Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Cefn yr Afon Rehabilitation Unit

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Cefn yr Afon Rehabilitation Unit as part of its programme of assurance work. Cefn yr Afon is an 18 bedded mixed gender community based open rehabilitation unit for individuals aged 18 and over. The unit is comprised of 18 single en-suite bedrooms with access to shared living facilitates, including a fully equipped kitchen and separate dining area. The unit is divided into three separate units known as houses. The first floor of the unit is allocated to office space and treatment room.

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 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 Unit Manager on 18 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 have made to make sure patients continue to receive the care and treatment according to their needs.

The following positive evidence was received:

A number of changes to the ward environment had been put in place due to the pandemic. The cleaning arrangements were described, particularly the efforts made by the domestic staff, who the unit manager stated had provided excellent support, training, mentoring and assisting staff, to make sure high cleaning standards were maintained.

We were told that there had not been issues with the supply of personal protective equipment (PPE) and the unit always had sufficient stock. The unit also had access to the COVID-19 hub in the nearby Princess of Wales Hospital, to re-order stock and there were no issues with the supply of equipment. There were hand washing stations with appropriate signage, posters relating to social distancing, chairs with crosses or ticks and PPE donning and doffing stations at the unit.

The system used to temperature check patients three times a day were described, these were documented and if symptoms existed the patient would isolate. The unit was split into three houses, as there had only been eight or nine patients in the unit over the last eight months, one house had been used as an isolation area. There were PPE stations in each of the bedrooms ready for this house to be used in the event of an outbreak, there was also a separate lounge and garden area.

During the periods of lockdown, since the outbreak of the pandemic, visitors were not permitted into the unit. We were told that patients were supported to contact relatives by electronic methods, telephone calls and also to write letters. If there was an emergency, the unit would look at allowing a relative to visit. The method that would be used was described, including the area used and the cleaning of the area before and after the visitors attended the unit. We were told of the use made of the gardens within the unit to allow relatives to meet patients during periods where visits were allowed.

The unit manager stated that patients were allowed leave in line with government guidelines. Additionally, visits to the local college for training were cancelled as was the work that patients did in local charity shops, which were organised to develop confidence and skills. We were also told that the Chaplain visited throughout the summer and provided a source of support.

We were told that staff kept the patients busy through crafting and other group activities,

but in smaller groups than previously. Patients continued to exercise as they wished, using areas away from the general public where possible, to reduce social contact and potential cross infection.

We saw evidence that house meetings between patients and staff continued throughout the pandemic and these also revolved around any specific announcements made by the Welsh Government. At the meetings the need for social distancing and the changes to routines and visits by relatives, were also discussed. We were also provided with evidence of the admissions pathway that included the need to ensure that new patients were COVID-19 free before admission and the need to isolate initially at the unit.

HIW had previously undertaken an unannounced Mental Health Act Monitoring Inspection at the setting in August 2015. Based on what we were told, the improvements identified at the inspection, the majority of which related to the environment, had been carried out to the benefit of the patients.

The following areas for improvement were identified:

We saw evidence that a ligature risk assessment had been completed in August 2019. The manager stated that the unit was an open rehabilitation setting and that there was a reduced risk of the need to address ligature points. Furthermore, the unit manager stated that the Head of Nursing had agreed and signed off the risk assessment, but we were not provided with evidence of this agreement. The risks identified included those classified as red risks, although there was no key provided to identify what constituted a red risk.

We believe that if a risk is sufficient to be classified as red, controls and actions should be put in place to mitigate these risks and the necessary work should be carried out to address these risks. Whilst we accept what the unit manager told us, we also believe that the health board should ensure there is a regular annual ligature point risk assessment and to maintain an action plan of the actions taken to address the issues identified. Additionally, the unit should ensure that any agreement to the unit not being required to be totally anti-ligature should be documented.

Infection prevention and control (IPC)

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 PPE.

The following positive evidence was received:

We saw evidence of the Infection Control Generic Audit Tool that had been completed by the

unit manager. This was a self-assessment of the various areas including, hand hygiene, general environment, cleanliness of equipment and rooms, and sharps management. The main issues identified related to worn or torn flooring and bathroom sealant mould that had been reported to the estates department.

We were told of the systems that were in place to monitor and manage IPC in accordance with COVID-19 requirements. These included liaising with infection control leads, reporting any concerns and keeping in touch with staff if there was a COVID-19 outbreak. Additionally, staff had undertaken individual risk assessments, as well as return to work risk assessments as required. As described above, there were hand washing stations and signage, disinfectant wipes and sporecidel wipes[1] if there were any COVID-19 patients. Staff operated a bare below the elbow system, in addition to wearing appropriate PPE and wearing medical scrubs[2]. Staff would arrive at work wearing their own clothes and then change into scrubs to work at the unit. Prior to leaving they would place the scrubs into a cleaning bag and wear their own clothes home.

