

Hospital Inspection (Unannounced)

Cardiff and Vale University
Health Board: University
Hospital of Wales:
Directorate of Clinical
Gerontology, Directorate of
Internal Medicine, Medicine
Clinical Board

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

Healthcare Inspectorate Wales (HIW) completed a scheduled, unannounced inspection at the University Hospital of Wales (UHW) on the 18 and 19 October 2016. The inspection focussed on patient areas associated with the Directorates of Clinical Gerontology and Internal Medicine respectively, both of which are part of the Medicine Clinical Board. The following wards were visited during this inspection:

Clinical Board-Directorate of Clinical Gerontology:

- C6

Ward C6 has 38 patient beds which are equally divided into a north and south side; a main reception desk being situated in the middle, at the entrance of the ward. The ward accepts both male and female patients.

Clinical Board-Directorate of Internal Medicine:

- C7

Ward C7 also has 38 patient beds which are equally divided into a north and south side; a main reception desk being situated in the middle, at the entrance of the ward. The ward accepts both male and female patients. Two days prior to this inspection, a pilot project was launched within the north side of the ward. Specifically, a different model of patient care was being piloted by the health board which is intended to ensure that patients get the most appropriate medical, nursing and therapies input for their needs. In practical terms, this meant that the beds in the north area (19 in total) would be used to provide

accommodation to patients who no longer need care in an acute hospital environment.

2. Methodology

We have a variety of approaches and methodologies available to us when we inspect NHS hospitals, and choose the most appropriate according to the range and spread of services that we plan to inspect. In-depth single ward inspections allow a highly detailed view to be taken on a small aspect of healthcare provision, whilst the increased coverage provided by visiting a larger number of wards and departments enables us to undertake a more robust assessment of themes and issues in relation to the health board concerned. In both cases, feedback is made available to health services in a way which supports learning, development and improvement at both operational and strategic levels.

The new Health and Care Standards (see figure 1) are at the core of HIW’s approach to hospital inspections in NHS Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The Standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1



NHS hospital inspections are unannounced and we inspect and report against three themes:

- **Quality of the Patient Experience:**
We speak with patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to inspection.
- **Delivery of Safe and Effective Care:**
We consider the extent to which services provide high quality, safe and reliable care centred on individual patients.
- **Quality of Management and Leadership:**
We consider how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also consider how health boards review and monitor their own performance against the Health and Care Standards.

Our team, for this inspection of patient areas within UHW, comprised of three HIW Inspection Managers (one of whom had overall responsibility for leading the inspection, one who had the role of sub-lead and a third who was shadowing the inspection visit), two clinical peer reviewers and two lay reviewers.

We reviewed documentation and information from a number of sources including:

- Information held by HIW
- Conversations with patients, relatives and interviews with staff
- General observation of the environment of care and care practice
- Discussions with senior management within the directorate
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- Consideration of quality improvement processes, activities and programmes
- Responses within completed HIW patient questionnaires
- Responses within completed HIW staff questionnaires.

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the quality, safety and effectiveness of healthcare provided and the way which service delivery upholds essential care and dignity.

3. Context

Cardiff and Vale University Health Board is one of the largest National Health Service (NHS) organisations in the UK. It provides day to day health services to a population of around 472,400 people living in Cardiff and the Vale of Glamorgan who need emergency and scheduled hospital treatment and mental health care. It also delivers care in people's own homes and community clinics.

The delivery of NHS primary care services in Cardiff and the Vale of Glamorgan, including general practitioners, community pharmacists, dentists, and optometrists are also the responsibility of the Board. Additionally, it serves the population across Wales for specialties such as paediatric intensive care, specialist children's services, renal services, cardiac services, neurology, bone marrow transplantation and medical genetics.

Cardiff and Vale University Health Board includes six in-patient hospitals, four out-patient hospitals (Dental, Cardiff Royal Infirmary, Whitchurch, and Lansdowne) and 18 health centres.

4. Summary

Overall, comments made by patients receiving care within both wards inspected, indicated that they were happy with the service provided by staff teams. We saw staff being courteous to patients and treating them with respect and compassion throughout the two day inspection. The health board had well established arrangements in place for patients and/or their carers to provide feedback on their experiences and to raise concerns (complaints) about healthcare delivery, in accordance with 'Putting Things Right' arrangements.

We did, however, find that aspects of care delivery needed to be improved in order to maintain patients' confidentiality and dignity.

We examined a sample of patient records in both wards inspected and found that all documentation was completed to a good standard and in sufficient detail, to assist all members of the ward team to meet patients' needs. In addition, risk assessments and plans of care were seen to be reviewed regularly and up to date.

We identified the need for improvements to aspects of health and safety, building maintenance and repair, medicines management, infection prevention and control and the recording of patients' weight. Overall, however, we were able to confirm that staff within the services inspected made every effort to ensure the health, safety and welfare of patients in accordance with professional guidelines, health board policies and procedures and the health and care standards.

We found that there was a considerable emphasis on implementing and monitoring systems and processes in place for the sustainable delivery of safe, effective person centred care.

Both wards inspected were also seen to be managed and run by staff who demonstrated a keen approach to providing good quality care to patients.

Details of the service improvements identified during our inspection can be found within Appendix A of this report.

Findings

Quality of the Patient Experience

Overall, comments made by patients receiving care within both wards inspected, indicated that they were happy with the service provided by staff teams. We saw staff being courteous to patients and treating them with respect and compassion throughout the two day inspection. The health board had well established arrangements in place for patients and/or their carers to provide feedback on their experiences and to raise concerns (complaints) about healthcare delivery, in accordance with 'Putting Things Right' arrangements.

We did, however, find that aspects of care delivery needed to be improved in order to maintain patients' confidentiality and dignity.

During this inspection we invited patients and/or their representatives, in both wards visited, to provide views about their current experience of hospital staff, the clinical environment and the care received, through the completion of a HIW questionnaire. Patients and/or their representatives were also given the opportunity to provide comments through face to face conversations with members of the inspection team.

There were a number of patients within both clinical areas however, who were unable to offer their views on the care they received. This was due to identified complex communication needs and cognitive impairment.

Seventeen questionnaires were completed and returned to HIW. When asked to rate the care and treatment they had received on a scale between zero and ten, fourteen patients gave a rating of between eight and ten. The remaining patients offered a score of five, six and seven respectively, on the basis that they didn't always receive prompt assistance from staff when requested, the noise from a neighbouring patient at night which disturbed their sleep and the absence of a drinking cup/lack of support to use their hearing aids.

Conversations with patients also provided us with a number of comments, some of which are shown below:

'Staff are really helpful, particularly during the day. Night care not so good; and staff seem a bit indifferent'

'Staff are helpful and attentive and support me to manage things on my own, or with support if needed'

'Staff pressures. Hard for them to do their job'

'We are very satisfied'

Dignified Care

People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs. (Standard 4.1)

Ward C7-Directorate of Internal Medicine, Medicine Clinical Board

During the two days of our inspection, we found that staff had very little time to sit, talk, and listen to patients. This meant that people's feelings, needs and problems may have not been addressed at times. A small number of patients also indicated that they didn't feel that they had enough information from medical staff about what was happening to them in respect of their current and ongoing care.

On day one of our inspection, a sensitive conversation between a patient and a doctor was overheard by a member of the inspection team. The issue was subsequently raised with the ward sister. On day two, a patient who spoke with us said that they were upset at overhearing a conversation between a doctor and a patient. At that stage, it became apparent that the conversations mentioned here, were the same. Whilst it was acknowledged that the doctor was speaking in a quiet tone, their voice could easily be heard and the curtains were not closed as a means of indicating that the discussion was meant to be private.

One patient was found to be wearing clothing heavily soiled with food; a situation which was brought to the attention of staff.

The above matters had the potential to impact negatively on the privacy and dignity of patients receiving care.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure that all patients are treated with dignity, at all times.

General issues

We observed staff teams on both wards being kind and respectful to patients and their visitors. We also saw staff making efforts to protect patients' privacy and dignity when providing assistance with personal care needs. Comments from patients confirmed that staff were kind and sensitive when carrying out

care. In addition, patients told us that staff helped them in a way so that they didn't feel embarrassed when using toilet facilities.

We saw that noticeboards in both wards visited, contained patients' first initial and their full second name as a means of assisting relatives and visiting staff to find where they were located in the ward. However, the noticeboards also contained information about aspects of care which had the potential to compromise patients' confidential information and undermine their dignity.

Improvement needed

The health board is required to describe the action taken/to be taken to ensure that patients' information is presented on noticeboards in a way which maintains patients' confidentiality and dignity.

Patients on both wards appeared comfortable and were able to wear day clothing or nightwear in accordance with their preference. Comments from patients confirmed this.

When asked about the cleanliness and tidiness of the wards, all patients who provided us with comments told us that they felt the wards were clean and tidy.

Individual Care

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being. (Standard 6.1)

Ward-C7 Directorate of Internal Medicine, Medicine Clinical Board

On day one of our inspection, we saw that a small number of patients were sitting in an armchair for long periods of time (around 4 hours), without any form of encouragement to change their position independently, or with support from staff. This situation, however, notably improved on day two of our visit.

General issues

We found that ward teams worked well with other members of the multi-disciplinary healthcare team to provide patients with individualised care according to their assessed needs, as far as possible.

We were able to confirm that staff on both wards had completed a range of nursing assessments to identify patients' individual care needs and promote independence and choice. Overall, we also found that staff provided care and

support to patients when they needed it. We saw staff encouraging and supporting patients to be as independent as possible. For example, we observed staff encouraging patients to walk and assisting them to sit up so that they could eat and drink independently. We also saw that water jugs, cups and daily personal items were placed within patients' reach so that they did not have to ask for assistance.

Public information about care and support was available, but more readily accessible within ward C6. We also found that such information was only available in English; ward signs also only being displayed in English. The health board was therefore advised to consider how it could improve this issue as a means of addressing people's linguistic needs in accordance with the health and care standards and current Welsh language legislation.

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation (Standard 6.2).

General issues

We saw that staff teams provided care in a way to promote and protect patients' rights.

For example, doors to single rooms were closed and curtains were used around individual bed areas when care was being delivered.

