Quality Check Summary
Aderyn
Activity date: 16 November 2020

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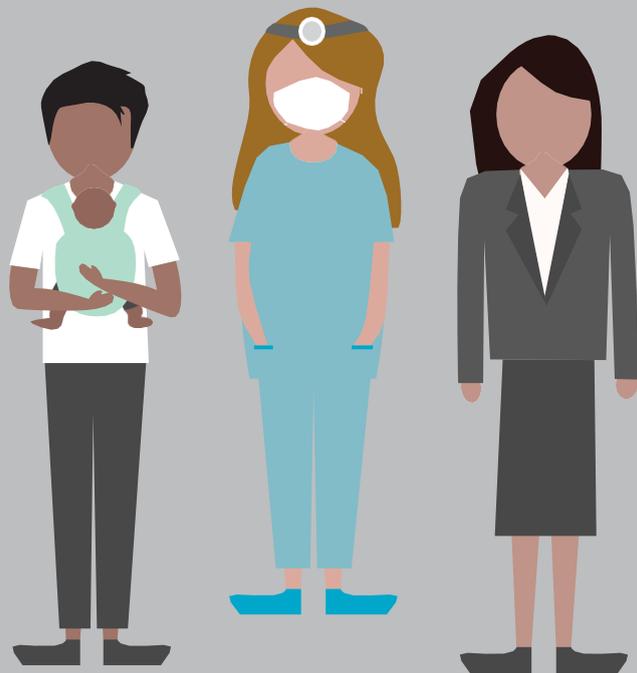
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In writing:

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

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Aderyn 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 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 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 registered manager and ward manager on 16 November 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 no confirmed cases of COVID-19, or any other infectious diseases, have been reported within the staff or patient group.

We were told that training specific to COVID-19 had been delivered to all staff.

We were told that cleaning schedules have been increased and the use of personal protective equipment (PPE) has been optimised with adequate stocks available.

We saw evidence to show that the service has conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands resulting from the pandemic.

We saw evidence to show that infection control audits have been completed on a regular basis.

We were told that patients and staff have been receiving regular COVID-19 updates during daily meetings. Regular communication has ensured everyone has up to date advice and guidance on COVID-19.

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 have been made to the environment as a result of COVID-19. These include the removal of some dining room furniture to help maintain social distancing. Two downstairs bedrooms have been set up where patients could be shielded/isolated should they test positive for COVID-19. Cleaning schedules have been amended to enable more frequent cleaning of all patient and staff areas.

We were told that patients have access to the hospital's extensive grounds to maintain their health and wellbeing. Additional activities were also provided during lockdown to keep patients occupied. An outside area was made available which allowed patients to receive

visitors. To maintain contact with family and friends, patients can use their mobile phones or use a tablet device.

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 and video 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 have been lifted, patients' leave status has been reviewed and amended to reflect the changes. 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.

We saw from the documents submitted and from discussions with the hospital and ward manager that any patient diagnosed with an infectious disease would be managed appropriately.

No areas for improvement 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 were provided with the policies and procedures in place for the prevention and control of infection, which included specific COVID-19 policies and guidance.

We were also provided with a number of audits that are undertaken to assess and manage the risk of infection. The audits had been completed internally by staff as well as an external agency in March 2019. The compliance rate of the recent audits submitted were high, but we did ask the hospital manager to evidence their progress against two recommendations in the historical audit undertaken by the external agency (see areas for improvement below).

We were told that staff have increased cleaning throughout the hospital for all patient and staff areas. We were told the hospital has sufficient PPE for staff and visitors which is regularly audited to ensure adequate stock levels. We were told that there are numerous posters displayed throughout the hospital to encourage regular hand washing and to maintain social distancing.

We were told about the systems and procedures in place to identify any staff or patient who may be at risk of developing COVID-19. We were told risk assessments have been completed for all staff. Each patient has an individual COVID-19 care plan and risk assessment in line with government guidelines.

We were told about 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.

Data submitted showed current infection rates for Clostridium Difficile[2] and Norovirus[3] was recorded as nil.

The following areas for improvement were identified:

The external infection prevention control audit submitted, dated March 2019, highlighted areas that required action. We were told these had been completed, but the document didn't evidence this. Therefore we recommended that the actions taken and the date they were completed are recorded to evidence completion of the recommendations.

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 manager and ward manager highlighted a good understanding of their responsibilities and the hospital's escalation and reporting processes. The hospital manager told us that they are well supported by the wider organisation's senior management team and have good networks with other hospital managers.

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[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.

We were told that no agency staff are used at the hospital. They have a number of regular bank staff that are used to cover staffing shortfalls.

At the time of the call, we were told that one nurse vacancy was being recruited and there had been minimal staff sickness.

We were told that patient dependency levels are assessed regularly and additional staff brought in to cover any increase in demand.

We saw evidence of high compliance rates of mandatory staff training. Staff training is on-going and most modules are completed via the e-learning system. We were told some Aderyn staff were able to provide some face to face training, for example donning and doffing PPE. This ensures that training can be delivered internally without the need for external providers to visit the hospital.

We were told that documented staff supervision takes place regularly and staff receive an annual appraisal. In addition to the already established staff support services, some additional methods have been established to support staff. These include reflective practise sessions led by the psychology team as well as a dedicated area where staff can go to take time out or have a quiet area to work from without being disturbed.

We were told that Mental Health Act reviews, and contact with external professionals, to include advocacy, has continued through phone calls and video conferencing. The service has been responsive to the lifting of restrictions put in place due to COVID-19 through reviewing risk assessments, and allowing more on site visits to take place, albeit in-line with their visiting procedures.

We were told that in accordance with risk assessments and planning, some patients have been able to access the community and visit family members, in line with current guidelines.

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: Aderyn

Service: Elysium Healthcare

Date of activity: 16 November 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 registered manager must confirm that the actions listed in the infection prevention control audit (external) have been documented to evidence their completion	Regulation 15 (1) (c)	Action plan for the external audit has not been attached to the infection control audit as evidence. The action plan was completed at the time of the external audit however I was unable to locate the action plan at time of the Tier 1 quality check on the 16th November	Philip Petts	In-place

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: Philip Petts

Date: 23/11/2020