We were also told of a recent unannounced inspection by the IPC team of donning and doffing of PPE at the unit. The verbal handover revealed no serious concerns, apart from being advised to obtain a second vital signs monitoring device that has been sourced via procurement.

The systems in place to ensure that all staff were aware of, and discharged their responsibilities for preventing and controlling infection, were described. These included keeping each other up to date with IPC guidelines and procedures, using the local hospital COVID-19 hub, which was described as a wealth of knowledge and checking Public Health Wales guidelines. Additionally, staff provided information to patients and also helped educate them on the guidelines.

We were told of the systems in place to ensure prompt identification of people who have, or were at risk of developing COVID-19 (or other infections). These included, care plans, vital signs being checked weekly, monitoring for symptoms, taking temperatures three times daily and where necessary, isolating patients. Patients had access to both a hospital doctor and general practitioner in addition to access to the out of hours unit at the Princess of Wales Hospital. Where a patient was required to isolate, there was a nominated nurse per shift to care for the patient. The unit were able to perform COVID-19 tests on site, as required, as the test kits were held at the unit. These would then be collected for testing at the Princess of Wales Hospital, with the results available through the clinical portal within 24 hours.

We saw evidence that two members of staff and a patient had been infected with COVID-19

[1] Sporicidal Wipes. Peracetic acid generating wipes for safe surface disinfection and the cleaning of non-invasive medical devices. Effective against spores in one minute.
[2] Scrubs are the sanitary clothing worn by surgeons, nurses, physicians and other workers involved in patient care in hospitals. Originally designed for use by surgeons and other operating room personnel, who would put them on when sterilizing themselves, or "scrubbing in", before surgery, they are now worn by many hospital personnel.

recently. We were told of the actions taken by the unit to contain the outbreak, to identify the cause of the outbreak and any lessons that could be learned. There were no current infections relating to COVID-19; Clostridium Difficile[3]; Norovirus[4] nor any other healthcare acquired infections.

The following areas for improvement were identified:

We saw evidence that the Health Board was currently reviewing and updating its IPC strategy. The new IPC strategy was to be presented to the IPC committee meeting in October 2020 for approval, then for sign off, with the aim of being in place across the Health Board by 1 December 2020. However, we saw evidence that three housekeeping documents relating to the Housekeeping Cleanliness Strategy, Management Policy and Standard Operating Procedures were also overdue for review. Additionally, we noted that the Emergency Pressures, Escalation Procedures was overdue for review, review due September 2019. The purpose of this document was to provide an operational approach to the effective management of capacity and escalation across all areas within the Health Board. This included all acute and community sites, mental health and CAMHS and primary care including the GP out of hours service.

The health board must ensure that these documents are also reviewed in light of the pandemic and to take account of any changes to legislation or best practice.

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:

The self-assessment provided stated that the unit offered community based rehabilitation to individuals who presented with low levels of risk and therefore did not require the constraints of a locked environment. The unit worked within a multidisciplinary team (MDT) model. The MDT worked in partnership with the person, their carers, families and other providers both from the statutory and voluntary sector, to ensure a high quality and varied service provision.

[3] Clostridium difficile, also known C. diff, is bacteria that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics.
[4] Norovirus, also called the "winter vomiting bug", is a stomach bug that causes vomiting and diarrhoea. It can be very unpleasant, but usually goes away in about 2 days.

The MDT at the unit consisted of various individuals focusing on the care, treatment and recovery of residents on the unit. This care continued throughout the pandemic.

The ward round process and visits by a doctor were described as well as the cover provided by the wider health board for absences and by the mental health act office. Meetings with patients and staff also continued during the pandemic, both face to face and virtually by teams. Patients had access to advocacy and to solicitors by telephone and visits, where appropriate. Access to care co-ordinators was facilitated by virtual means as was clinician input.

We were provided with copies of the monthly house meetings between patients and staff, where relevant topics were covered such as explaining patient access to the community and the restrictions on leave due to local lockdowns.

The unit manager described the system of ensuring there were sufficient staff on the ward with appropriate skill mix and gender and scheduled accordingly. Any shortages were met by bank staff and if there were any concerns, the manager could escalate this and often staff members come from other units as necessary. We were also provided with the impact assessment made relating to how the establishment and staffing levels would comply with The Nurse Staffing Levels (Wales) Act 2016. We also noted that the Bridgend Mental Health Clinical Service Group was in the process of drafting and obtaining approval for an escalation policy for resolving any staffing issues.

The unit had appointed one of their qualified staff to lead in ensuring staff complete mandatory training. This role included recording when training was due and to book staff on any training. Staff were encouraged to complete the online training and any other training as this become available such as phlebotomy[5] training. We saw evidence that the majority of mandatory training was 100 percent, where compliance was lower, we saw evidence of the action being taken to address these areas.

The system in place for managerial supervision was described with clinical leads overseeing on a one to one basis. The unit manager stressed the importance of mentoring and coaching, as well as supervising case notes. The unit manager also said that the senior nurse provided very good support.

In addition to there being a well-being portal to support staff welfare, we were told that another qualified member of staff had been allocated a role to support the wellbeing of staff. They provided a link role with the health board and ensured that up to date information was available to staff. There was a quiet room on the unit for staff to use as required and staff also had access to the unit manager and clinical leads, as well as the senior nurse. Staff could also be referred to Occupational Health and for psychological input, as necessary.

[5] A phlebotomy is the process of making a puncture in a vein usually in the arm, with a cannula, for the purpose of drawing blood. The procedure itself is known as a venipuncture, which is also used for intravenous therapy.

Based on the conversation with the unit manager there was evidence that systems had been implemented for training, reporting and managing staff. The unit manager believed that it was important to make sure all staff felt they were working as part of a team. We were told that changes had been implemented including team building, a new clinical room, the whole unit had been repainted and all documents were stored and archived as necessary.

In addition to regular staff meetings, where information was passed onto staff, we also saw evidence of the regular COVID-19 management meetings held with the inpatient rehabilitation service group. The topics included leadership during the developing COVID-19 crisis, visitors and reduction of infection measures.

We saw evidence that, at the time of the call, the ward had four registered mental nurse vacancies against the establishment. Additionally, there was one unqualified vacancy and one long term absence. The service manager stated that three of the qualified vacancies were being advertised, and that the unqualified vacancy had been filled. The unit manager stated that there had been no more than ten patients in the unit recently and that this was unlikely to change in the near future. Therefore, filling the three vacant posts would be sufficient to manage the unit at its current numbers and acuity. 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.

The following areas for improvement were identified:

During the course of the quality check the need for a formal feedback process was discussed and the unit manager agreed that there was a need to put a process in place. Patient feedback is a valuable source of information and should be used to improve the quality and safety of the care delivered and to make improvements in service areas.

The health board must ensure that the feedback process is put in place and that regular feedback is obtained from staff, patients and relatives.

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: Cefn yr Afon Rehabilitation Unit

Date of activity: 18 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	A ligature risk assessment had been completed in August 2019. The manager stated that the unit was an open rehabilitation setting and that there was a reduced risk of the need to address ligature points. The risks identified included those classified as red risks.	Standard 2.1 Managing Risk and Promoting Health and Safety			

	The health board must ensure that: • Red risks are addressed within an appropriate timescale and no longer than three months • A regular annual ligature point risk assessment is carried out • An action plan is maintained to address the issues identified • Any agreement to the unit not being required to be totally anti-ligature should be documented.		Senior Nurse to liaise with estates Department to ensure that work is complete within the next 3 months The ligature risk assessment has been reviewed on 04.12.20 and will be reviewed annually. An plan has been developed to log all issues identified through the risk assessment process and is reviewed monthly by the Unit Manager and issues escalated to senior nurse Risk assessment competed to understand and mitigate the decision to have minimal anti ligature environment	Senior Nurse Unit Manager Unit Manager Senior Nurse	31st March 2021 Completed 04.12.2020 Completed 04.12.2020 Completed 07.12.2020
2	We saw evidence that three	Standard 3.1	Housekeeping Cleanliness	Executive	31st March

	housekeeping documents relating to the Housekeeping Cleanliness Strategy, Management Policy and Standard Operating Procedures were overdue for review. Additionally, we noted that the Emergency Pressures, Escalation Procedures was also overdue for review. The health board must ensure that these documents are reviewed in light of the pandemic and to take account of any changes to legislation or best practice.	Safe and Clinically Effective Care	Strategy, Management Policy and Standard Operating Procedures Emergency Pressures and Escalation Procedures September 2016 –September 2019 is due review by Executive Board, CTMUHB	Board, CTMUHB Executive Board, CTMUHB	2021 31st March 2021
3	A formal feedback process was not in place at the unit. The health board must ensure that a feedback process is put in place and that regular feedback is obtained from staff, patients and relatives.	Standard 6.3 Listening and Learning from Feedback	<u>STAFF</u> Monthly Staff meetings are now in place with a process for staff to contribute to the agenda. Minutes will be taken and displayed in staff areas <u>PATIENT/RESIDENTS</u> There is a system in place to	Unit Manager	Completed 04/12/2020 Completed 07/12/2020

			capture Service user views through confidential surveys which will be used to develop the service Regular Patient House meetings are being undertaken weekly. Minutes are taken and displayed on patient notice boards <u>RELATIVES</u> Family liaison meetings to be conducted via telephone with patients and family liaison leads, due to restrictions to visitors to the unit during pandemic. Post pandemic more face to face opportunities will be utilised although the use of technology will continue		Completed 07/12/2020 31/12/2020

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: Beverley Francis, Unit Manager

Date: 07.12.2020