Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Bryngofal ward, Prince Phillip Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Bryngofal ward, Prince Phillip 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 ward manager (interim) on 26 October 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:

We were told that a number of changes had been made to the ward environment as a result of the pandemic. The ward had reduced their bed numbers from 18 to 16 to ensure that red zones are available for symptomatic and COVID-19 patients. Social distancing measures have been put in place, which included rearranging the dining areas so more space is available between tables and patients. A Perspex screen has been fitted to the kitchen's serving area to protect patients and staff when serving meals. Patients have their own en-suite bedrooms and these are to be used whilst the communal toilets are temporarily closed.

Advice and guidance has been received from the infection control team to ensure best practice and additional cleaning schedules have been put in place. PPE is available throughout the ward for staff, patients and visitors. The use of information technology (IT) for virtual meetings have enabled communications to continually take place. In addition, staff meetings/hand overs have been relocated to a bigger room. This allows social distancing to be maintained.

We were told that visiting arrangements have been changed in line with government and health board guidelines. Whilst visitors were not permitted to the ward, preparations, where applicable, were made for visits off the ward which would support social distancing measures. Changes to visiting times and patient leave is being monitored in multi-disciplinary team meetings to ensure risk and patient capacity/understanding is being checked.

Due to the restrictions in place, alternative means of communication are being utilised for patients to maintain contact with their family and friends. Ward iPads and patients' own devices are utilised. We were told patients can be assisted and supported to face-time and send e-mails. In addition, patients can have access to the ward telephone.

We were told that patient routines were being maintained as normally as possible. To help combat boredom due to COVID-19 restrictions, additional ward based activities were offered. Patient meetings continued to take place and staff provided up to date guidance regarding COVID-19. The ward manager expressed his gratitude of the staff and their achievements during the pandemic to keep patients active.

We were provided with evidence of a number of policies and procedures relating to COVID-19 which were specific to the mental health directorate. We were told that there were sufficient supplies of PPE for staff, patients and visitors. Staff had received training on the correct donning and doffing of PPE and fit testing of masks.

We were told that the ward did not have any positive COVID-19 patients, or any other healthcare acquired infections at the time of our call. We were told of the systems in place to ensure the prompt identification of patients who were at risk of developing COVID-19, or other infections.

The self-assessment submitted, 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. In addition to the existing staff well-being services, we were told staff had access to psychological support and increased supervisions, free counselling services and peer support.

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 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 changes had been made to the environment as a result of COVID-19. PPE and hand sanitizers have been made available. Cleaning schedules have been amended to enable more frequent cleaning of all patient and staff areas.

We saw evidence of various risk assessments that had been carried out including, ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of the weekly ward manager checks, completed in September 2020. A review of this document highlighted some outstanding actions, which are documented below. We were told that the alarms had been fixed so they now have full coverage throughout the ward and that additional alarms had been purchased to ensure sufficient numbers/contingency for the ward.

We were told that the clinical treatment and intervention for patients has mainly stayed the same during the pandemic. Multi-disciplinary team meetings, involving external professionals, have continued with all reviews scheduled under the Mental Health Act 1983, conducted within prescribed timeframes. Face to face meetings were suspended at the outset of the pandemic, with telephone and video calls used to ensure patients continue to have access to external professional services, including advocacy. Some face to face visits have recently resumed with adherence to social distancing guidelines.

We were reassured from discussions with the ward manager that any staff diagnosed with COVID-19 would be managed appropriately.

The following areas for improvement were identified:

The weekly ward manager check document submitted had some outstanding issues that need to be resolved. We were told that the broken fire door has not yet been replaced, but has been ordered. This action needs to be completed as a matter of urgency to ensure the health and safety of the ward against the risk of fire. Also, we were told of some other long standing issues that need to be addressed and prioritised for the ward.

We saw evidence of incident data and recognise that Bryngofal has some of the highest incident numbers within the health board. This is documented in the self-assessment form as well as in the quarterly report for the clinical practice in relation to restrictive physical interventions in mental health services. Whilst it is agreed that an acute ward, such as Bryngofal might expect the most acutely unwell individuals, the data provided in the self-assessment requires more details/analysis of these incidents.

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, which included their Covid-19 Infection Prevention and Control Guidance.

We were provided with a number of audits that are undertaken to assess and manage the risk of infection. An infection, prevention and control (IPC) audit completed in August 2020 showed 91 percent compliance. The areas covered in this audit included checks of hand-hygiene and equipment cleanliness. We asked if the actions identified in the credits for cleaning (C4C) audit had been completed and we were told not all had. This document needs to be reviewed and any actions outstanding completed.

We were told staff have increased cleaning throughout the hospital for all patient and staff areas alongside the implementation of PPE stations upon entering the ward. Hand washing facilities are available for patients and staff throughout the ward.

We were told of the systems and procedures in place to identify any staff or patient who may be at risk of developing COVID-19. This was evidenced in the COVID-19 inpatient pathway policy, which included flowcharts and action tables. We were told risk assessments have been completed for all staff. Depending on the outcome of the assessment, the organisation will determine if the staff member needs to be removed from patient areas or self isolate.

We were told of the systems in place to ensure all staff were aware of and discharged their responsibilities for preventing and controlling infection. This was evidenced by the

compliance data submitted for infection, prevention and control training. In addition, PPE donning and doffing training and FFP3[1] mask training had been delivered for staff. As a result of these measures the current infection rates for Clostridium Difficile[2] and Norovirus[3] were nil.

