Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Aberbeeg

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Aberbeeg 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 25 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 and email (for staff). 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. Visual prompts are displayed around the hospital that include signs for hand washing and how to don and doff PPE. Rooms have notices which indicate the maximum number of people allowed in at any given time. Two meter floor markers are located in the corridors and dining room to help maintain social distancing. Extra hand sanitising stations have also been added.

We were told mealtimes have been extended to ensure the area has an appropriate number of patients and staff at any one time. This ensures sufficient distance for those in the dining

room. Staff meetings are taking place in bigger rooms to maintain social distancing. Increased cleaning of high touch areas, including door handles, light switches and keypads has been implemented for 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 the hospital's laptop.

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 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 an audit that had been undertaken to assess and manage the risk of infection. The audit had been completed internally by staff in June 2020. The audit provided evidence to show that the actions identified had been completed.

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 are maintained. 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 patients. 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] were recorded as 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:

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 access to advice and guidance when required.

We were told that minimal agency staff have been used at the hospital. They have a number

[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.

of regular bank staff that are used to cover staffing shortfalls.

At the time of the call, we were told that there were two nurse vacancies, one of which had been offered to a candidate. 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 were provided with training statistics and saw a high compliance rate for courses completed via the e-learning system. However, face to face training courses had low compliance. We were told that courses are being delivered and staff are attending, but due to social distancing and safety measures, numbers for these courses are reduced. Staff have also received COVID-19 specific training to ensure they have up to date skills and knowledge, for example donning and doffing PPE.

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 (counselling and occupational health) we were told of the additional interventions in place to support staff wellbeing. One of these was an additional budget for wellbeing activities. The use of this additional funding was discussed with staff to ensure it was used to support them in the most effective way.

We were told that Mental Health Act reviews, and contact with external professionals, to include advocacy, has continued, mainly via phone calls. There was some disappointment expressed by the hospital manager that there had been a lack of use by some external professionals to use video calling, despite this being the hospital's preference in these circumstances. Video calling we were told would provide patients with a better service than telephone alone.

We were told the service has been responsive to the lifting of restrictions put in place due to COVID-19 through reviewing risk assessments and care plans, and arranging community access and/or family visits, albeit in-line with hospital procedures.

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: Aberbeeg

Date of activity: 25 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	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: Jessica Wilson

Date: