received:

The ward manager outlined some of the changes that have been implemented on the unit due to the onset of COVID-19. These changes have included the reorganisation of some of the key areas of the unit, including the room used for patient ward round meetings and the area of the unit used for patients to eat their meals. The reorganisation of these rooms has meant that there is more space available, which has allowed for social distancing between individuals.

A social distancing risk assessment and a unit specific COVID-19 management plan has been developed. Within the plan it details that corridor traffic in the unit should be reduced as much as possible for staff and patients. Impromptu corridor conversations must cease, to mitigate the risk of the spread of infection.

The Covid-19 management plan details that any access to the unit, including from clinical staff, must be prearranged. Visitors must wear face masks, available on the PPE station at the main entrance, and also sign in on entry. Access to the unit is controlled by a latch on the inside of the main entrance door. This prevents any unscheduled individuals entering the unit.

The ward manager confirmed that initially all visits were suspended following the introduction of the lockdown in March. Patients were able to maintain contact with friends and family either via phone or virtually, using equipment within the unit. Patient visits have subsequently been reintroduced under restrictions. A room within the unit is available for prearranged patient visits to take place. We were informed that prior to any visit which take place, a risk assessment must be completed. Also, face masks must be worn and the room is cleaned following each visit.

Additionally, we were informed a seating area in the unit garden was utilised over the summer period to allow visits to take place. The ward manager confirmed that this was the preferred patient choice for visits. We were told that health board approval has been granted for a gazebo to be installed in garden to allow for these visits to continue regardless of the weather, which will mean that visits can still take place without individuals having to enter the unit.

Patient leave from the unit was also suspended in the initial lockdown. The ward manager

confirmed that during this initial period, patients were able to have escorted walks around the main hospital grounds for fresh air. We were informed that escorted and unescorted leave arrangements have now been reintroduced for patients following relevant risk assessments.

The ward manager explained that a new Occupational Therapist (OT) had recently started working on the unit and that activities available to patients has improved. However, given the restrictions in place, activities were mainly ward based aimed at helping patients develop relevant skills as part of the rehabilitation, for example cooking sessions. We were informed that some outdoor activities were available to patients, which have included walking groups.

Evidence provided by the service outlined that every patient on the unit has an individualised rehabilitation programme, based on the specific needs. We were informed by the ward manager that patients are routinely monitored by staff and efforts have been made to ensure that patients are kept up to date with the latest guidance and restrictions in place throughout the pandemic period. The ward manager confirmed daily discussions take place with patients, which also allow them to raise any concerns or queries around the arrangements in place.

The ward manager informed us that one of the main challenges for staff throughout the pandemic period has been the effect that the restrictions has had on patient motivation. We were informed that plans are in place to provide staff with training in this area in the near future. It is hoped that this training, as well as the additional input from the unit OT, will enable the service to improve the patient motivational issues, to help patients progress in their future care pathways by better engaging in their rehabilitation programmes.

Incident data provided details that in the last three months there were six incidents relating to patient abusive / disruptive behaviour. The ward manager outlined the incident reporting process which will involve the relevant staff member completing and submitting an incident report via Datix. A copy of this report is subsequently sent to the ward manager and any other relevant senior managers. It is then the ward manager's responsibility to investigate and ensure an action plan is agreed and implemented.

The ward manager confirmed that ligature checklists for the unit are in place which are reviewed every week. There is also a ligature risk assessment available.

No improvements 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:

As previously detailed, we saw evidence of a unit specific COVID-19 management plan which has been developed. The purpose of this document is to support staff in maintaining a safe environment for themselves and the patient group during the pandemic. A COVID-19 risk assessment was also provided, which documented what the service deemed to be the key risks and existing control measures in place on the unit.

The ward manager informed us that throughout the pandemic there have been regular health board updates provided to all staff via email in relation to guidance and required changes to service provision. We were informed that daily safety huddle discussions take place with staff to ensure they are aware of the changes, and to provide them with the opportunity to raise any queries or suggestions.

The ward manager confirmed that daily discussions also take place with patients in regards to the guidance to restrictions in place. Additionally we were informed that relevant infection prevention and control posters were displayed throughout the unit to remind individuals of the importance of following the guidance in place, for example with regards to hand washing. We were informed that three new wall hand sanitisers had also been installed within the unit, to allow staff and patients to regularly clean their hands.

Evidence provided confirmed that all patients have an individual risk assessment agreed by the Multi-Disciplinary Team (MDT) which is aligned to their understanding of COVID-19 and the associated risks and required restrictions.

All staff were required to complete mandatory infection prevention and control training as part of their roles. Evidence provided by the service detailed that at the time of our review staff compliance levels for this training was 87 percent. Also, the ward manager told us that all staff were required to complete a specific COVID-19 e-learning module.

We were informed that a system was in place to respond should any patient develop COVID-19 symptoms. There are two en-suite bedrooms available on the unit which have been designated as ‘Red’ rooms. These rooms are to be used to treat any symptomatic or positive patients as and when required. The ward manager confirmed that this arrangement aims to ensure that the relevant patient can be treated in isolation. Staff only enter the bedroom for essential reasons, such medications and meals, wearing the required PPE equipment.

Evidence provided by the service detailed that a unit specific cleaning schedule has been

developed, in conjunction with domestic staff, to ensure that the areas of the ward which experience 'heavy traffic' are appropriately cleaned on a daily basis. Additionally, we were informed that arrangements were in place to ensure that on the occasions one of the 'Red' bedrooms was used to treat a symptomatic patient, the room would require a deep clean before the bedroom can be used again.

The following areas for improvement were identified:

On review of the evidence submitted by the service, it was highlighted that the review dates of three health board policies, relating to infection prevention and control, had elapsed by significant periods. During discussion with the ward manager, no additional information was available in relation to the status of the policy reviews. As a result, following on from the discussion with the ward manager, HIW requested additional assurance from the health board in regards to the issues identified. Subsequently, the health board confirmed that the content contained in the policy documents was fit for purpose and supports the national guidance in relation to the COVID-19 pandemic. The initial health board response also confirmed that the policies in question have been reviewed and are pending approval at the Infection Prevention Sub Group scheduled for 13 October 2020. An additional update from the health board on the status of these policies can be found in the improvement plan response on page 11.

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:

Evidence provided outlined that arrangements were in place to routinely monitor staffing levels, to ensure that there are appropriate numbers to deal with the current risks and the required patient observation levels on the unit. The ward manager confirmed that he felt that staffing levels on the ward were sufficient and safe. We were also informed that contingency plans were in place to respond to any staffing shortfalls which occur on the unit. We were told that previously staffing levels had been affected due to five members of staff needing to shield. During this period the unit was able to borrow staff from other wards and also had access to bank staff to ensure there were adequate staffing levels.

The ward manager confirmed that weekly MDT ward round meetings have continued throughout the pandemic period, with each patient being reviewed every other week. We

were informed that consultant input has not been affected throughout the pandemic and additional to the input provided as part of the MDT meetings, we were told that ad-hoc clinical advice is available where required.

Evidence provided detailed that during the pandemic a service review of the health board rehabilitation model took place. This subsequently resulted in the availability of more psychological input to support both staff and patients on the unit. As a result the unit now has a full MDT consisting of Mental Health Nurses, Healthcare Support Workers, an Occupational Therapist, Psychologist, Consultant Psychiatrist and Community Mental Health Nurses. As part of the MDT discussions, patient rehabilitation programmes are regularly reviewed, as patient leave has been now been reintroduced.

We were informed that that the frequency of Mental Health Review Tribunals has not been affected during the pandemic. However, meetings now take place via telephone conference. Additionally, we were informed that patients on the unit have been able to access advocacy support and to speak to their solicitors as and when required. However, contact is again is by phone.

Staff mandatory training compliance data was provided which detailed that the overall compliance level was 94 percent. The ward manager felt that training available to staff was good. However, as previously outlined, given the issues experienced in relation to patient motivation, as a result of the restrictions, we were informed that staff training in this area is a priority for the service.

Evidence provided outlined that staff were still able to access additional support where required, via the health board employee assistance support structures, which included Occupational Health. We were informed available support services and contact information is regularly circulated to staff. Additionally, as previously mentioned staff on the unit were also now able to access psychological support, which could be accessed either through their line manager or by contacting the Psychologist directly.

The following areas for improvement were identified:

The health board Mental Health Bed Escalation policy was submitted by the service as evidence. Following review of this document it was highlighted that the scheduled review date was January 2020. In light of the concerns already highlighted around missed policy reviews dates, we will be recommending that the health board should undertake a review of the governance arrangements in place, to ensure that policies are consistently being reviewed and updated, as and when scheduled.

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.

Improvement plan

Setting: Carreg Fawr Unit - Bryn Y Neuadd Hospital

Date of activity: 29 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 should review the governance arrangements in place to ensure policies are consistently being reviewed and updated when required.	Health and Care Standards Standard 3.4 – Information Governance and Communications Technology	The MHLD Division Policy Group terms of reference were agreed on the 27.08.2020. It meets on a monthly basis. All documents which are nearing the review date are highlighted in advance to ensure allocation of a professional to review, and monthly updates are required as to process and any obstacles which may need escalation. Policies are also considered in relation to risk and the effect of removal from the intranet and circulation if they have not been reviewed and updated prior to the review date. During March to September 2020 the Policy Group was stood down due to Covid 19; since resuming documents are now being	Hilary Owen / Francine Moore	Complete

			tracked and reviewed with a monthly report produced for the MHLD Leadership Team Quality, Safety and Experience Meeting. A new corporate task and finish group will be established to take forward a review the current "policy on policies," develop a plan for a new policy tracking IT system and ensure plans are in place for professional each area to maintain current policies.	Matthew Joyes/Bethan Wassell	30/11/2020
2	The health board should ensure that the four policies highlighted as requiring review, are reviewed and updated as soon as possible.	Health and Care Standards Standard 3.4 – Information Governance and Communications Technology	The MHLD 0045 Bed Escalation Policy has been reviewed and this has been sent for consultation until the 12 November 2020 to then be presented at the MHLD Policy Group meeting on the 17 of December 2020 for Ratification. The IPC policies are currently being reviewed with additional resource secured to complete this, and will be approved by the IPC Group.	Wendy Lappin / Paul Hanna Amanda Miskell	17/12/2020 30/11/2020

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: Matthew Joyes – Acting Associate Director of Quality Assurance

Date: 27/10/2020