Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Betsi Cadwaladr University Health Board - 21101
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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check within Betsi Cadwaladr University Health Board as part of its programme of assurance work. The setting is an eight bedded learning disability ward, located within Betsi Cadwaladr University Health Board.

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.

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 members of the ward staff on 28/02/2022 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- **How is the risk of infection assessed and managed to keep patients, visitors and staff safe?**
- **How do you identify and effectively manage COVID-19 outbreaks / nosocomial transmission?**
- **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 do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?**
- **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?**

- **How do you ensure that equality and a rights based approach are embedded across the service?**
- **What arrangements are in place to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussion and decision making is undertaken appropriately and sensitively?**
- **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:

- Most recent environmental risk assessment/audit
- Monthly incident theme review - last 6 months
- Monthly use of restraint and seclusion review (please specify types of restraint used: physical/mechanical/use of medication) - last 6 months
- Risk assessment for mechanical restraint

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:

We asked staff about the changes that had been made to the ward environment as a result of COVID- 19. They informed us that additional cleaning has been implemented, with staff members responsible for keeping designated areas clean whilst on shift. In addition, all flyers on the patient noticeboard have all been laminated to make them easy to clean.

Staff informed us that most of the off- site therapeutic support services were suspended due to COVID. As a result, many activities were introduced on the ward for patients including cooking, gardening, board games and a projection screen for films.

We were also told that most visiting was stopped as a result of COVID, and was only permitted for end of life patients. Such visits were 20 minutes long and those visiting would enter through a back entrance, wearing full personal protective equipment (PPE). Due to the limited understanding of patients on the ward, some took longer to adjust to family members not being able to visit. Staff informed us that they used video call as much as possible, in

order to maintain contact between patients and their families. Staff have since been able to support patients to have visits off site in their family's homes. They also have use of a room in a different part of the hospital, where socially distanced visits can take place, depending on individual's risk assessments. Staff told us they have also ordered a gazebo to allow for visits in the garden in the summer months.

Staff told us that, even though they make every effort to socially distance from each other, patients find this difficult. Some will use touch to communicate, such as holding a staff member's hand. However, we were told that most patients don't generally interact with each other and naturally distance from each other. Also, during meal times, chairs are placed at two metre distances at either end of the tables and staff are in the process of swapping the sofas in communal areas to chairs, in order to improve social distancing.

We were informed that most ward staff have had active support training. Each patient has an individual support plan which includes all likes and dislikes of food and activities. Staff highlighted the important of finding what motivates each patient as part of their assessment process. They encourage patients to participate in activities and personal care as much as possible so to help them prepare to leave the ward and go back out into the community. Also, patients are encouraged to do their own shopping. This allows staff to complete capacity and financial assessments of the patients.

We asked staff how staff and patients are kept safe from COVID-19 risks while using transport. They informed us that all three vehicles have their own risk assessments and each patient is also individually risk assessed to use the transport. Masks are to be worn in the vehicles and we were told that one of the vehicles does allow for social distancing. Each vehicle is cleaned after every use and there is also a first aid kit and a level two PPE kit in each.

Staff informed us that positive behaviour support (PBS) plans are used to support patients with challenging behaviour. If restraint is needed, staff will use a less restrictive technique, which staff described as a no pain technique. Staff undertake Violence and Aggression training as part of the training for physical restraint, however we were told that some staff have had problems locating the relevant training on their online system. Senior staff are currently working to resolve this issue.

We were also told that compliance around practical restraint training is low at present due to the training being suspended during the pandemic. This has now been reinstated and new staff are being prioritised, however it is still a slow process due to only six people being able to do the training at a time, in order to maintain social distancing. Staff did also inform us that they have internal trainers for physical intervention training and staff are all compliant with this, having had refresher training last year, and will have it scheduled again this year when due.

We were told that one patient on the ward is currently risk assessed for use of a mechanical restraint. This is to prevent self-harm. According to staff, the use of this restraint has reduced

since the patient has been on the ward, due to them finding alternative ways to show frustrations. Staff informed us that the risk assessment for this patient is reviewed regularly.

Staff informed us that all best interest decisions are made by a multidisciplinary team (MDT), the family members of the patient and the patient themselves, if they are able. Meetings with the MDT and family members occur monthly, however the psychiatrist or psychologist can call additional meetings with the family to discuss diagnosis and care plans. Staff will also ensure family members receive minutes from any meetings they are unable to attend. Families can also contact the ward and ask staff to raise issues at meetings if they are unable to attend.

We were told that some staff are Welsh speakers and they wear relevant badges to indicate this. They are aware of courses available for any other staff wishing to learn Welsh and, due there being small numbers on the wards, patients know which staff members they can go to if they wish to converse in Welsh. Staff also keep a list of all Welsh radio channels for any patients who wish to listen to them. The ward also have access to a translation service, should they require it.

The following areas for improvement were identified:

We saw evidence of a risk assessment for the use of mechanical restraint. Although the risk assessment is detailed and regularly reviewed, we require the following information to be added:

- The rationale use of the mechanical restraint should be included in the introduction. It should also include information relating to the risk if the restraint is not used.
- risk ratings should also be completed through the risk assessment in order to confirm or determine the level of risk
- The risk assessment should also state who the individual decision makers were and should be read and signed off by all staff.

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 policy and COVID-19 specific policy

- Most recent infection control risk assessment/audit

The following positive evidence was received:

We saw evidence of the infection prevention and control (IPC) policy and COVID-19 specific policy for the ward, as well as the most recent infection control risk assessment. All were complete and up to date.

