Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Mesen Fach, Bryn Y Neuadd

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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

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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Mesen Fach ward, Bryn y Neuadd Hospital as part of its programme of assurance work. The ward is one of three inpatient wards situated in Bryn y Neuadd Hospital. It provides assessment and treatment, and therapeutic support services for up to nine patients with learning disabilities.

HIW's quality checks form part of a new tailored 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 services. 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 assurance and inspections can be found here.

We spoke to the Ward Manager on 26 May 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 as a result of COVID-19 to the following:
    - Physical environment
    - Routines, visiting arrangements and contact with loved ones
    - Behaviour management
    - Patient access to community/leave, activities and social networks (including formal leave where the Mental Health Act applies)?

- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?

- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health and care professionals where needed?

Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and DOLS legislation, and how are patients' rights being safeguarded?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent environmental risk assessments / audits
- Patient voice data
- Hospital passport / profiles
- Details of incidents; specifically incidents of challenging behaviour, restraint and seclusion

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The ward has single en-suite patient bedrooms and two lounge areas, which we were told supports effective self-isolation and social distancing. Staff added that patients are also able to benefit from access to well-presented and spacious outdoor areas.

We were told that visiting and access to community based activities had been restricted to prevent the transmission of COVID-19. Staff told us that this initially led to a drop in motivation and a slight increase in challenging behaviours. However, it was positive to note that staff had continued to provide a nurse-led therapeutic service in an effort to replicate activities that were usually accessed within the community. This included frequent use of the outdoor space, risk-assessed use of a vehicle and making pizzas to replicate the take-away experience.

Staff told us that ward routines, such as meal times, had remained consistent throughout the pandemic. Staff added that all patients have their own routines and that each patient has an individualised plan based on the activities that they prefer to undertake. Staff added that this plan is created with the input of families wherever possible and that behaviour is monitored to assess how patients are responding to certain activities.

We found that MDT meetings had continued throughout the pandemic on a virtual basis. Staff commented that this had worked well and that there had been positive input from all specialisms. Staff confirmed that MDT meetings would be increased if required and that specialist teams are encouraged to attend weekly ward rounds to support patient needs.

We were told that the patient feedback group had been stopped during the pandemic due to infection control reasons. However, it was positive to note that the ward had used an alternative method to capture the patient voice. We saw an example of a brief questionnaire that is completed weekly by each patient. This asks the patient to write what makes them happy, sad and what things they wish to tell their doctor. Staff confirmed that this feeds into each patient's MDT meeting, which helps to provide individualised care.

We confirmed that all patients had received a physical health check upon admission to the ward. This ensures that the overall health and well-being needs of patients are being met. Staff told us that this service is provided by a local GP practice and that the input from the practice had been very beneficial. It was positive to note that the GP has an active role, attending the ward weekly and MDT meetings as required.

We confirmed that each patient had a hospital passport[1] in place. We saw an example of this and found it to be comprehensive and individualised to the patient. This helps to ensure that the needs of the patients are fully described should they require admission to another ward.

The unit provides assessment and treatment for adults who are admitted with acute needs and, as such, patients can sometimes display challenging behaviours. Staff told us that a positive behaviour support (PBS) model is followed and confirmed that the methods used to manage these behaviours are part of each patient's individual care or PBS plan.

We reviewed restraint data and found that restraint had been used on an infrequent basis. Where restraint had been used, we found that this had been done for minimal durations. We reviewed one incident with the ward manager who was knowledgeable of the incident and provided details of the debriefing and learning that had taken place. We confirmed that relatives and the MDT had been involved throughout.

Staff confirmed that a ligature risk assessment had been recently undertaken and told us that this is reviewed twice each year. Staff added that individual risk assessments are completed for patients who are considered to be at risk of self-harm.

We found that a health and safety risk assessment and self-assessment audit had been completed in response to the pandemic. These had been recently reviewed and contained updated actions. However, we found that there had been a significant length of time between the reporting of some historical maintenance issues and their completion. Whilst the maintenance issues had since been completed, the health board is advised to review and monitor timescales on other wards to assure itself that similar delays are not being experienced at this site.

No areas for improvements were identified.

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Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Generic infection control policies and Covid-19 specific policies
- Current data on infection rates
- Most recent infection control risk assessments / audits

The following positive evidence was received:

The ward manager described how staff are kept up-to-date with the latest infection prevention and control (IPC) information, which included attendance at a daily safety meeting and through a staff bulletin.

The ward manager confirmed that training in how to correctly apply and remove PPE had been provided to staff and that there were donning and doffing champions on the ward whose role is to encourage good practice. It was positive to note that additional training and support from the IPC team had been provided, which were told had promoted a good awareness of IPC procedures amongst staff.

We were told that PPE usage had been difficult for some patients. However, it was positive to note that clear face masks were being trialled on the ward. It is hoped that this trial will help to promote clear communication between staff and patients.

Staff confirmed that visiting to the ward had been managed on a cautious basis. We were told that all professional visitors are pre-planned and that staff are expected to wear an appropriate uniform and PPE. For family visitors, we were told that a checklist is used to risk assess each visit and that designated spaces are used to maintain social distancing.

We found that IPC considerations had been assessed as part of the health and safety risk assessment and self-assessment audit. This had been supplemented by a recent positively scored audit from the health board IPC team. Staff told us that there had been regular input from the IPC team throughout the pandemic.

We were told that one COVID-19 positive patient had been cared for on the ward. Staff confirmed that this patient was successfully isolated in a designated en-suite room on the ward and that a separate staff team was allocated to provide care. Staff told us that a review by the IPC team had been undertaken and we confirmed that relatives were involved in the care and treatment of this patient.

We confirmed that regular COVID-19 testing of staff was being undertaken and that all staff had received their vaccination. We confirmed that patients who had been on the ward for a period of time had also received their vaccination. Staff described how patients were supported to understand COVID-19 and the need for the vaccine, which included use of stories and picture books.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health professionals where needed.

The key documents we reviewed included:

- Escalation policies
- The most recent audit/review of the detention paperwork for patients subject to the Mental Health Act 1983, along with an action plan of how any areas identified will be addressed
- Corporate policies/processes to ensure preparedness for future pandemic emergency
- Mandatory training records for all staff
- The current percentage completion rates for mandatory training
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- The number of safeguarding referrals

The following positive evidence was received:

The ward manager demonstrated a clear knowledge of the ward, its patients and they were complimentary about the way in which staff had responded to meeting the needs of patients during the pandemic.

We found that there were agreed staffing levels across the ward and that staff were aware of the procedure to follow should any staffing concerns need to be escalated. The ward manager noted that there was good engagement from senior management when reviewing staffing needs.

We were provided with the mandatory training statistics and found an overall good level of compliance. The ward manager described what plans were in place to source additional training to meet the needs of learning disability staff. It was positive to be told that disciplines, such as speech and language therapy and psychology, were working closely with the directorate to meet this need.

We confirmed that the five patients who were detained under the Mental Health Act had access to virtual tribunal hearings and were able to access advocacy services if required. This helps to ensure that the rights of patients are protected.

The following area for improvement was identified:

The aim of an assessment and treatment service is to provide treatment on a short term basis for patients with a learning disability. We found that there had been four discharges within the last three months and it was positive to hear that staff placed emphasis on ensuring the lasting success of these. We were provided with examples in which ward staff had temporarily moved with new staff teams to help integrate the patient into their new environment. We also heard positive examples of close working with community and complex needs teams to further support the patient.

However, we found that one patient had been admitted to the ward for a significant period of time and another patient who had been admitted in September 2020. Staff explained that there had been previous attempts to discharge the first patient into suitable placement and that the on-going delay is due to the lack of a suitable therapeutic and social provision within the locality.

Whilst we were assured that safe care is being provided, the health board must provide HIW with additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements 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 the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: Bryn y Neaudd Hospital

Ward: Mesen Fach

Date of activity: 27 May 2021

The table below includes improvements identified during the 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/	Service Action	Responsible Officer	Timescale
1	The health board must provide HIW with additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit.	Health and Care Standards, 5.1	**Operational A&T Pathway.** On admission, the inpatient team will be working closely with the external community LD teams to identify suitable, person centred placements. Early planning for discharge will form part of the A&T pathway. MDT meetings will be held fortnightly including care coordinator, advocacy and external MDT & family to ensure that	Head of Operations Head of Nursing Community Ops Manager Ward Manager	1 Month

			planning for discharge is a continuous process aligned with the A&T pathway. Monthly clinical commissioning groups have been established. Membership includes Head of Nursing, Clinical operational Managers and Operational lead for CHC. All complex cases are discussed at this forum and provide a platform for escalation and mitigation of any potential barriers for discharge. This forum will be opened up to LA partners to promote collaborative planning for discharge.		

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: William Haydn Williams – Head of Operations and Service Delivery
Date: 23.06.2021