Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Brynheulog Ward, Newtown Hospital

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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

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Brynheulog Ward, Newtown Hospital as part of its programme of assurance work. Brynheulog ward was a 14 bed stroke rehabilitation ward. The ward was described as the stroke rehabilitation ward for North Powys and patients were transferred there from a wide range of district general hospitals. Medical cover was provided through a shared agreement between two local GP practices.

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 Senior Sister on 15 October 2020 who provided us with information and evidence about their setting, the Community Services Manager for Mid Powys was also in attendance. 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:

A number of changes to the ward environment were described, these included ensuring the distance between beds allowed for safe social distancing. Regular huddles were introduced to inform staff of changes to COVID-19 guidance. Additionally, all changes were recorded on a wipe board in the staff room. We were told that if there were any suspected cases of COVID-19, the ward would become a red zone, with full PPE and visors worn, until the result of the test was received. Additionally, management would be informed and any planned visits would be cancelled.

Staff encouraged families and patients to maintain contact with each other, through using computer to computer calls, smart phones and the portable telephone. Patients and families booked slots to use the equipment. If the patient was considered to be end of life, families were allowed to visit in a side ward. The process that the families followed was described, to maintain staff, patient and family safety. Families were also involved, by virtual means, as well as patients, in the multi-disciplinary team discussions of the patient care plans.

We were provided with evidence of a number of policies and procedures specific to COVID-19, including Infection, Prevention and Control (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. There were very few aerosol generating procedures in the ward, apart from cardiopulmonary resuscitation[1]. The fit tested masks were kept next to the resuscitation trolley, with staff names clearly marked, for ease of use during an emergency. There were also posters on the wall, which were regularly changed when updated, with advice on PPE. In line with guidance, community admissions to the ward were tested for COVID-19 on admission.

We were told that there had been an outbreak of COVID-19 on the ward, in May 2020, at the height of the pandemic, when several members of staff and patients had contracted COVID-19. We saw the evidence on how the outbreak was managed, documented and the actions taken, both within the ward and throughout the hospital. This included deep cleaning of the ward, and additional training for staff, including how to deal with staff, patient and relatives anxiety. This evidence also described a root cause analysis, which included the potential causes for the outbreak. There were no healthcare acquired infections at the time of the quality check.

Additionally, we were told that whilst staff had access to online training, face to face training sessions had been limited during the pandemic. Where training could be completed by electronic learning, training time had been allocated to staff. We saw evidence that the majority of mandatory training was over 80 percent. However, the face to face training, such as resuscitation and fire safety was under 75 percent. We were told that there had been issues with basic life support training, which had been escalated to the training department.

[1] A medical procedure involving repeated cycles of compression of the chest and artificial respiration, performed to maintain blood circulation and oxygenation in a person who has suffered cardiac arrest.

The fire safety training had been arranged for late October. 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 saw evidence of the COVID 19 awareness update, which included the current guidance and summary of principles. Additionally, we were provided with a copy of the COVID-19 Prevention and Response Plan. This was a joint plan with Powys County Council and led by the Chief Executives of the organisations and the Director of Public Health and Public Protection.

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 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 were told that the ward had a multi-disciplinary focus with weekly goal setting meetings and weekly multi-disciplinary team meetings. Due to the nature of strokes, patients had varying levels of cognitive impairment. The length of stay of the patients could be considered higher than normal due to the need for complex discharge planning and varying degrees of discharge care destinations.

Patient dignity was maintained at all times through a number of methods, which included drawing curtains, when necessary, with do not enter signs on the curtains. We were told that this was part of the ward ethos. The ward team also believed they needed to be aware of respecting the patients and ensuring confidentiality, as the staff, as well as the patients, were all members of the local community. "This is Me"[2] documents were used for dementia patients and stroke patients with cognitive problems to aid respect and dignity. The Butterfly[3] scheme was also used where appropriate and this was identified via a magnetic symbol on the patient flow board. A number of other methods to maintain patient dignity were also described such as encouraging staff training on dignified care and in ensuring appropriate care planning for patients who are unable to maintain their own dignity.

[2] 'This is me' is a leaflet produced by the Alzheimer's Society to help hospital staff better understand the needs of people with dementia. The leaflet provides professionals with information about a person with dementia to help enhance the care and support they receive whilst in an unfamiliar environment.
[3] The Butterfly Scheme provides a system of hospital care for people living with dementia or who simply find that their memory isn't as reliable as it used to be.

The process used to investigate instances of patient falls and pressure damage was described. This included using alarm mats, where patients regularly stepped out of bed and were at risk of falling. The ward used the All Wales Multifactorial Assessment, a falls prevention tool, to ensure patients were being supported with their basic fall prevention needs.

When patients were admitted, we were told that their skin was checked, the patient was given the appropriate mattress and they were put on skin bundles, as necessary. The patient was then checked on a regular basis, depending on the risk. The patient was also given a leaflet to raise awareness of the need to keep moving. Staff received additional training on pressure area management from the tissue viability team. Where there had been instances of pressure damage, the causes were investigated and the care plan updated. Photographs of the pressure damage were also sent to the tissue viability team, for them to view the damage remotely and comment as necessary.

We saw evidence of the Quality Checks in Health Care, this tool was used to undertake observational quality checks on those receiving healthcare in any care setting within Wales. This then provided evidence of ongoing and continuous improvement at the point of care, quality assurance, demonstrated good practice and innovative solutions. We also saw the action plan that listed how the findings would be achieved and to gain ongoing assurance this was implemented.

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:

We saw evidence of good hand hygiene and bare below the elbow audit scores. We also saw evidence of the planned review that was undertaken by the senior nurse for IPC. The purpose of the visit was to review current practice, discuss measures where the ward areas could be zoned and to provide clear guidance of the PPE that was required in each area. The visit also provided staff with an opportunity to ask questions on any concerns that they had in relation to infection control measures. The walk around identified zones in line with infection prevention guidance. Due to the geography of the ward it was not possible to segregate red and amber zones, each room was identified using zoning posters and staff were aware of infection control guidance.

We were told that the majority of staff had completed aseptic non touch technique (ANTT)[4] training. The ward adopted the ANTT principles and link nurses assessed team compliance in practical learning sessions. Knowledge was evidenced through written and practical assessments. We were told of the IPC policy which gave advice and guidance on all aspects of IPC and a lead nurse to support and ensure compliance. The link nurse for infection control met regularly with the ward team and cascaded relevant updates and learning back to their areas. Two registered nurses led on this on the ward, with the support of the ward sister. Additionally, the ward sister had also completed the ANTT assessor training.

No improvements 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 of the process undertaken by the ward to ensure that staffing levels maintained the safety and effective care of the patients. The process started eight weeks in advance of the shift and had various checkpoints that required approval and agreement, to ensure there were sufficient staff working on the ward. The senior sister stressed the importance of knowing the staff and who was available. There had not been any instances where minimum staffing levels, as required by the Nurse Staffing Levels (Wales) Act 2016[5], had not been met. Staff were aware of the need to report on DATIX, the system used to record incidents, when the required levels were breached. There was a 'Know how we are doing board' located on the ward that included information on agreed and actual staffing numbers per shift.

We were provided with evidence that showed that the ward was up to establishment with qualified staff.

The self-assessment provided, stated that there was visible leadership on the ward assuring appropriate staff were in place. There was an open and honest culture and staff would escalate any issues that arose. We were told that leading by example was important, as was knowing your staff as individuals, as well as employees. They would then feel they could approach

[4] ANTT is a method used to prevent contamination of wounds and other susceptible sites by ensuring that only sterile objects and fluids come into the contact with these sites and that the risk of contamination is minimised.
[5] https://www.legislation.gov.uk/anaw/2016/5/enacted

management with any problems or issues. Ward meetings were held regularly and staff who were on sickness absence were contacted, by the ward, regularly by telephone or by virtual methods, in addition to human resource contact.

The evidence provided showed that there was only 53 percent compliance with the performance appraisal and development reviews (PADR)[6]. We were also provided with evidence of the plan in place to ensure full compliance by the end of November 2020. HIW would expect these to be completed as agreed and would see ensuring compliance with completion rates for future PADR's to be a priority for the health board.

We were also told that staff received a 90-day review to monitor development of staff and to promote good knowledge-based care. Any areas highlighted for development were actioned and a plan made to source education.

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.

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

Improvement plan

Setting: Newtown Hospital

Ward: Brynheulog Ward

Date of activity: 15 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	No Improvements identified.				

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: Lesley Sanders Community Services Manager

Date: 26th October 2020