Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Enlli Ward, Bronglais Hospital

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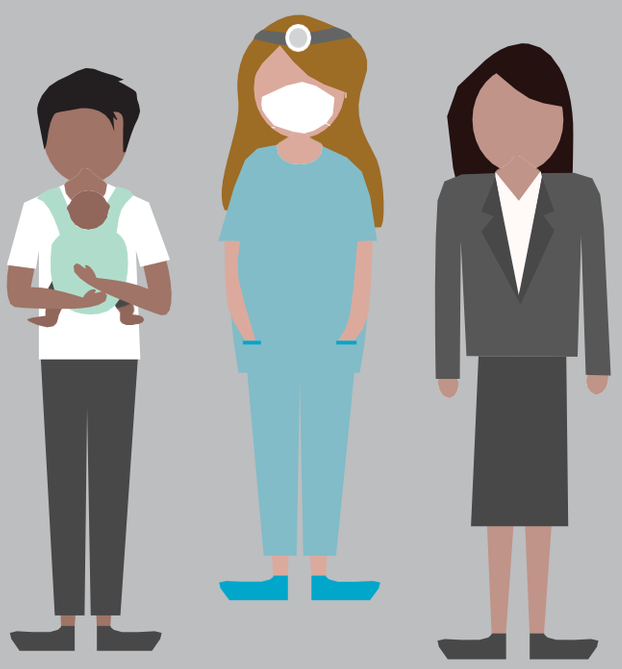

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Enlli Ward, Bronglais Hospital as part of its programme of assurance work. Enlli Ward is an older adults mental health unit with capacity for 11 patients.

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 Service Manager on 2 March 2021 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:

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 October 2020.

We were told that changes had been made to the environment as a result of COVID-19. Personal Protective Equipment (PPE) and hand sanitizers had been made available. Cleaning schedules had been amended to enable more frequent cleaning of all patient and staff areas.

The ward was split into two areas, the amber area provided an isolation for patients awaiting COVID-19 screening results or those displaying symptoms of COVID-19. There was a lounge room within the amber area where one patient at a time could eat meals and watch TV. We were told that this area was thoroughly cleaned after each use. The green area housed all other patients who had received a negative COVID-19 test result.

Social distancing measures had been put in place, which included rearranging the dining areas so more space was available between tables and patients. In order to ensure staff could maintain social distancing, a room had been converted into a second office. Furniture and seating had been removed from various areas of the ward to allow for social distancing and adequate cleaning. A one way system had been put in place through the ward to reduce contact between staff and patients. We were told that most patient bedrooms had their own en-suite bathroom. Shared bathrooms were situated in the green area and were thoroughly cleaned between use.

The manager described the visiting arrangements, which followed the health board policy and government guidelines, that is, no visitors were permitted unless necessary for end of life care. They explained that staff would contact patients' families at least once per week to provide updates on the patients' condition. We were told of the changes made to patients' leave requests. Leave was possible in certain cases following a thorough risk assessment, chaperone and full use of PPE. We were provided with a copy of the policy that supported this.

Due to the restrictions in place, alternative means of communication were used for patients

to maintain contact with their family and friends. Patients had access to iPads and a RITA[1] system that allowed them to have video calls with relatives.

We were told that Multi-Disciplinary Team (MDT) reviews were undertaken once a week. Patients were also seen and reviewed daily, where observation levels were assessed. Staff explained that they had to adapt to remote working with professionals and outside agencies via video calls. There had been an increase in virtual meetings for ward rounds, MDT meetings, family contact, best interests and discharge planning meetings.

We were told that daily staff meetings were instigated and facilitated by senior management to offer peer supervision, support and dissemination of information to ward managers. This also updated management and staff with the ever-changing COVID-19 guidelines. We were told that learning opportunities were also identified as a result of these meetings.

Staff told us 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 by the Occupation Therapist (OT). Patient meetings continued to take place and staff provided up to date guidance regarding COVID-19. The ward manager expressed their gratitude of the staff and their achievements during the pandemic to keep patients active.

No improvements were identified.

Infection prevention and control (IPC)

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 IPC Guidance. We saw evidence of IPC audits that had been undertaken within the last year to assess and manage the risk of infection. An IPC audit completed in July 2020 showed 82 percent compliance. The areas covered in this audit included checks of hand-hygiene and equipment cleanliness.

We were told staff had increased cleaning throughout the ward for all patient and staff areas, alongside the implementation of PPE stations when entering the ward. Hand washing facilities were available for patients and staff throughout the ward.

We saw evidence of a COVID-19 Admission Screening Policy which set out procedures to ensure patients admitted or transferred were screened for COVID-19 beforehand. We were

[1] RITA, which stands for Reminiscence Interactive Therapy Activities, is an evidence-based digital therapy system which allows patients to use apps, games and other leisure activities as part of their hospital recovery.

told of the systems and procedures in place to identify any staff or patient who may be at risk of developing COVID-19. Also, we were told risk assessments had been completed for all staff. Depending on the outcome of the assessment, the organisation would determine if the staff member needed 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 in a Social Distancing Guidance policy setting out the actions and responsibilities of management and staff in order to prevent the spread of the virus. In addition, we were told that PPE donning and doffing training and mask training had been delivered to all staff.

No areas for improvement were identified.

Governance

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

The following positive evidence was received:

Staffing numbers were provided, which we were told, were considered sufficient to maintain patient care and safety on the ward. We were told that patient acuity could fluctuate without a predictable pattern. As a result of this the staffing levels and requirements were reviewed on a daily basis in order to support the team in providing safe and efficient care.

We were told that bank staff were used to cover sickness and increased demand, due to patient acuity. The data provided showed that the ward had two registered mental health nurses and one healthcare support worker vacancies and no staff sickness. The ward were in the process of recruiting staff to fill these vacancies and this would ensure the ward then had a full establishment of staff.

Compliance data with staff mandatory training was provided, this showed a number of areas with high rate of compliance (82.25 percent overall compliance). However, we were told that classroom based training had been suspended during the pandemic. Staff explained that plans were in place to recommence face to face training. We were told that staff had access to computers to complete online training.

Data provided showed a 100 percent compliance rate with staff appraisals and we were told that there was adequate support in place for staff. The ward manager told us that in addition

to the daily handovers, daily staff meetings, at described above, were held to ensure staff had up to date information. In addition to the employee assistance scheme, the psychology wellbeing support service[2] was available to staff who may be experiencing anxiety or similar as a result of COVID-19. The ward manager conducts regular 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 received a copy of the complaints procedure, Putting Things Right. The ward manager told us that immediate risk would be escalated to the appropriate person directly. Regular meetings with senior staff members were held regularly to discuss issues.

We were told that Mental Health Act reviews, and other contact with external professionals, had continued through phone calls and video conferencing. The advocacy representative had visited the ward and continued to see patients face to face.

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.

[2] https://hduhb.nhs.wales/healthcare/services-and-teams/staff-psychological-well-being/

Improvement plan

Setting: Bronglais Hospital, Aberystwyth

Ward: Enlli Ward

Date of activity: 2 March 2021

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:

Date: