Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Quality Check Summary

## Abergarw Manor
## Community Step Down Facility

Activity date: **26 August 2020**

Publication date: 23 September 2020

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Digital ISBN 978-1-80082-222-1

# Findings Record

## Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Abergarw Manor Community Step Down Facility as part of its programme of assurance work.

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 Ward Manager on 26 August 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

## COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were told that the facility had been opened as part of the health board's response to COVID-19. It was set up to provide additional bed capacity and rehabilitation, and ongoing support to patients before their final discharge home or into residential care. We saw evidence of a health board operating policy for the Care, Treatment and Management of People Requiring Transfer into Community Step Down Beds during COVID-19 Pandemic. This document reflected that the premises had been developed in conjunction with the local authority who had worked with the health board estates, facilities and infection prevention

and control teams towards ensuring key standards for the premises were met and risks mitigated appropriately. The facility closed on 31 August 2020.

We reviewed documents which showed that the health board had processes in place to ensure staff had up to date guidance regarding COVID-19 arrangements. All staff had access to the health board intranet which had a specific designated area for a COVID-19 clinical hub. This included a link to Public Health Wales for relevant up-to-date information. This included links for healthcare professionals to access advice to include PPE, occupational health and education and training. A daily e-mail was also sent to staff with an update of information relating to COVID-19.

We were told that cleaning at a level deemed appropriate by the ward manager took place in all areas of the facility. There was also full PPE available throughout for use by staff and visitors who attended the service to visit relatives receiving end of life care. Processes were in place to ensure adequate stocks of PPE were available. We reviewed documentation which reflected an Infection Prevention Control (IPC) PPE audit had been undertaken on 17 August 2020 with 100% compliance rate. We were told that all staff which included bank, agency and students had received regular updated training in donning and doffing PPE and how to correctly dispose of PPE.

We reviewed documents which reflected that the health board's infection, prevention and control team worked in line with national guidance. We also saw infection control audits were undertaken, actions taken to address any areas of concern were also recorded. We were informed that a designated IPC nurse visited the facility every other day initially, and more recently on a weekly basis to ensure correct guidelines and procedures were followed by staff.

We were told that hand sanitiser gel dispensers were located throughout the facility for use by staff and patients. Visitors were advised of the need to practice excellent hand hygiene upon their arrival.

**No areas for improvement were identified.**

## 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 any pressure or tissue damage which has occurred. We also questioned the setting 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 were told that any identified risks to the environment were addressed immediately where

possible, or escalated to senior management where necessary to ensure the environment was fit for purpose and safe for patients. We were told that a process was in place to monitor and report risks and a record of any outstanding or incomplete jobs maintained. We were told that the majority of issues were addressed promptly, however further details relating to this is referred to in the areas for improvement below.

We were told the environment was kept clean and clutter free with good lighting and all equipment was fit for purpose and checked for servicing compliance. We were also told a new fire safety system had been installed within the facility and daily fire checks and weekly fire testing were carried out with the results being recorded.

It was explained to us that patients have been supported to maintain contact with families and friends through telephone calls and the use of electronic devices. We were told that, due to lockdown restrictions, visiting within the facility was limited and only palliative care patients were allowed visitors. We were told that visitors were supported to see patients, and provided with PPE and advised of hand hygiene requirements. We were also told that visitors were enabled to visit patients through windows and that one lounge area had been used purely for window visitors.

We were told that falls risks and assessments were completed and it had been identified this was the greatest risk to patients in the facility, due to the patient group. We also saw documentation which supported that falls audits were completed. In addition, pressure damage was a highlighted risk and we were told staff addressed the risk with robust assessments, care bundles and use of equipment where appropriate. The service also had access to a dietician to provide patients with nutritional support and advice. A speech and language therapist (SALT) was also available every week to carry out patient swallowing assessments. We were also informed that he tissue viability nurse worked closely with staff in the facility to provide advice and support around prevention and wound management. It was explained to us that a physiotherapist had been re-deployed to work within the facility to assist patients with mobility. An occupational therapist would carry out an assessment of patients prior to their discharge. We were also told the facility had access to a general practitioner (GP) and nurse practitioner and that out of hours cover was always available.

We were told that, in order to maintain patients' dignity, staff provided patient centred care and worked with compassion to be respectful and value patients' wishes and choices. We were told that all patients had individual bedrooms and their doors could be shut and window blinds closed when requested. We were told that good communication between staff and patients was key and patient choice was always taken into consideration. A high standard of food was provided and patients were able to select their meal choices from a menu. We were also told that staff arranged social events for patients. Patients could also access the secure grounds of the facility to sit outside to maintain their wellbeing.

We were told the facility provided access for patients to a Chaplain who would attend in PPE and have discussions with patients. In addition, a member of the dementia team and age connect were accessible to patients all day.

**The following areas for improvement were identified:**

As referred to earlier in the report, we were told that the facility had not been used for a number of years prior to its re-opening at short notice due to the Covid-19 pandemic. We reviewed an environmental risk assessment dated 1 July 2020 which, we were told, had been completed to establish whether the facility was sustainable for long term use. The document reflected a number of risks within the environment which had not been addressed. These included the following:

- Carpets in all areas need to be replaced with suitable flooring resulting in IPC risk, manual handling and falls risk
- Urgent requirement of a new boiler
- Roof above the main lounge area in need of repair or replacement following assessment
- Numerous windows in all areas need of replacement handles and repairs as they were unable to be opened or closed properly
- Inadequate facilities for bathing patients who require specialist equipment for bathing in the bathrooms on both floors
- Shower in downstairs shower room is in need of replacing as it is old, dated and leaking
- Number of issues highlighted with the lift due to its age and size
- Ceiling tiles need replacing in all downstairs areas to comply with fire regulations.

We were told that the outcome of the risk assessment was that senior management had determined that the building was not sustainable in the long-term for use as a step down facility without undergoing major refurbishment. As such, the facility was closed on 31 August 2020. We recognise the facility was opened at short notice due to the evolving situation due to the COVID-19 pandemic, however we recommend that if similar facilities are required at short notice in the future, the health board should consider conducting an environmental risk assessment prior to commissioning any future premises for patient admissions. This will enable the health board to identify, monitor and act on any risks identified due to the environment to ensure that patient's health, safety and welfare are promoted and protected.

We reviewed a health board emergency pressures escalation procedure document. The purpose of the escalation procedure is to provide an operational approach to the effective management of capacity and escalation for managing beds across all areas within the health board to include all acute and community sites. It was noted that the document had been drafted in September 2016 and was due for review in September 2019. We recommend that the document is reviewed and it content considered and updated where necessary.

## Infection prevention and control

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 saw evidence of an infection control policy and other supporting policies and procedures for the prevention and control of infection. The health board also has a Covid-19 clinical hub on the intranet which is referred to earlier in this report. We saw evidence of audits in place to assess and manage the risk of infection.

It was explained to us that the facility had a designated IPC nurse lead who attended weekly to provide guidance and advice to staff. We were told that equipment was cleaned and stored appropriately according to guidelines with the use of a visual tape denoting “I am clean” in place.

We were told that all patients are required to be tested for COVID-19, and a negative result obtained, prior to being admitted to the facility. Patients are also tested prior to their discharge to their home or to a care home. We were told the facility has had no cases of COVID-19 during the time it was open and any positive results would have been reported to Public Health Wales.

We were also informed that IPC precautions were in place to monitor and reduce the risks of infection. The facility had single rooms for all patients which allowed them to facilitate isolation if required. Additionally we were told of other precautions were in place to aid in identifying, monitoring and reducing risks which included screening for MRSA, COVID-19 swabbing and monitoring for signs of influenza.

**The following areas for improvement were identified:**

We were told that the health board provides all IPC training for staff on a face to face basis and there was no option for on-line training. We were informed that all face to face training had been cancelled since February 2020 and that classroom training has not re-commenced. A recommendation relating to training has been made in the Governance section below.

## Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

**The following positive evidence was received:**
We were told that the hospital had low levels of staff absence and vacancies. This was supported by documents provided. The staffing establishment was considered prior to the opening of the facility and staffing levels were determined on an ongoing basis in accordance with the health board's health rostering policy to ensure staffing resources were appropriately allocated to provide a high quality and efficient care. We were told this included detailed information about staff including skill mix, sickness, leave, study leave, non-clinical working day, supernumerary staff etc.

It was explained to us that by following the rostering policy, managers could make informed decisions and review and change rosters by providing details on staffing levels in real time which assisted with planning for demand, allowing to take account of sickness, skills and competencies, staff changes, patient acuity and dependency. We were told that ward managers plan staffing levels eight weeks in advance and rotas were available to staff six weeks in advance. This allowed for planning to deliver safe and effective care in response to patient care needs and acuity of the ward.