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:

We were provided with staffing numbers that we were told are considered sufficient to maintain patient care and safety on the ward. We were told that patient acuity can fluctuate with no predictable pattern. As a result of this the staffing levels and requirements are reviewed on a daily basis in order to support the team in providing safe and efficient care. During working hours the ward manager will ensure that there are safe staffing levels. Out of hours the nurse in charge has access to the out of hours clinical coordinator to escalate staffing issues.

We were told that bank staff are being used to cover sickness, vacancies, patient acuity and to cover for medical exemption due to COVID-19 reasons. In March 2020, the section 136 suite was centralised in Bryngofal for the whole health board. As a result of this, staffing numbers were increased per shift and this was sourced via bank staff.

The data provided showed the ward had two registered mental health nurses and one healthcare support worker vacancies and two staff on long term sick leave. The vacancies were being recruited into and this will ensure the ward has a full establishment of staff.

We were provided with compliance data for staff mandatory training. Whilst there were a number of areas showing a high rate of compliance (75 percent overall compliance), there

[1] A FFP3 mask is worn when carrying out potentially infectious aerosol generating procedures
[2] Clostridium difficile, also known C. diff, is bacteria that can infect the bowel and cause diarrhea. The infection most commonly affects people who have recently been treated with antibiotics.
[3] Norovirus, also called the "winter vomiting bug", is a stomach bug that causes vomiting and diarrhea. It can be very unpleasant, but usually goes away in about 2 days.

were issues identified which need to be reviewed. These are listed below in the Improvements Identified section. We were told that staff had access to computers to complete online training and that the ward manager encourages his staff to complete their training when they experience quiet periods on the ward.

We were told that there was adequate support in place for staff. Data provided showed a high compliance rate with staff appraisals. The ward manager told us that in addition to the daily handovers, staff meetings had been conducted to ensure staff had up to date information. In addition to the employee assistance scheme, the psychology team were offering support to any member of staff who may be experiencing anxiety or similar as a result of COVID-19. The ward manager conducts monthly supervisions with all staff and has an open door policy in place.

The ward manager was also very complimentary about the staff and the work that they had accomplished during the pandemic.

We did not receive a copy of the escalation policy, but did receive the complaints procedure, Putting Things Right. The ward manager did tell us that immediate risk would be escalated to the appropriate person/s directly. Regular meetings which involve senior staff members take place regularly and provide platforms for discussing issues.

We were told that Mental Health Act reviews, and other contact with external professionals, to include advocacy, has continued through phone calls and video conferencing.

The following areas for improvement were identified:

We were provided with mandatory training statistics and found that the data did not correspond fully with the discussions had with the ward manager. The main reason we were told for this is due to a lag in the system. Training has been completed by staff but is not quickly recognised by the reporting system. For example, we saw that the COVID workforce risk assessments were listed as 50% complete on the data provided. However, we were told these had been completed for all staff, therefore the data should show 100% compliant.

In addition, we were told that most classroom style training had been postponed due to social distancing and safety measures. The training data provided clearly shows how this has impacted on ensuring staff have up to date skills. The data provided for life support training for levels 1 and 2 are both under 40%. This means that over half of staff on the ward do not have up to date skills and knowledge in this area.

Whilst it is acknowledged that COVID-19 has greatly impacted on delivering face to face training, the health board must review the training information and provide assurance that staff on duty have the necessary skills to provide safe and effective care. In addition, a review of the delay in accurate training data being reported should be undertaken and ways of improving this actioned.

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 Phillip Hospital

Ward: Bryngofal Ward

Date of activity: 26 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 health board must review the weekly ward manager checklist to ensure the fire door is replaced as soon as possible and arrange for the longstanding issues to be fixed	Health & Care Standards – 2.1 managing risk & promoting health and safety	- Review checklist and identify outstanding issues. - Fire door issue to be escalated to Director of Estates. - Any other longstanding issues to be escalated to estates operations manager. - Longstanding issues to be repaired and an action plan to undertake this agreed.	Ward Manager Head of Service Senior Nurse Operations Manager	Completed Completed Completed Completed

2	The health board must review the incident data submitted to HIW and provide more detail/analysis of the incidents	Health & Care Standards – 2.1 managing risk & promoting health and safety	- Review all the data of incidents on Bryngofal from the last quarter. - Identify any themes from the quarterly incident reports. - Undertake analysis of the findings. - Present findings of analysis to the ward managers' forum.	Ward Manager Ward Manager Senior Nurse/ Ward Manager Ward Manager	Completed Completed Completed Completed
3	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	Health & Care Standards – 2.1 managing risk & promoting health and safety	- Ward Manager to review outstanding nursing issues that need to be resolved and rectify these. - Any issues identified for estates to be forwarded to Estates Operation Manager and resolved. - C4C audit to be completed and reviewed by Ward Manager to ensure issues are resolved.	Ward Manager Ward Manager/ Operations Manager Ward Manager/ Domestic Supervisor	Completed Completed Completed
4	The health board must review the training data and provide assurance that staff have up to date skills and knowledge to provide safe and effective care as well as reviewing the training data to ensure the reports provide an accurate and current compliance figure.	Health & Care Standards – 3.4 information governance & communications technology and 7.1 workforce	- Training compliance to be scrutinised and a position statement to be completed. - Where there is poor compliance identified, an improvement plan will be produced.	Ward Manager Ward Manager	Completed Completed

			- Compliance against the improvement plan will be monitored and scrutinised via the ward managers' forum. - Any issues that require escalation, would then be escalated to the Head of Service to take to the Mental Health/Learning Disabilities Business Planning Assurance Group.	Senior Nurse Senior Nurse	Completed Completed

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: Kay Isaacs

Date: 14th January 2021