Staff informed us of the changes implemented as a result of COVID–19. Changes have included minimalizing the ward environment, hand sanitizer dispensers placed throughout the ward, cleaning all areas of the ward at the start and end of each shift and cleaning the shower after each use. We were also told that there are donning and doffing champions on the ward and regular hand washing audits are completed.

Staff wear PPE masks at all times but will increase PPE if there is a COVID positive patient on the ward. There is also the option for them to wear sensitive masks to help prevent skin irritation. All staff have completed donning and doffing training and will also change into their uniform on the ward, and change back at the end of their shift before leaving.

We were informed by staff that all patients have individual risk assessments regarding PPE, however none of them will wear masks on the ward as it can hinder their ability to communicate.

Patients all undertake bi-weekly PCR testing, except for one patients who has two weekly PCR tests and daily LFT tests due to being a transplant patient. Staff must also have a negative LFD test before coming onto shift.

We were told that staff increased discussions with patients around germs and keeping people safe. They also produced easy-to-read documents for patients to help them understand what was going on during the pandemic and how to keep themselves and others safe. Staff also told us that, due to them constantly wearing masks, patients have struggled to read facial expressions. Staff have relied more heavily on Makaton to communicate and have increased their use of pictures and symbols.

Staff told us about the process used during the last COVID positive case on the ward. The patients isolated between their room and a lounge only used by them. Staff wore increased PPE and a specific risk assessment was completed. We were also informed that, at the beginning of each shift, nominated staff members were identified to solely work with this individual in order to prevent cross contamination. Also, this patient was nursed in gowns whilst positive to allow for deep cleaning and to prevent the need for laundry from this patient to be taken to the laundry room.

When asked about how lessons learned are shared, staff informed us that clinical supervisions are often used to share such information. During the first lockdown, staff had socially

distanced group supervisions so they could discuss information updates and how they could learn. Lessons learned are also communicated through 'putting things right' meetings, where minutes from specialist service meetings are also shared.

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 mental health professionals where needed.

The key documents we reviewed included:

- Brief description of the model of care for LD services including details of any residential provision
- Details on the speciality of the ward/service including number of beds and current occupancy
- Management structure (showing reporting lines from setting manager upwards)
- Number of admissions and discharges (3 months)
- "Number of patients subject to DOLS or MHA (list the actual sections patients are detained under)
- Compliance with hospital passport/health profile reviews being in place (any tool that would be passed to secondary care in case of an admission)
- Compliance with Annual Health Checks
- Current staff vacancies (listed by role)
- Current staff sickness (listed by role)
- Monthly staff agency use (3 months)
- Monthly bank staff use (3 months)
- Current percentage completion rates of mandatory training, including patient specific essential training, (listed by individual subject)
- Patient Voice data for the last 3 months
- Escalation policy
- The corporate policy/process to ensure preparedness for future pandemic emergency

The following positive evidence was received:

We saw evidence of detailed staff vacancies and staff sickness listed by role We also saw a comprehensive escalation policy and a policy to prepare for a future pandemic emergency. Both were complete and in date.

We were told that staffing levels are assessed and reviewed regularly to ensure safe staffing. Staff also informed us that bank staff are often used to help cover staff sickness and the need for bank staff increased when 15 members of staff were off sick due to COVID-19.

Staff told us that senior managers can review the online training system and chase up low compliance for mandatory training. In cases of low compliance, ward staff are asked to provide rationale for this. We were also informed that the levels of staff sickness and new staff are currently affecting compliance figures.

When asked about admissions and discharge, staff confirmed that they are still following the health board's COVID-19 policy around this. We were also told that all patients are referred for advocacy and meetings with advocates often take place over MS Teams, due to most working from home. Staff also informed us that the ward has support from the local GP who visits the ward weekly, but will also attend at additional times if needed. They will push to get hospital appointments for patients if needed and are very responsive in replying to emails and phone calls throughout the week.

We asked staff about how ethical dilemmas around individual patient care are considered and how support is sought. Staff gave us the example of the initial ethical dilemma around the decision to use soft restraint for one of the patients. They told us of the good MDT working around this case and that communication was clear between family and staff, resulting in everyone agreeing to the required outcome. In this case the patient didn't have capacity to be involved in the decision, therefore the MDT (including family members) had in depth conversations around best interest in order make the best decision for the individual.

Staff informed us that the deprivation of liberty authorisations (DOLs) are reviewed regularly and dates of such renewals are included in ward rounds. We were told that all renewals sent to Betsi Cadwaladr health board have been completed in a timely manner. Only delay was one that had to be sent to Sussex for renewal.

No areas for improvements were identified.

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: 21101 – Betsi Cadwaladr University Health Board

Date of activity: 28/02/2022

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/ Regulation	Service Action	Responsible Officer	Timescale
1	We require the risk assessment for the mechanical restraint to include the following information: • The specific use of the mechanical restraint should be included in the introduction. It should also include information relating to the risk if the restraint is not used. • risk ratings should also be completed through the risk assessment in order to confirm or determine the level of risk • The risk assessment should also	Standard 2.1 Managing Risk and Promoting Health and Safety	To review the risk assessment for the mechanical restraint, to include the requested information.	Matron. Ward Manager.	Completed. Risk assessment reviewed to include the required information on the 29/03/2022. Signed by the full MDT.

	state who the individual decision makers were and should be signed off by all staff.				

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

Date: 30/03/2022