Conversations with patients and their families also revealed that they were encouraged to spend time together, in accordance with their wishes.

We did find, however, that there was very limited information available to patients who may wish to spend time with individuals who could support them with spiritual and pastoral aspects of their care.

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback (Standard 6.3).

Conversations with both ward teams and senior staff confirmed that the health board had well established and understood arrangements in place for handling concerns (complaints) raised by patients and/or their representatives. These arrangements were in accordance with 'Putting Things Right'¹.

We were also provided with a summary of how the health board had recorded and responded to people's concerns (complaint) raised with regard to health care services provided by wards C6 and C7 respectively. As a result we were able to confirm that concerns had been dealt with in an appropriate way.

¹ *Putting Things Right* - the arrangements in place for handling and responding to concerns about care and treatment provided by the NHS in Wales.

Delivery of Safe and Effective Care

We examined a sample of patient records in both wards inspected and found that all documentation was completed to a good standard and in sufficient detail to assist all members of the ward team to meet patients' needs. In addition, risk assessments and plans of care were seen to be reviewed regularly and up to date.

We identified the need for improvements to aspects of health and safety, building maintenance and repair, medicines management, infection prevention and control and the recording of patients' weight. Overall however, we were able to confirm that staff within the services inspected made every effort to ensure the health, safety and welfare of patients in accordance with professional guidelines, health board policies and procedures and the health and care standards.

Staying healthy

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities. (Standard 1.1)

Ward C6-Directorate of Clinical Gerontology, Medicine Clinical Board

We found that patients were provided with information about the types of care, support and opportunities available to them. This included how to obtain information and support from the local community health council, advocacy and services within the third (also known as the voluntary) sector. This meant that patients and their families/representatives were enabled to obtain information about how they might explore additional ways of seeking a healthy and more active life.

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

We found there were no leaflets and no noticeboard information about the types of care and support available to patients in the local community. Discussions with the health board did however reveal that leaflets had recently been developed to assist patients and their families to understand the pilot project which has begun within the north area of C7. Such leaflets, we were told, would be in use in the very near future.

Given the nature of the pilot project, the ward sister told us that a bid had been put forward to secure funding for reminiscence and activity equipment and large wall clocks, in support of patients with short term memory loss/cognitive impairment. We were also informed that the ward team were liaising with senior staff to arrange for volunteers (from Cardiff University, Cardiff Metropolitan University and Vale College) to come to the ward and spend time with patients during the day.

Safe care

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented. (Standard 2.1)

Ward C6- Directorate of Clinical Gerontology, Medicine Clinical Board

We found that appropriate ward access and exit arrangements were in place to ensure that patients were safe. We also saw that the ward environment was well maintained (as a result of re-decoration in recent years) and uncluttered, which assisted with the prevention of slips, trips and falls.

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

A tour of the ward, at the beginning of our inspection, revealed an outdated environment which was in need of re-decoration, maintenance and repair. Equipment storage was minimal which meant that the main corridor linking the north and south sides of the ward was difficult to walk through freely and safely, presenting a risk to patients who had the ability to move away from the bedside.

We saw that a number of cleaning fluids were not locked away in the sluice room which could easily be accessed by patients or unauthorised persons. Given the risk this posed, we brought the matter to the attention of ward staff who locked the cleaning products away as required.

We also saw that the day room was not visible to staff due to its location and was very small, making it difficult to use by patients who may need the use of moving and handling equipment to sit in the chairs provided.

The health board was therefore advised to consider the above environmental issues in the light of the project that has begun within the north side of the ward and the importance of helping patients to optimise and maintain their level of mobility prior to moving on to longer term care arrangements. In addition, the current layout of the environment was not conducive to establishing an

appropriate range of social/stimulating activities in accordance with patients' wishes and assessed abilities.

We found that there were a number of portable oil radiators in use during our inspection. Conversation with relevant estates and ward staff indicated that they had been in use for a number of days due to a major problem with the heating system within one particular part of the hospital premises. We also saw a completed risk assessment form in relation to this issue. However, whilst HIW acknowledged the need to provide patients with an alternative form of heating, none of the radiators in use were protected by any form of covering and were extremely hot to the touch. This had the potential to cause harm to patients, staff or visitors. At the time of our discovery, the heating had been restored to the ward so the radiators were taken out of use.

Improvement needed

The health board is required to provide details of the contingency plans to be put in place in the event that portable heating appliances need to be used in the future. This is to ensure the health, safety and welfare of patients, staff and visitors.

We saw that the carpet and gripper rod at the entry of the day room were raised and loose which posed a risk of falls to anyone who entered the area. Discussions with the ward sister indicated that the matter had been reported to the maintenance department in a prompt manner. The remedial work had not, however, been completed. We also found that such delays were not unusual. This matter was therefore raised with an appropriate member of the health board staff and the work completed on day two of our inspection.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that maintenance and repair requests are dealt with in a timely manner. This is to ensure that the health, safety and welfare of patients, staff and visitors is maintained.

General findings

Access and signage to both wards could be improved, as brief conversations with a small number of relatives indicated the difficulties they had experienced in finding these areas of the hospital. We also found that nursing, medical staff and patients' families were delayed in getting to both wards for up to 15 minutes, on average, whilst waiting for access to lifts to the sixth and seventh floors respectively. This was due to the number of lifts that were not in operation; the remaining lifts being very slow. This had the potential to impact

negatively on patients at such times that staff need to reach these areas of the hospital quickly, in response to patients' needs.

Improvement needed

The health board is required to provide HIW with details of the action to be taken to ensure the effective operation of the lift systems at UHW.

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage. (Standard 2.2)

We found that patients within both clinical areas had access to appropriate pressure relieving and moving and handling equipment. We also saw ward staff and physiotherapists supporting patients in a calm manner, with gentle verbal prompts at such times when they needed assistance to change their position or to mobilise.

Both wards had established processes in place for the recording and management of the development of any tissue/pressure damage.

People are assessed for risk of falling and every effort is made to prevent falls and reduce avoidable harm and disability. (Standard 2.3)

Ward C6- Directorate of Clinical Gerontology, Medicine Clinical Board

We found that a patient receiving care in this clinical area had fallen whilst alone in a toilet. The person concerned was identified as being in need of support to mobilise. Appropriate action was being taken forward following the patient's fall and lessons learned by staff, would be undertaken through discussions about the incident at a ward meeting and multidisciplinary meeting, to minimise the risk of such incidents occurring in the future.

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

Conversations with the ward sister and senior nurses indicated that health board staff were working closely with the University of South Wales to try and set up a pilot scheme in the very near future whereby patients would be offered the use of a coloured Zimmer frame of their own choosing, following an assessment of their mobility. This was as a means of reducing falls and in response to research which shows that patients with cognitive impairment would be more likely to use a Zimmer frame in a colour of their choice to mobilise around clinical areas. The current equipment on offer in ward areas is the same colour and patients, as described above, often tend to try and

mobilise without a Zimmer frame as they all look similar. Such actions can result in patient falls.

General findings

We examined a sample of patients' records in both wards and spoke with the patients concerned as well as the staff who were caring for them.

It was evident that documentation relating to falls risk assessments were fully completed for each patient concerned. A physiotherapist visiting the wards also told us that all patients, without exception, would undergo a falls risk assessment on admission. This was with a view to obtaining a clear view of patients' level of mobility and the equipment that may be required to assist them, as a means of preventing falls within the clinical environment and at the point of discharge from hospital. Physiotherapists also informed us that patients' mobility needs were discussed with ward staff and doctors during 'board rounds'². This was also observed during a 'board round' meeting.

We were provided with a health board improvement document which set out the action taken and that which was planned, in order to reduce the risk of patient falls. The improvement plan made specific reference to the way that the health board had improved patient safety information sharing during staff shift changes. The plan also referred to recently completed staff training on falls prevention and the trial of the use of equipment (such as sensor mats and slipper socks) to further reduce the risk of patient falls.

We found that staff on both wards had completed relevant audit activity in respect of the management and prevention of falls and that good practice in relation to this element of care was being followed. However, we found that such audits were not always completed monthly as required by the health board.

We saw that all patients had easy access to their call bells to enable them to call for assistance from ward staff when needed. In addition, we were able to confirm that the health board made every effort to learn lessons from incidents relating to patient falls.

² Board rounds are used as a process to improve communication among the multidisciplinary team (MDT), enhancing team working and providing a more co-ordinated approach to discharge planning.

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections (Standard 2.4).

Ward C6- Directorate of Clinical Gerontology, Medicine Clinical Board

We saw a used bar of soap in a shower room. The use of bars of soap is not permitted in accordance with existing infection prevention and control measures, due to the risk of transfer of bacteria from one person to another.

The health board should consider how it will ensure that all staff adhere to national and local infection prevention and control procedures in the future (specifically around the use of soap bars within the ward).

We discovered that the ward dishwasher was broken; a matter which had been reported to the hospital estates department two days before our inspection. The machine had not been repaired. This meant that housekeeping staff had to hand wash used crockery and cutlery. This issue was again brought to the attention of the estates manager; the repair being completed on day two of our inspection.

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

We saw a blood stain on the side of a couch within a room used to provide care to outpatients. This was brought to the attention of a member of staff who indicated that the room had been in recent use. Despite this, there is a need to ensure that all equipment is free from bodily fluids at the point of use.

We were provided with a completed copy of a '*Hospital Cleanliness Spot Check*' (*Direct Observation Audit Tool*)-dated 23 May 2016. The person who completed the audit had identified some areas that required improvement, specifically in relation to the need for clarity as to who should clean commodes, bed frames and intravenous infusion drip stands. Whilst it is good that the person concerned highlighted this issue, we found that the matter had not been completely resolved, nor had the audit resulted in an improvement plan, the outcome of which could have been monitored. In addition, no further audit had taken place since May 2016, to check on the situation.

Improvement needed

The health board is required to inform HIW of how it will ensure that appropriate action is taken following the completion of cleanliness spot

checks and that staff always ensure that equipment is clean and free from bodily fluids prior to and after use.

General findings

The ward teams were commended for challenging members of the inspection team to remove wristwatches for the purpose of hand washing and to refrain from sitting on patients' beds during discussions. This demonstrated that all staff were aware of aspects of the system in place for infection prevention and control.

We also saw nursing and medical staff washing hands in between providing care to patients as well as using hand gel at appropriate times. Staff were also observed to be wearing aprons and gloves at appropriate times. The health board was, however, reminded of the need to ensure that there is sufficient hand gel available to staff in both areas at all times, to promote and sustain good practice.

Patients who spoke with us stated that they were never provided with the opportunity to wash their hands before eating their meals. Subsequent discussions with staff confirmed that they did not do this. The health board was therefore reminded of the need to ensure that patients were given such an opportunity from an infection prevention and control perspective. Failure to do this may also impact negatively on patients' dignity.

Conversations with staff highlighted some confusion as to how continence products should be stored prior to use and in accordance with agreed infection prevention and control measures. Staff were very receptive to our advice to contact infection prevention and control colleagues for guidance.

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury (Standard 2.5).

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

One of the patient records selected by the inspection team contained reference to difficulties in weighing the person concerned. The same set of records also suggested that the patient may have lost weight, but there was no clear evidence of this. In addition, the actual weight recorded was followed by a question mark which gave the indication that this was not accurate. This meant

that the patient concerned may have been at risk of malnourishment. This was brought to the attention of ward staff.

Improvement needed

The health board is required to describe how it will ensure that there are suitable systems in place and equipment available, to record and monitor patients' weight.

One patient was seen to be unable to reach their food when served (on day one of the inspection). The patient was also seen to be in need of re-positioning. This was not the case on day two of the inspection.

General findings

We reviewed the content of a sample of patients' records in both wards and spoke with staff who were caring for the people concerned. As a result, we found that plans of care, in relation to eating and drinking, accurately reflected the needs of the patients who spoke with us. We also found that both ward teams sought the advice of other professionals, such as dieticians and speech and language therapists, in response to patients' identified changing needs. This meant that there was an overall emphasis on ensuring that patients were well nourished.

Members of our inspection team observed a lunchtime period on both days of our visit and were able to confirm that patients were generally well supported during those times. For example, we saw nursing staff, health care support workers and dietetic assistants helping patients to eat and drink. We also saw that such support was unhurried and caring; staff offering patients sufficient opportunity to take a break in-between eating and taking a drink. Patients also appeared to be well positioned, either in their bed or at the bedside, to assist them to eat their food.

We found that relatives were encouraged to visit at mealtimes to assist their family members to eat and drink, in accordance with their wishes and preferences.

There was drinking water available at all times during our inspection and patients told us that they liked the food provided and were happy with the portion sizes.

Patients had a choice of meal each day, but only had minutes to choose before it was served. Making such a choice, in a short period of time, however, appeared to be difficult for some patients with complex communication needs and/or cognitive impairment. The health board should therefore consider the

use of pictorial menus to assist patients, as appropriate. We saw that the food served, in both clinical areas visited, appeared appetising and was well presented.

We were able to confirm that patients were provided with therapeutic diets (for example, pureed) in accordance with their identified needs. In addition, snacks such as toast and sandwiches were available to patients on a 24 hour basis.

There were signs, within both wards, which indicated that mealtimes were 'protected'³. However, we did find that, although the arrangement was highlighted, it was not working in practice. This was because medical staff were seen approaching patients whilst they were eating which could compromise their dietary intake.

People receive medication for the correct reason, the right medication at the right dose and at the right time (Standard 2.6).

Ward C6- Directorate of Clinical Gerontology, Medicine Clinical Board

On viewing a sample of patients' care and medication administration records, we found that the oxygen therapy required by one patient had not been prescribed as required. This matter was brought to the attention of staff and prompt action taken to ensure that the matter was rectified. Further conversations with ward staff, however, revealed that this issue occurred on a regular basis. This meant that there was the potential for error in the administration of oxygen therapy. However, we were informed that no such instances had arisen to date.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that, in instances where oxygen therapy is required by patients, this is prescribed on the All-Wales medication chart.

³ Protected mealtimes is the term and system used in hospitals to alert people to the need to avoid interrupting patients when they are eating. This is in recognition of the connection between good nutrition and recovery from ill-health.

General findings

We observed registered nurses administering medication to a small number of patients in both wards, making sure that they were not disturbed during this crucial time. We also looked at a chosen sample of patients' medication charts, viewed the arrangements for storing medicines and controlled drugs and spoke with staff to confirm their understanding of their responsibilities in relation to this important aspect of patients' care.

As a result, we found that staff, in both clinical areas visited, adopted a safe approach to medicines management in accordance with the health board policy and relevant professional guidelines.

Conversations with staff confirmed that they were well supported by pharmacy colleagues in terms of medicines management in general. We did, however, identify a lack of understanding (on the part of some staff), regarding the use of a 'blister pack' symbol applied to the '*Patient Status at a Glance*' information boards. This was apparently meant to identify, at an early stage, how patients' medication needed to be packaged in preparation for their discharge from hospital. The health board should consider taking steps to ensure that all staff understand this process, to avoid potential confusion and/or error in the future.

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. (Standard 2.7)

General findings

This health and care standard was not explored in great depth. However, discussions with ward and senior staff and information made available to us during our two day inspection, revealed a very good understanding of the adult protection process. We also found that there were suitable systems in place for the reporting, management and investigation of any alleged abuse.

We further found that ward staff had a good understanding of the application of Deprivation of Liberty Safeguards (DoLS)⁴ legislation; DoLS assessors being present within ward C7 on day two of our inspection.

⁴ The Deprivation of Liberty Safeguards (DoLS) came into force in England and Wales in April 2009 under amendments to the *Mental Capacity Act 2005*. They were introduced following a

Effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs. (Standard 3.1)

General findings

This health and care standard was not considered in depth. We did, however, hold conversations with senior managers in order to determine how All-Wales safety alerts, relevant to their clinical practice, were made known to all staff. As a result, we were satisfied with the process in place (within the clinical areas inspected) in terms of raising awareness and making any changes to care practice, as and when appropriate.

In communicating with people, health services proactively meet individual language and communication needs. (Standard 3.2)

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

We spoke with the ward sister who informed us that staff working within the north side of the ward, were to commence using 'This is Me'⁵ documentation to help improve their understanding of patients' needs, preferences and wishes. The introduction of this documentation was planned to coincide with the recently implemented project to provide accommodation to those patients who no longer required acute hospital care.

decision in the European Court of Human Rights (ECHR). Article 5 of the *Human Rights Act 1998* requires that no one should be deprived of their liberty except in certain, pre-defined, circumstances (for example in instances where individuals do not have the capacity to make decisions about their future care).

⁵ This is Me is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. <https://www.alzheimers.org.uk/thisisme>

General findings

Conversations with patients and staff, in addition to our observations of the clinical environments, highlighted the following areas that require improvement:

- We found that patients, whose first language was Welsh, had been offered the opportunity to speak with staff through the medium of Welsh. It was not clear however, which of the staff, working within either of the clinical areas visited, had the ability to speak Welsh. For example, one member of staff was seen wearing a badge indicating that they could speak Welsh. However, this was not the case. This meant that opportunities may be missed in terms of meeting patients' individual needs
- We saw some information displayed within both wards relating to the use of the '*butterfly scheme*⁶'. However, conversations with staff, and examination of patients' records, showed that the system was not being consistently applied or understood. This may mean that some patients' language and communication needs were not being addressed
- There was an absence of appropriate (coloured) signs to assist patients with cognitive impairment to find their way around the wards (for example, to toilet and bathing facilities). This can increase patient anxiety and reduce independence

The health board should consider improving staff communication methods and making the signage more patient friendly. This is particularly relevant in respect of the availability of Welsh speaking staff, the use of a system that is designed to assist communication with patients with cognitive impairment, and the presentation of the clinical environments inspected.

⁶ The Butterfly Scheme provides a system of hospital care for people living with dementia, or who simply find that their memory isn't as reliable as it used to be. The system is designed to assist staff to identify patients who have dementia or memory impairment and how to support them. <http://butterflyscheme.org.uk/>

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance (Standard 3.5)

General findings

We examined a sample of patient records on both wards inspected and found that all documentation was completed to a good standard and in sufficient detail to assist all members of the ward team to meet patients' needs. In addition, risk assessments and plans of care were seen to be reviewed regularly and were up to date.

We were provided with evidence of audit activity in relation to the completion of patient records. This showed that the ward teams were aware of their accountability for record keeping in support of effective clinical judgements and decisions. We found, however, that such audits were not completed on a regular basis.

We further found that staff signatures, designations and dates of entry were absent within a small number of patient records. The health board should address this matter through wider audit activity, or through staff awareness sessions.

Timely care

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff (Standard 5.1).

General findings

Throughout our two day inspection, within wards C6 and C7 respectively, we found, overall, that staff were able to respond to call bells and verbal requests from patients for assistance, in a timely manner.

We did see one record which indicated that staff had experienced some difficulty in responding to a patient during the night. However, the written entry provided assurance that the patient's needs were met.

5. Quality of Management and Leadership

We found that there was a considerable emphasis on implementing and monitoring systems and processes in place for the sustainable delivery of safe, effective person centred care.

Both wards inspected were also seen to be managed and run by staff who demonstrated a professional approach to providing good quality care to patients.

Staff and resources

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need (Standard 7.1).

We found both wards to be managed and run by staff who demonstrated a professional approach to providing safe and effective care to patients. Discussions held with members of the ward teams, and senior nurses from the two clinical directorates (that is-gerontology and internal medicine respectively), demonstrated that they were also well aware of issues which required improvement and had a clear commitment to addressing these in order to raise the standard of care and support to patients.

Conversations with staff within both wards revealed that they were clear about their roles and responsibilities and told us they felt well supported by senior staff on a day to day basis.

Both ward sisters worked in a supervisory capacity. This meant that they were visible within their clinical areas and in a position to provide practical support and advice to staff.

Ward C6-Directorate of Clinical Gerontology, Medicine Clinical Board

We found that regular assessments (known as patient acuity) were undertaken to try and match the number and skills of staff with patients' changing needs. As a result, the health board had increased the number of registered nurses on duty.

We also found that the ward sister actively encouraged staff to offer their views on services provided. This was seen as a means of encouraging an open, positive culture within the ward.

Staff who spoke with us revealed that they were supported in their work through regular competency assessments.

Ward C7- Directorate of Internal Medicine, Medicine Clinical Board

Conversations with the ward sister and senior nurses revealed that there had been a significant influx of new staff to this clinical area within the past nine months. Whilst we acknowledged that the health board had been pro-active in filling such a large number of registered nurse vacancies, the number of new staff (10) had clearly resulted in additional challenges for the ward manager and senior nurses, in respect of staff induction and on-going support.

Similarly, although the project underway on the north side of the ward had resulted in the need for fewer registered nurses, the need for health care support workers had increased. This matter was in the process of being addressed. We were also made aware of the revised arrangements in place concerning the north side of the ward in respect of ensuring appropriate medical support for patients, as and when needed.

Senior managers provided us with verbal and written information regarding a project established by the health board to ensure that patients get the most appropriate medical, nursing and therapies input for their needs. The project had actually begun two days prior to our inspection and involved the creation of an 'Acute Inpatient' care zone and one which would care for the needs of patients in the recovery/rehabilitation phase of their care.

As far as ward C7 was concerned, this meant that half of the beds in the north area (19 in total) would be used to provide accommodation to patients who had completed their rehabilitation and recovery. The new model of care was planned to deliver care to patients who were, in the main, waiting for a place in their known discharge destination (for example, a residential or nursing home). Care being provided was therefore at a level to ensure that patients were safe, and to prevent any deterioration in their physical, mental health, or their general abilities.

Staff within both clinical areas inspected, were invited to complete a HIW questionnaire in order to seek their views about training and development, aspects of patient care and communication/teamwork within the organisation.

Eleven out of the twenty questionnaires distributed were completed by a variety of professionals. Of that number, nine staff had received a formal appraisal of their work and relevant training in the past twelve months. Nine staff indicated that they were unable to meet the conflicting demands on their time at work. Four staff also indicated that feedback about changes made in response to reported errors and clinical incidents could be improved. The health board is therefore advised to consider how these matters may be improved in the future.

Apart from the above, the questionnaires provided positive views about the organisational culture.

Governance, leadership and accountability

Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care. (Health & Care Standards, Part 2 Page 8)

General findings

There was a mandatory staff training programme in place. However, we found that staff experienced difficulties in completing self directed learning and e-learning due to the competing priorities they faced in caring for patients with complex, unpredictable needs. We were, however, made aware that ward sisters were doing their best to identify staff training requirements and seek support for those needs to be met so as to ensure that staff remained competent and confident in the workplace.

We were also provided with information regarding the nurse foundation training programme for April 2016-March 2017 which listed the topics to be covered in support of the provision of safe and effective care.

Ward sisters within both clinical areas visited provided us with a sample of completed audit activity on request. However, it was not always clear as to whether action/improvement plans had been created following completion of those audits. The health board should consider whether staff require some additional support with regard to audit activity in the future so as to ensure that areas of service identified for improvement are monitored and action taken by named staff within prescribed timescales.

We saw the agenda and notes associated with meetings held by the Quality, Safety and Experience committees (internal medicine and gerontology clinical directorates). Both sets of information provided us with details of initiatives, projects and the patient stories discussed. This was on-going, with a view to improving patient care and delivery, in accordance with the health and care standards.

6. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit this to HIW within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/units within the wider organisation.

The actions taken by the health board in response to the issues identified within the improvement plan need to be specific, measurable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the health board's improvement plan remain outstanding and/or in progress, the health board should provide HIW with updates, to confirm when these have been addressed.

The health board's improvement plan, once agreed, will be published on HIW's website.

Appendix A

Hospital Inspection: Improvement Plan

Hospital: University Hospital of Wales (UHW)

Ward/ Department: Ward C6-Directorate of Clinical Gerontology; Ward C7-Directorate of Internal Medicine, Clinical Board Medicine

Date of inspection: 18 and 19 October 2016

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
10	The health board is required to provide HIW with details of the action taken to ensure that all patients are treated with dignity at all times. This is particularly in respect of the need to ensure that staff have time to listen to patients and the way in which conversations are conducted with patients, at the bedside.	Both Nursing and Medical staff informed off HIW findings and reminded of the need to maintain privacy at the bedside Supervisory Ward Sister to ensure there is a suitable quiet area for patient consultation within the ward area For patients who are unable to leave their bed area staff to ensure that verbal consent is received from patients that they are happy to	Senior Nurse/ Supervisory Ward Sister	December 2016

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		<p>have difficult discussions at the bedside</p> <p>DECI audits and '2 minutes of your time surveys' to continue to be undertaken on C7 to monitor patient experience</p> <p>Recommendations to be shared and discussed with medical and nursing staff at Quality Safety and experience meetings and relevant forums within the directorate and at MCB Quality Safety and Experience meeting</p> <p>Recommendations to be shared at junior doctor induction day within MCB and with relevant Clinical Directors</p>	<p>Lead Nurse</p> <p>Lead Nurse</p> <p>MCB Clinical Director</p>	<p>February 2017</p> <p>February 2017</p> <p>January 2017</p>
11	<p>The health board is required to describe the action taken/to be taken to ensure that patients' information is presented on noticeboards in a way which maintains patients' confidentiality and dignity.</p>	<p>The patient information boards have the patient's first name initial and surname on the patient orientation boards. The ward has trialled the use of initials on the board to protect patient confidentiality but it led to confusion and increased patient safety risk</p> <p>To date the UHB has not received any concerns either formally or informally regarding the information displayed.</p> <p>The Supervisory Ward Sister to consider alternatives to ensure confidentiality and patient safety is maintained</p>	<p>Supervisory Ward Sister</p>	<p>January 2017</p>

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Delivery of Safe and Effective Care				
16	The health board is required to provide details of the contingency plans to be put in place in the event that portable heating appliances need to be used in the future. This is to ensure the health, safety and welfare of patients, staff and visitors.	If the Main Boilers or its supply mechanism fail at UHW and heat cannot be supplied to the wards (Redundancy within the Boiler system) then only, “estates approved” and issued “Oil Filled” radiators are to be utilised. These are to be put onto “medium” and are thermostatically controlled and have over-load protection. These radiators minimising any fire risk and provide a minimised risk to the patient from direct heat at this setting. These are only to be used in an emergency short term situation until the main systems are operational. This action to be circulated to estates teams for awareness	Head of Estates & Facilities	November 2016
16	The health board is required to provide HIW with details of how it will ensure that maintenance and repair requests are dealt with in a timely manner. This is to ensure that the health, safety and welfare of patients, staff and visitors is maintained.	The maintenance system at the UHB is logged via a backtraq software system. When the user logs a “reactive request”, they set a priority for the maintenance team from four levels of choice. These are priority 1 to 4. Priority 1 being the most urgent and request assistance within 24 hours. Priority 2 within 3 days (target) and priority 3 (within two weeks).	Head of Estates & Facilities	In Place October 2016.

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		<p>The teams have a KPI of these reactive requests and have some 2500 a month (UHW) to manage. The teams' backlog is currently 600. This is approximately under two weeks' worth of requests. This is constantly being managed and presented at Service Board Level for performance. It is envisaged a full review of the software system and the delivery of Planned maintenance will take place in 2017.</p>		
17	<p>The health board is required to provide HIW with details of the action to be taken to repair and ensure the continued operation of the lift systems at UHW.</p>	<p>UHW is committed to an All Wales contract for service and repair of their lifts (Circa 120). In 2016 it was found that the current contractor was underperforming and found our lifts in a very poor state of repair. A new national provider was selected just for Cardiff and Vale UHB we are now working closely with these to ensure they maximise availability of our aging lift stock. The manning, budget and serving frequency has been increased to minimise disruptions. Papers are being drafted to secure funding over the medium and longer terms to ensure their ongoing reliability and availability for staff visitors and patients.</p>	Head of Estates & Facilities	In Place October 2016

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
20	The health board is required to inform HIW of how it will ensure that appropriate action is taken following the completion of cleanliness spot checks and that staff always ensure that equipment is clean and free from bodily fluids prior to and after use.	<p>Monthly cleaning audits (Credits 4 Cleaning) to be undertaken by Operational Services in conjunction with the Supervisory Ward Sister and actions implemented as required.</p> <p>Findings of audits to be shared with all staff during safety briefings</p> <p>Senior Nurse and Supervisory Ward Sister to ensure there is a robust equipment cleaning rota in place</p>	<p>Supervisory Ward Sister</p> <p>Supervisory Ward Sister</p> <p>Supervisory Ward Sister/Senior Nurse</p>	<p>December 2016</p> <p>December 2016</p> <p>December 2016</p>
21	The health board is required to describe how it will ensure that there are suitable systems in place and equipment available to record and monitor patients' weight.	<p>The UHB Nutrition and Catering Steering Group have secured funding for sit on scales.</p> <p>The same group are currently gathering information on the status of hoist scales through out the organisation to gather evidence to support a timelier repair of hoist scales if out of order.</p>	Lead for UHB Nutrition and Hydration Group	March 2017
23	The health board is required to provide HIW with details of how it will ensure that, in	Medication chart audit undertaken on a monthly basis.	Supervisory Ward Sister	January 2017

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	instances where oxygen therapy is required by patients, this is prescribed on the All-Wales medication chart.	<p>Staff reminded in safety briefing at beginning of each shift on the need to ensure all oxygen prescribed.</p> <p>New all Wales prescription charts to be implemented with the oxygen prescription on the front cover.</p> <p>Ward Consultants and pharmacists advised of HIW findings and reminded of prescribing procedures for the administration of oxygen.</p> <p>Circulation of SBAR to all wards reminding the correct prescribing instructions for oxygen</p>	<p>Supervisory Ward Sister</p> <p>Supervisory Ward Sister</p> <p>Lead Nurse</p> <p>Lead Nurse</p>	<p>December 2016</p> <p>December 2016</p> <p>December 2016</p> <p>December 2016</p>
	Quality of Management and Leadership			
	No improvements identified			

Health Board Representative:

Name (print):

Title:

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Date:

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