We were told that additional cover was accessed through bank or agency staff who would support and cover for annual leave and sickness. We were told that the same staff were utilised to ensure consistency of staff within the facility. In addition, managers had worked clinical shifts where required. We were told that year three and four student nurses had been given contracts to work at the facility in line with their student competencies to facilitate person centred care and assist with assessments and safe and effective discharge planning of patients.

It was explained to us that support had been made available to staff in a variety of ways. Members of senior management had been attending the facility weekly and were available to staff for discussions and support. Senior managers were described as being accessible and supportive. A member of the human resources team had also been assigned for staff as well as initial direct access to a psychologist to provide support for group or one to one sessions. We were told that wellbeing services and contact numbers were displayed within the facility and staff could be referred to occupational health services or self-refer if needed. We were told that staff within the facility all pulled together and provided a real team effort to provide an effective service to patients. This had resulted in relatives and visitors feeling appreciative of the service resulting in staff feeling valued.

We saw documentation which reflected that compliance figures provided for staff's personal appraisal development review (PADR) were at 100% for the previous 12 months. This was not reflective of the whole of the staff within the service as staff had been drafted in from various locations and the responsibility for their PADR compliance lay with their individual substantive managers.

**The following areas for improvement were identified:**

We saw evidence that the overall mandatory training compliance for individual staff at the facility was generally low. We were told that this was as a result of all face to face training being cancelled since the outbreak of the pandemic. This included violence and aggression training, immediate life support, fire safety and safeguarding. We were also told efforts were being made to re-introduce face to face training, however class numbers were smaller to enable social distancing measures to be adhered to. We recommend that a review of mandatory training compliance is undertaken and other methods of delivering training are explored to improve compliance levels.

# 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.

# Improvement plan

Setting: Abergarw Manor, Bridgend Integrated Locality

Service: Community Step Down Facility

Date of activity: 26 August 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 | We recommend that the health board should consider conducting an environmental risk assessment prior to commissioning any future premises for patient admissions. This will enable the health board to identify, monitor and act on any risks identified due to the environment to ensure that patient's health, safety and welfare are promoted and protected. | 2.1 Managing risk and promoting health and safety | CTM Integrated Locality Group (ILG) Leads will ensure that environmental risk assessments are completed prior to commissioning any future premises. Arrangements will be made to review and action risk assessments in a timely manner to ensure the environment promotes the health, safety and welfare of the people who will be occupying the premises. | ILG Director of Operations | Immediate |
| 2 | We recommend that the health board reviews its policy for emergency | 2.1 Managing risk and | A revised Emergency Pressures Escalation Plan has been drafted | Civil Contingencies | 1st October 2020 |

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| | pressures escalation procedure which was due for review in September 2019. | promoting health and safety | (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site. | Manager | |
| 3 | We recommend that a review of mandatory training compliance is undertaken. | 7.1 Workforce | The Health Board recognises that the overall performance in regard to staff completing their mandatory training across many services and at all levels of the organisation has been impacted upon by the COVID pandemic. The position of each clinical and administrative area is now well understood across the health board and through both the new Integrated Locality Group (ILG) operating model and within corporate departments, targeted actions plans to improve such are being re-established. These plans are being monitored through the ILG performance review mechanisms and are being supported by the Workforce & Organisational Department Business Partners. All ILGs and Corporate Departments will be targeted with remedial action plans being set by 31 October 2020 | ILG lead Corporate team managers Director of Workforce & Organisational Development and Director of Operations | Action plans by 31 October 2020 with 80% compliance achieved by 31 March 2021 |

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| | | | with a trajectory of improvement to the 80% levels by 31 March 2021. These will be monitored by the Director of Workforce & Organisational Development and Director of Operations with bi monthly reports through to the Management Board. The Health Board is also exploring alternative means of providing fire training to staff (at least in the short-term while social distancing measures remain in place), and reducing the requirement for face-to-face training, while considering relevant statutory requirement.<br>With regard to Face to Face Infection, Prevention & Control training, we currently run the following courses:<br>Level 1 (all staff) E learning<br>Level 2 (patient facing staff) E Learning<br>Level 3 (clinical managers) Face to Face, which did stop due to Covid19 pandemic however, this face to face training recommenced September 2020.<br>Donning and doffing face to face (supplemented by on line resources) is provided for all | | |

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| | | | staff who are required to wear PPE across the health board. | | |

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: Ana Llewellyn, Nurse Director, Bridgend Integrated Locality Group

Date: 10 September 2020