Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Rushcliffe Independent Hospital (Aberavon)

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Rushcliffe Independent Hospital (Aberavon) as part of its programme of assurance work. Rushcliffe Independent Hospital (Aberavon), provided care, treatment and structured rehabilitation for up to 18 patients, some of whom are liable to be detained under the Mental Health Act 1983.

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 are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Registered Managers on 27 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?

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 had made to make sure patients continued to receive the care and treatment according to their needs.

The following positive evidence was received:

We were told that during the pandemic, the hospital dealt with a number of agencies including HIW, Public Health Wales (PHW) and the Welsh Government to establish the changes that needed to be put in place. There were a number of regular meetings where COVID-19 guidelines and changes were discussed and passed onto staff and patients. We were told that there were regular environmental audits, and we saw evidence of one of these audits. Additionally, the number of housekeeping staff was increased to ensure additional cleaning was carried out.

The hospital managers informed us that all visitors to the setting, whether visitors or professionals, had to inform the hospital of their visit in advance and they were screened for COVID-19 symptoms by telephone initially. There were then physical health investigation checks carried out when they arrived at the hospital. A number of physical changes to the ward were also described.

We were told of the changes that were made to the ward routines, which included all non-essential staff contacting the hospital by electronic means. Staff who were considered vulnerable following a risk assessment worked from home, where applicable. Patients and staff now eat at separate times, to reduce the numbers present and to ensure social distancing. The dining areas were also cleaned in-between the various sittings. Staff also served the patients, whereas previously patients served themselves. The ward handover was also now carried out in the conference room to allow staff to maintain social distancing and with the windows open, to improve ventilation.

In addition to the monthly meetings with patients, we were told that there were now additional meetings, known as emergency meetings. These were held every time there were changes made to government guidelines. These were attended by patient representatives who then passed the information onto patients. Carers were also informed of the changes. There were also daily meetings about the health of the patients and any changes to the patient care were discussed with the patients.

The support provided was described as “immense”. Staff were acutely aware of the effects of COVID-19 and patients received additional support. This included bringing resources to them, such as gym equipment, where previously they would visit the local gym. Electronic methods were used to replace home visits when these were not allowed. Every process was

communicated to the patients and changes were not made without informing the patients initially. We were told that whilst there had been increased anxiety in patients, no restraints had been used. We were told that low moods were seen in some patients, as opposed to aggression.

Prior to the periods of lockdown, we were told that there were meetings with patients to discuss their concerns about being able to contact their nearest relative and carer. The registered managers also contacted all relatives to discuss this issue with them. When guidelines allowed, visits were made in the hospital grounds or in the local community. These visits were risk assessed and patients were accompanied by hospital staff. All patients had a mobile phone, to keep in touch with their relatives. Additionally patients could use the facilities provided by the hospital to contact their relatives, online. Every visit risk assessment was also discussed at multi-disciplinary team (MDT) meetings, in line with government guidelines. These risk assessments were undertaken to ensure the safety of staff and patients, taking into consideration their rehabilitation and physical mental health needs.

The following areas for improvement were identified:

We were supplied with evidence of environmental risk assessments that were completed for six areas in the hospital. The risks were grouped together on one side of the form and all the mitigating actions on the other side. They were not linked from the individual risk to the mitigating action. We were not supplied with environmental risk assessments for all the areas of the hospital, including the gardens, staff rooms, conference room and storerooms.

The registered provider is required to complete an environmental risk assessment, in full, for every area of the hospital, ensuring that an action plan is completed where required. The assessment should be kept up to date and review annually.

There was not a ligature risk assessment in place at the hospital that identified:

- all the ligature risks, throughout the hospital including the grounds,
- the mitigations and controls in place to manage the risks; and
- any actions required to further reduce the risks.

The reference to ligature points within the current environmental risk assessments did not address all the requirements that should be within a ligature risk assessments as described above.

The registered provider must complete a ligature point risk assessment in full.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. 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. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were provided with a copy of the hospitals COVID-19 policy which set out procedures for patients and staff to reduce the spread of the virus. The purpose of this document was to support staff in maintaining a safe environment for themselves and the patient group during the pandemic. A COVID-19 risk assessment was provided, which documented what the service deemed to be the key risks and existing control measures in place in the hospital.

We were told that each patient had a care plan which included a COVID-19 risk assessment. These were reviewed at the weekly MDT meeting where care pathways were planned and mitigation of risks were put in place.

The registered managers told us that they had regular contact with PHW who provided instruction on correct procedures to follow, in order to prevent the spread of infection and mitigate the risk of cross contamination. Additionally, we were informed that relevant infection prevention and control posters were laminated and displayed throughout the hospital. These reminded individuals of the importance of following the guidance in place for example, with regards to hand washing and use of PPE.

The registered managers told us that in the initial stages of the pandemic they had difficulty obtaining face masks. However, following communications with the local health board these were sourced and we were told stocks of PPE have been adequate since. We were told that staff regularly monitored patients' personal hygiene products to ensure that they had an adequate stock in order to maintain personal hygiene standards. Where possible, patients were encouraged to obtain their own personalised reusable masks. However, these were also provided where necessary.

Visitors were by appointment only and we were told that they were contacted 24 hours prior to arrival to complete a COVID-19 risk assessment. On arrival visitors were provided with hand hygiene facilities and PPE as well as having their temperature checked.

We were provided with evidence that showed staff received specific training in the prevention and control of COVID-19, which included the correct use of PPE. We were told that two members of staff from the same household tested positive of COVID-19 but one was on annual leave for two weeks prior to testing positive. This instigated the whole hospital being tested. The registered managers told us that any patients who developed

symptoms were able to self-isolate as all rooms were individual private rooms with en-suite bathroom facilities. We were told that there had not been any cases of patients testing positive for COVID-19.

No improvements were identified.

Governance

As part of this standard, HIW considered how the setting ensured there were 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 were continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

The registered managers discussed how patients' right were safeguarded. Mental Health Act reviews and other contact with external professionals, including advocacy, has continued through teleconferencing. Patients had continued access to solicitors through telephone and video calls.

We were told that staffing had not been an issue since the start of the pandemic. This was due to the recruitment of six staff members who had been appointed for a new stepdown unit which had been suspended due to the pandemic. The staff were then redeployed in the hospital. The registered managers informed us that they had only used agency staff, on a limited number of occasions, due to staff shortages at short notice, when necessary.

We saw evidence of patient acuity levels which we were told had been assessed regularly in order that staff numbers met the demand with increased dependency. We were told that there had not been staffing issues, where higher levels of observation were required.

We were told that allied health professionals had been flexible in ensuring changes to the services they provide were minimal. Members of the MDT had been involved in activities such as playing pool and they also delivered sessions whilst walking outside with patients. We were told that the occupational therapist continued to provide a service throughout the pandemic.

Throughout the pandemic, five members of staff had to shield due to COVID-19, including the Registered Manager who was able to work remotely from home as his duties could be carried out from there. Where staff would usually be eligible for statutory sick pay only, an initiative was started to pay for absence if staff developed symptoms of COVID-19, in order to reduce the risk of cross contamination.

We saw evidence of staff training records and were told that staff could access training through their personal email accounts as face to face training had been suspended. The registered managers told us that they provided staff with details of support available for financial hardship, childcare issues and wellbeing support. This was circulated in a newsletter via email. We were told that staff were also supported through the appraisal system.

We were told that the director had kept in weekly contact with the registered managers to provide support and discuss any issues requiring escalation. They also had fortnightly meetings with head office where any ethical issues were raised.

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.

Improvement plan

Setting: Rushcliffe Independent Hospital

Ward: Aberavon

Date of activity: 27 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	There were limited areas covered by the environmental risk assessments in the hospital. The risks were also grouped together as were the mitigating actions. We were not supplied with environmental risk assessments for all the areas of the hospital. The registered provider is required to complete an environmental risk	Standard 12 Environment Standard 22 Managing Risk and Health and Safety	1. Environmental risk assessment completed – to be completed annually 2. Medical equipment to be calibrated on an annual basis	1. Graham Godfrey (Health and Safety Officer) 2. David Kwei (Hospital Manager) and Health and Safety Officer	1. Completed 2. Completed

	assessment, in full, for every area of the hospital, ensuring that an action plan is completed where required. The assessment should be kept up to date and review annually.		3. Housekeeping audits: Laundry, environmental and cleaning audit – to be completed every three months 4. Kitchen audits: to be completed every three months 5. Maintenance audit: Health and Safety – to be completed monthly	3. Vicky Williams (Head of Housekeeping) 4. Nicola Jones (Head of Catering) 5. Andrew Williams (Maintenance Officer)	3. By the end of January 2021 4. By the end of January 2021 5. By the end of each month
2	There was not a ligature risk assessment in place at the hospital. The registered provider must complete a ligature point risk assessment in full. This must include: • Identification of all the risks throughout the hospital • The likelihood and consequence of the risk (as a score)	Regulation 9 (Policies and Procedures) Regulation 26 (Fitness of Premises) Regulation 47 (Safety of Patients and Others)	1. Ligature risk assessment completed, including all risks, likelihood and consequence, controls, mitigating actions, further actions required and responsibility assigned. 2. Complete ligature risk assessment every 12 months.	1. Hospital Manager 2. Hospital Manager	1. Completed 2. Scheduled before 31 Dec 21

	• The controls or mitigating actions in place • The further actions required to manage this risk • Who is responsible for managing each risk. The assessment must then be updated regularly with the actions carried out and reviewed annually.				

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: Robert Tamirepi **Role: Registered Manager** **Date: 17/12/2020**

Name: David Kwei **Role: Registered Manager** **Date: 17/12/2020**