Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Dignity and Essential Care Inspection (unannounced)

Cardiff and Vale University Health Board

University Hospital for Wales

B6 Trauma and Orthopaedic

22 and 23 July 2014

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.
Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978 1 4734 2

Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care inspection in B6 trauma and orthopaedic ward at the University Hospital for Wales, part of the Cardiff and Vale University Health Board on 22 and 23 July 2014.

Our inspection considered the following issues:

- Quality of the patient experience
- Delivery of the fundamentals of care
- Quality of staffing, management and leadership
- Delivery of a safe and effective service

2. Methodology

HIW's dignity and essential care inspections review the way patients' dignity is maintained within a hospital ward/unit/department and the fundamental, basic nursing care that patients receive.

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

- Information held by HIW
- Conversations with patients and relatives, and interviews with staff
- Discussions with senior management within the health board
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- General observation of the environment of care and care practice

These inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues about the quality and safety of 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, 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, is also the responsibility of the health board. Additionally, it serves a wider population across south and mid 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 the Vale Health Board include nine hospitals and seventeen health centres including the University Hospital of Wales (UHW) which is a major 1,000 bed hospital situated in the Heath district of Cardiff. UHW is a teaching hospital of Cardiff University School of Medicine and it was officially opened in 1971. It is the third largest University Hospital in the UK and the largest hospital in Wales.

Ward B6 is a 38 bedded ward dealing with hip fracture and general trauma patients. It delivers its care through a shared care model with the orthogeriatric consultant lead alongside specialist trauma input from trauma and orthopaedic consultants. The ward came into being in November 2011 after a major reorganisation of the trauma and orthopaedic beds.

Operationally B6 is organised as two distinct 19 bedded areas with designated nursing teams within the ward establishment. Each 19 bedded area has an orthogeriatric pathway facilitator[1].

[1] An orthogeriatric pathway facilitator is an assigned staff member that conducts ward rounds to help ensure effective coordination of care and access to specialist therapies in line with recognised good practice.

4. Summary

We made a number of findings in relation to the delivery of the fundamentals of care, quality of the staffing, management and leadership, and the delivery of a safe and effective service for which we requested immediate assurance from the health board following the inspection.

The health board has provided HIW with a satisfactory response detailing its actions, responsible officers and reasonable timescales, and this can be found at Appendix A.

Overall, we found that patients felt the quality of their experience whilst on this ward was positive. When asked about their care, patients we spoke to were satisfied with the way in which care was provided and felt they were listened to and involved in decisions about their care.

We observed a number of positive interactions between staff and patients during the inspection. Staff were aware of the need to protect the privacy and dignity of all patients. However, on a small number of occasions we did not observe this. Patients would benefit from staff paying more attention to maintaining and protecting people's privacy and dignity at all times.

Our findings in relation to the fundamentals of care were as follows:

- Patients and relatives we spoke to felt that staff communicated with them effectively and in a manner sensitive to their needs. They also told us that they had been given the option to communicate in a language of their choice. We observed the efforts made by staff to help patients who may have difficulties with their short term memory. This was achieved through the use of large pictorial signs on doors and coloured tape on handles (to make them more visible)

- Patients told us that they were happy with the way that staff approached and spoke to them. During the inspection we observed a small number of occasions when patients bedside curtains were fully closed before undertaking care or treatment

- We found that patients were routinely encouraged to regain as much independence as their medical condition could allow. There is scope to improve the day room for the use of patients and their relatives

- We observed that staff were pro-active in working towards improving relationships with patients through initiatives such as 'This is me'. Patients who spoke to us told us that they were able to receive visitors at times other than the ward visiting times with the prior agreement of the ward sister

- Patients we spoke to did not report any concerns or problems in relation to rest and sleep and told us they were able to rest throughout the day or night. Staff we spoke to reported that at times they had experienced shortages of linen which may result in difficulty providing an extra pillow or bedding for comfort purposes

- All of the patients that we spoke to told us that their pain was well managed and that they were comfortable. Our review of a sample of patient documentation found that some records lacked evidence of consistent use of pain scoring to fully inform the assessment, management and review of the effectiveness of pain relief that had been administered

- Patients told us that they received assistance with their personal hygiene and appearance in accordance with their needs and wishes

- We found that patients' nutritional needs were met and there was evidence to support this recorded within patient documentation. We observed staff ensuring that all patients received appropriate assistance and encouragement to eat and drink. However, we found that fluid intake was recorded inconsistently in patient records and patients had not been offered hand washing or hand wipes prior to meal times

- Staff we spoke to were aware of procedures for oral hygiene and patients who were able to, were supported to clean their teeth and dentures independently. However, we found that some patient records lacked evidence to confirm that oral care had been provided and we could not be assured that all patients' oral care needs were being met all of the time

- Patients were supported and were able to use their toileting method of choice. However, staff need to consistently ensure that patient dignity is maintained during personal care. Patients would benefit from more regular evaluation of continence to ensure appropriate care is provided

- We found evidence that staff were using a pressure area assessment tool to assist with identifying those patients who may be at risk of developing pressure damage

Overall, we observed that the ward was a particularly challenging environment due to the size and long distance between nursing stations and patient bay areas. Patients would benefit from increased staff visibility in the ward bay areas. The ward team would benefit from more open and joined up communication between health care support workers and registered nurses to

ensure patients whose conditions may have changed are identified and assessed at the earliest opportunity.

We observed that the ward was at times disorganised and that there was a lack of focussed organisation between the staff resource. This was compounded by issues with some modes of communication, such as the patient information boards, which we found were not effectively coordinated and kept up-to-date with relevant information to aid staff. The disorganised nature of the ward, as illustrated above had a negative impact on the completion of documentary evidence of how patients' individual care needs had been met.

5. Findings

Quality of the Patient Experience

Overall, we found that patients' experience of the service whilst on this ward was positive. When asked about their care, patients we spoke to said that they were satisfied with the way in which care was provided; they were listened to and involved in decisions about their care.

During our inspection we spoke to a number of patients and relatives and provided them with an opportunity to complete a patient, relative and carer feedback questionnaire. We did this to obtain their views of the service provided within Ward B6.

Four questionnaires completed by patients and relatives were returned to us following the inspection. Each of those questionnaire responses indicated that the people 'strongly agreed' or 'agreed' that the ward was clean and tidy and staff were polite to them, their friends and family.

All patients responding to the questionnaire reported that they 'strongly agreed' or 'agreed' that staff on Ward B6 were kind and sensitive to them when carrying out care and treatment. They also indicated that they had a choice in terms of meeting their toilet and or continence needs and that staff were generally prompt in responding to their calls for assistance.

We held conversations with patients who described how they had been involved in their care choices. They also provided us with positive comments about staff attitude and behaviour. Patients were very complimentary about staff and said they were called by their preferred name.

Patients were very complimentary about the prompt and compassionate way which staff were seen to be caring for them, particularly those who appeared to be distressed and were calling out for assistance. We also observed staff speaking in an appropriate manner; assisting one patient to sit closer to the nursing station in order to be able to provide them with closer observation and support.

Conversations with a number of patients highlighted that they were not aware of the concerns and complaints process at Cardiff and Vale University Health Board or how to make a complaint. However, most patients indicated they felt able to discuss any concerns they had with the senior staff on the ward and if a satisfactory outcome was not reached, felt able to make a more formal complaint.

When asked about their care, patients were satisfied overall with the way in which care was provided. Patients and relatives felt that they were listened to by the ward team. They also told us that they felt involved in decisions about their care planning and treatment choices and felt that they understood the care and treatment being provided.

During the inspection we observed that staff were dressed in accordance with the All Wales NHS Dress Code[2]. However, some staff were not wearing name badges as a clear means of identification to assist patients in identifying their role within the ward team.

Recommendation

The health board must ensure staff adhere to the All Wales NHS Dress Code, principle 5, which requires all staff to wear identification at all times which is clearly visible.

[2] All Wales NHS Dress Code specifies the principles that all NHS staff must adhere to and highlights specific expectations for all staff directly involved in the delivery of clinical services. The dress code applies equally across clinical and non-clinical staff working within NHS Wales.

Delivery of the Fundamentals of Care

We observed a number of positive interactions between staff and patients during the inspection. Staff were aware of the need to protect the privacy and dignity of all patients. However, on a small number of occasions we did not observe this. Patients would benefit from staff paying more attention to maintaining and protecting people's privacy and dignity at all times.

We made a number of findings in relation to the delivery of the fundamentals of care for which we requested immediate assurance from the health board. The health board have provided HIW with a satisfactory response detailing their actions which can be found in Appendix A.

Communication and information

People must receive full information about their care in a language and manner sensitive to their needs

Patients and relatives we spoke to felt that staff communicated with them effectively and in a manner sensitive to their needs. They also told us that they had been given the option to communicate in a language of their choice. We observed the efforts made by staff to help patients who may have difficulties with their short term memory. This was achieved through the use of large pictorial signs on doors and coloured tape on handles (to make them more visible).

We observed various measures taken by staff on the ward to help patients who may have difficulties with their short term memory or who lack understanding of the ward layout. Such measures included large pictorial signs to help patients identify toilet and bathroom facilities and the application of brightly coloured tape on door handles, so that they were easier to see. It was evident that staff were trying to communicate as effectively as possible with patients.

We found that the ward staff did not have access to a loop hearing[3] system for patients who had hearing difficulties and that there were no bilingual signs or

[3] An Audio Frequency Induction Loop (AFIL), commonly referred to simply as an **Hearing Loop** is an assistive listening system that provides access to facilities for those with a hearing impairment

leaflets in the patient day room. This may mean that some aspects of patients' needs were not being met.

Recommendation

The health board is advised to review the availability of suitable communication aids on the ward.

We found that there were large clocks located in all of the ward areas to help orientate people, but some of the clocks had the incorrect time of day set which could confuse patients.

Recommendation

The health board is advised to ensure that information provided to patients on the ward is accurate.

In one of the nine bed ward areas we were able to hear staff speaking, in clearly audible voices, with a patient when administering personal care behind a closed curtain. We also found other staff speaking loudly to patients who were in their bed or bedside chair. Those conversations could be heard from across the room and from the corridor. This meant that conversations with the patient may be overheard by other patients, visitors or staff. Conversely, we observed some patients who found it difficult to clearly hear the nursing staff speaking to them as they were some distance away.

Recommendation

The health board is advised to ensure that patients are communicated with in a way that enables them to receive and respond to the information given.

Patients told us that they were able to speak in the language of their choice and that staff would try to accommodate their wishes and preference in this regard. We also reviewed a sample of patient records which indicated that patients' preferred language was recorded on admission to the ward. However, discussions with some staff indicated that they did not have sufficient knowledge of the Language Line[4] service available to the health board. Staff did tell us they had relied on the presence and support of patients' family

[4] The language line is a service which offers professional interpreters to help facilitate consultations with patients.

members who were able to translate information/conversations to help their relative.

Recommendation

The health board must ensure that patients receive full information about their care in a language and manner sensitive to their needs.

Respecting people

Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

Patients told us that they were happy with the way that staff approached and spoke to them. During the inspection we observed a small number of occasions when maintaining a patient's dignity was compromised by staff not ensuring patients bedside curtains were fully closed before undertaking care or treatment.

Patients told us that they were happy with the way that staff approached and spoke to them. They were complementary of the staff on the ward and told us staff were caring and addressed them by their preferred name. We observed a small number of instances where patients were not referred to by their preferred name and referred to as 'love'. However, none of the patients who spoke to us expressed dissatisfaction with this.

We observed one instance of staff on the ward discussing a specific patient's condition near to the ward entrance and the conversation could be heard within the ward and corridor areas. While we understand the need for nursing staff to discuss patients, staff should be mindful of where such conversations take place and maintain patient confidentiality by ensuring conversations about patients cannot be overheard by others.

Recommendation

The health board is advised to ensure that patient confidentiality and privacy are respected as far as possible, especially in hospital wards, public areas and reception areas.

We observed a small number of instances where bedside curtains were not kept fully closed when personal care or treatment was being given. It was apparent that staff found it very difficult to keep curtains closed at times when they needed to use or move equipment at patients' bedsides due to the limited space available.

Recommendation

The health board is advised to ensure that patient dignity and privacy must be protected at all times.

Promoting independence

The care provided must respect the person's choices in making the most of their ability and desire to care for themselves.

We found that patients were routinely encouraged to regain as much independence as their medical condition could allow. There is scope to improve the day room for the use of patients and their relatives.

We observed some patients sitting in chairs at the side of their bed as well as in their beds. Patients told us that they were encouraged by staff to maintain their independence and that they could walk around the ward or sit at their bedside according to their personal preference.

We found that patients and their relatives had the use of a day room with a television and a number of books. However, we also found that there were limited opportunities for social or recreational activity for patients.

We found that the day room was unwelcoming and the carpet was stained. We also observed that it was being used for purposes other than a facility for patients and relatives. A large photocopier was present in the room and was used by staff at various times of the day. In addition, the day room was being used by nursing staff to complete their written updates of patients' records and to take breaks from their caring responsibilities.

Recommendation

The health board is advised to consider the use of the current patient day room and that the room is a suitable environment for patients.

We observed that elements of the 'Butterfly Scheme[5]' were in operation. The butterfly logo could be seen at some patients' bedsides. This indicated if the patient had a dementia related memory impairment which they wished staff to

[5] The Butterfly Scheme http://butterflyscheme.org.uk/ allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

be aware of. We found in some patient records there was a butterfly scheme carer sheet containing helpful information about the patient and preferences which would minimise any potential distress during their hospital stay. Staff who spoke to us confirmed that the scheme had recently been introduced to the ward and that it was yet to be fully and consistently implemented. However, we found that the staff were committed to fully learning about the scheme and progressing towards its full intended use.

Relationships

People must be encouraged to maintain their involvement with their family and friends and develop relationships with others according to their wishes.

We observed that staff were pro-active in working towards improving relationships with patients through initiatives such as 'This is Me[6]'. Patients who spoke to us told us that they were able to receive visitors at times other than the ward visiting times, with the prior agreement of the ward sister.

The ward had structured visiting hours in place, although staff informed us that the arrangements were flexible so that individual patient and/or relatives' circumstances could be considered.

We found that efforts were being made to enable patients who had difficulties with communication, to make their preferences known to staff. Specifically the ward team had recently adopted the use of the 'This is Me' initiative. The initiative allows patients and relatives to provide information regarding their wishes and preferences associated with care and support. The ward sister informed us that the initiative is yet to be fully established within the ward. However, staff were working towards including an outline of the initiative within a booklet for patients and their relatives so that they are able communicate their wishes regarding their preferred name, television programme and choice of hot drink.

Rest, sleep and activity

Consideration is given to people's environment and comfort so that they may rest and sleep.

---

[6] 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.

Patients we spoke to did not report any concerns or problems in relation to rest and sleep. Patients did tell us they were able to rest throughout the day or night. Staff we spoke to said they had experienced occasional shortages of bed linen and pillows.

We observed that patients were able to sleep during the day as they wished. However, we did find that the ward was quite noisy, with phones being left to ring on the ward at times. This may not be conducive to patients resting during the day.

The stock of pillows, blankets and linen on the ward was low. Staff we spoke to said that there was an inadequate stock of pillows, blankets, and linen at all times. They also told us that there have been occasions where they have had to obtain additional linen stock from other wards.

Recommendation

The health board is advised to ensure that there is an adequate stock of linen and pillows at all times to meet patient's needs

<u>Ensuring comfort, alleviating pain</u>

People must be helped to be as comfortable and pain free as their circumstances allow.

All of the patients that we spoke to told us that their pain was well managed and that they were comfortable. Our review of a sample of patient documentation found that some records lacked evidence of consistent use of pain scoring to fully inform the assessment, management and review of the effectiveness of pain relief that had been administered.

Conversations with patients revealed that their pain levels had improved through the use of prescribed medication, that they felt comfortable and that their pain was well controlled all of the time.

Our review of patient documentation found that pain assessment scores had been recorded at the point when patients' pain had been identified. However, subsequent assessment and scoring of pain in some cases was inconsistent. We were unable to identify comprehensive evidence to support the

effectiveness of analgesia[7] administered and we could not always find up-to-date pain scores in patients' records. Pain scores appeared to be undertaken with the observational rounds rather than in relation to individual patient need at times when patients experienced pain. We found that at times there was no obvious re-evaluation of the effectiveness of pain relief given.

Recommendation

The health board is advised of the need to ensure that patients' level of discomfort, pain or distress is regularly assessed and recorded. Results of decisions can then be recorded for the continuity of patient care.

Personal hygiene, appearance and foot care

People must be supported to be as independent as possible in taking care of their personal hygiene, appearance and feet.

Patients told us that they received assistance with their personal hygiene and appearance in accordance with their needs and wishes.

Patients on the ward appeared well cared for and were washed and clean. We observed that some patients were wearing their own clothing. Conversations with staff on the ward highlighted that they encourage patients to wear their own clothing and that they have an adequate supply of soap, toothbrushes and denture pots on the ward for patients to use.

We were told by staff that three of the healthcare support workers have received training in foot care and that they regularly undertake foot care for patients. We observed one of the healthcare support workers cutting a patient's nails and recording the care given within the patient's care record.

Staff we spoke to expressed concerns that at times there has been a shortage of gowns for patients to wear on the ward. The ward sister told us that the shortage of gowns has been escalated to senior management within the health board and as a result the ward are happy to be included in a health board trial of new nightdresses and pyjamas. The new items have been designed specifically for the ward with the involvement of the ward staff. The ward sister indicated that they are expecting to receive the trial nightdresses and pyjamas within the next few weeks.

[7] Analgesia or painkiller is any member of the group of drugs used to achieve relief from pain.

Eating and drinking

People must be offered a choice of food and drink that meets their nutritional and personal requirements and provided with any assistance that they need to eat and drink.

We found that patients' nutritional needs were met and there was evidence to support this recorded within patient documentation. We observed staff ensuring that all patients received appropriate assistance and encouragement to eat and drink. However, we found that fluid intake was recorded inconsistently in patient records and patients had not been offered hand washing or hand wipes prior to meal times.

Our review of a sample of patient documentation demonstrated that patients' nutritional needs are assessed on admission to the ward. We found that the All Wales Nutritional Care Pathway[8] was used with all patients for the first 48 hours of their stay on the ward. The nutritional care pathway was then reviewed by the nurse and, where required, a referral to the dietician for further dietetic assessment of the patient was made, or if no referral was necessary, the patient was removed from the pathway.

Further review of the sample of patient documentation found that patients on the nutritional care pathway food charts had their food intake recorded consistently. However, the recording of patients' fluid intake was inconsistent. The majority of the fluid charts that we reviewed had no fluid intake recorded for two days. We escalated this to a nurse on the ward who told us that that the fluid intakes were normally completed.

Recommendation

The health board is advised to demonstrate that documentation is fully completed and reviewed in accordance with the All Wales Nutritional Care Pathway.

[8] All Wales Hospital Nutritional Care Pathway is a protocol which provides technical guidance for caterers, dietitians and nursing staff responsible for meeting the nutritional needs of patients who are capable of eating and drinking.

The ward had protected mealtimes[9] in place and we observed this in practice during the inspection. Staff told us that relatives are encouraged to attend at mealtimes and assist their loved ones. This was evident, as we observed three patients being assisted by their relatives.

The ward operated the 'Red Tray[10]' initiative and we observed meals being distributed on red trays to patients who required assistance. In general, we saw that staff were aware of the initiative and were prompt in going to assist patients with red trays. Our review of a sample of patient documentation found that All Wales Food Charts[11] were appropriately completed immediately after a mealtime and by appropriate staff members. Our review of a sample of patient documentation found that All Wales Food Charts were appropriately completed immediately after a mealtime and by appropriate staff members.

Patients were able to have a choice of size of meal and they told us they could ask for more if they wished. The ward had arrangements in place to ensure patients who were not present on the ward during mealtimes had access to suitable food. A patient reported that they had previously been provided with food from the ward fridge when they had been absent from the ward during a mealtime.

Patients that were able to drink independently had ready access to fluids, and water jugs were replaced regularly throughout the day and on request. Patients told us that water jugs were within reach and hot drinks were also available regularly on request. Patients requiring assistance to drink were observed being assisted by nursing staff.

---

[9] Protected mealtimes is a period of time over lunch and evening meals, when all activities on a hospital ward are meant to stop. This arrangement is put in place so that nurses and housekeepers are available to help serve the food and give assistance to patients who need help. Protected mealtimes also prevent unnecessary interruptions to patients' mealtimes.

[10] The Red Tray system helps to reduce nutritional risk in hospitals. The trays provide a signal that vulnerable patients need help and support from staff, or that the patient has a poor dietary intake. The system is a way for staff to easily identify patients who require help with eating. The tray acts as a prompt to staff to quickly provide assistance to patients so that their dignity and the quality of their meal time are not compromised.

[11] All Wales Food Charts are records of the type and quantity of all food and drink consumed by a patient throughout the day. These food charts should be completed by appropriate NHS staff after each meal.

We observed the preparation for a mealtime and all patients were appropriately positioned in order to comfortably eat their food. Nursing staff did not check patients had washed their hands prior to mealtimes and we did not observe ward staff offering hand wipes or hand washing. Patients we spoke to said they had not been offered hand washing or wipes prior to mealtimes and they had not seen this happening on the ward.

Recommendation

The health board is advised to ensure that patients are offered the opportunity to either to wash their hands or use hand wipes prior to eating their meals in accordance with their wishes and in keeping with the fundamentals of care.

Oral health and hygiene

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

Staff we spoke to were aware of procedures for oral hygiene and patients who were able to, were supported to clean their teeth and dentures independently. However, we found that some patient records lacked evidence to confirm that oral care had been provided and could not be assured that all patients oral care needs were being met all of the time.

Healthcare support workers we spoke to were aware of the mouth care process and one of them reported that they cleaned dentures for patients and that patients can be referred to dental services if required.

Patients who spoke to us reported that they were able to clean their teeth and dentures as regularly as they wanted to. Staff informed us they had toothbrushes available for patients to use. However, we did observe some patients who had food remnants in their teeth and who would benefit from additional attention paid to oral care.

Our review of a sample of documentation found limited evidence of an oral hygiene bundle used on admission. We observed that a patient who had been unwell was in urgent need of oral care. We escalated this to the nurse in charge of the ward on the first day of our inspection.

Immediate assurance recommendation – see Appendix A

The following day we reviewed the patient's records and it was not possible to ascertain whether the mouth care for this individual had been assessed, or any such care had been provided, as the patient's records and care plan had not

been updated to include any record of further assessment or delivery of the care we had requested.

Recommendation

The health board is advised to ensure that all care given is documented within the patient records.

Toilet needs

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

Patients were supported and were able to use their toileting method of choice. However, staff need to consistently ensure that patient dignity is maintained during personal care. Patients would benefit from more regular evaluation of continence to ensure appropriate care is provided.

We found that the toilet and bathroom facilities were clean and had emergency assistance buzzers within easy reach. However, we found that the patient shower rooms were cluttered with equipment such as Zimmer frames and commodes which had to be moved in order to access the facilities.

Recommendation

The health board is advised to ensure that toilet and bathroom facilities are clear from unnecessary clutter and equipment.

Staff who spoke to us told us the ward stocked two types of continence pads in various sizes and stock levels were adequate. We confirmed this by checking the available stock within the store room.

Our review of one set of patient documentation found that a patient had been wet and soiled several times during the day, despite the use of continence pads. The patient had not been referred to a specialist continence nurse for further assessment. Our conversations with staff found that staff preferred to assess the continence needs of patients themselves and select suitable products for use. In the patient records we reviewed, it was not clear that patients' continence needs were being fully evaluated and referred promptly to a specialist continence nurse where continence was not being controlled with the methods used by the ward nursing staff.

Recommendation

The health board is advised to ensure that the All Wales Continence Bundle[12] is used consistently.

We observed a single instance when a patient's bedside curtain was not fully closed when receiving assistance from nursing staff to use a bedpan. This is not acceptable practice.

Recommendation

The health board is advised to demonstrate that patient dignity is maintained at all times.

We observed at times when the ward was particularly busy that patient buzzer calls for assistance were taking in excess of six minutes to answer. The health board has provided us with assurance of the actions taken in relation to this finding which can be found in Appendix A of this report.

Preventing pressure sores

People must be helped to look after their skin and every effort made to prevent them developing pressure sores.

We found evidence that staff were using a pressure area assessment tool to assist with identifying those patients who may be at risk of developing pressure damage.

Our scrutiny of a sample of patient documentation found that a pressure area assessment tool was used on the ward. The patient documentation contained individualised pressure area risk assessments which were undertaken on admission. There was evidence of pressure area care and monitoring being undertaken by nurses during intentional rounding[13] and all pressure area assessments we reviewed were up to date and contained evidence of regular monitoring and evaluation.

---

[12] The All Wales Continence Bundle provides nurses with tools to identify the immediate and longer term continence needs and support patients require.

[13] Intentional rounding is a structured process where nurses on wards in acute and community hospitals and care home staff carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.

Appropriate mattresses had been provided to patients who had been assessed as being at an increased risk of developing pressure areas. Staff we spoke to told us they try to obtain pressure relieving mattresses at the earliest opportunity. Staff also told us that in the event of delays in obtaining pressure relieving mattresses, they paid extra attention to other methods of pressure area relief, such as more regular turning and repositioning of the patient.

We observed that the ward displays safety crosses[14] to communicate its performance on the incidence of pressure areas with patients and visitors.

[14] Safety crosses are colour coded crosses seen on wards to make visible to patients and visitors any incidence of adverse avoidable events (such as a patient developing a pressure ulcer).

Quality of Staffing, Management and Leadership

Overall, we observed that the ward was a particularly challenging environment due to the size and long distance between nursing stations and patient bay areas. Patients would benefit from increased staff visibility in the ward bay areas. The ward team would benefit from more open and joined up communication between health care support workers and registered nurses to ensure patients whose conditions may have changed are identified and assessed at the earliest opportunity.

We made a number of findings in relation to the quality of staffing, management and leadership for which we requested immediate assurance from the health board. The health board has provided HIW with a satisfactory response detailing its actions which can be found at Appendix A.

The guiding principles for nurse staffing, issued by the Chief Nursing Officer for Wales, state that on a medical/ surgical ward during the day there should be no more than seven patients allocated to each registered nurse. Staffing on the first day of our inspection met the minimum requirement. We observed that on the second day of our inspection the ward was under-staffed due to illness and that the ward sister was included within the nursing numbers to provide direct patient care. As a result, the ward sister was unable to spend time organising the nursing team and patient care, and had limited time available to focus on a management and leadership role within the multi-professional team.

Immediate assurance recommendation – see Appendix A

Staff who agreed to speak with us expressed concern relating to the number of staff available to meet the needs of the patient group during the night and over the weekend. Our discussion with the ward sister indicated that at times the health board's formal escalation protocol has been followed in order to obtain additional nursing staff when staff numbers fell below the minimum requirement. However, we were told that at times the nursing bank has been unable to provide adequate resource and in these instances the ward sister would personally provide cover, as we observed during the second day of our inspection.

We observed that the ward was a particularly challenging environment due to the size and long distance between nursing stations and patient bay areas. There were periods when nursing staff were not routinely visible in the patient bay areas due to working around the nursing station.

Immediate assurance recommendation – see Appendix A

On the second day of the inspection six staff took a break at the same time during the morning. This reduced the number of staff available to provide continuous patient care and observation in the patient bay areas.

Immediate assurance recommendation – see Appendix A

The ward was full during the inspection and the majority of patients were elderly with complex medical needs, some also with dementia or other cognitive impairments. We observed a ward round being undertaken by various doctors specialising in medicine, care of the older person and psychiatry as well as trauma. The orthogeriatric pathway facilitator attended the ward round and we were advised by the health board that it is normal practice on this particular ward for the ward sister not to be present on all ward rounds. The majority of ward rounds are attended by the orthogeriatric pathway facilitator, who we were informed, communicates the outcomes of the ward round to the ward sister. This is to ensure effective coordination of any changes to the patients care plan and discharge arrangements.

We noted a heavy reliance on healthcare support workers to maintain observations and safety scorings, for example National Early Warning Scores (NEWS)[15]. It was found that it may be some hours before the trained nurses reviewed these observations to amend care as necessary.

Immediate assurance recommendation – see Appendix A

It was difficult to identify clear organisation of professional accountability on the ward at times because there was a lack of clarity as to who was in charge or delegating work to the unregistered healthcare support worker staff.

Immediate assurance recommendation – see Appendix A

We observed an instance when a patient's condition had changed, and we felt that they required a timely assessment by a registered nurse. This was slow to be recognised and responded to by the nursing team on the ward. Attention was provided to the patient when the inspection team escalated their concerns and requested a registered nurse to review the patient's condition.

Immediate assurance recommendation – see Appendix A

[15] The National Early Warning System (NEWS) system assists healthcare staff to consistently detect deterioration in patients' condition, so that they can call for urgent medical help.

We found that the ward team would benefit from more open and joined up communication between healthcare support worker staff and registered nurses and between nursing, medical and therapy staff. Better communication would assist in identifying, at the earliest opportunity, patients whose condition may have changed.

Immediate assurance recommendation – see Appendix A

We reviewed the records of a number of previous staff meetings and found that only five nursing staff had attended the last team meeting in July 2014. Staff meetings are a good opportunity for staff to receive information and share views and we were unable to find or gain information about greater engagement of the wider team.

Our review of a sample of patient documentation demonstrated that we were unable to easily identify clear medical or multi-professional patient management plans. The planned course of treatment and care was not possible to establish from the records, indicating a lack of overall leadership by doctors in relation to the management of a patient's stay on the ward. Some case notes demonstrated that although core nursing care plans were used, these did not clearly reflect planned individualised patient care.

Immediate assurance recommendation – see Appendix A

Delivery of a Safe and Effective Service

People's health, safety and welfare must be actively promoted and protected. Risks must be identified, monitored and where possible, reduced or prevented.

We observed that the ward was at times disorganised and that there was a lack of focussed organisation between the staff resource. This was compounded by issues with some modes of communication, such as the patient information at glance boards, which we found were not effectively coordinated and kept up-to-date with relevant information to aid staff. This meant that staff struggled at times to provide full focus and attention to documenting evidence of how they have fully met patients individual care needs.

We made a number of findings in relation to the delivery of a safe and effective service for which we requested immediate assurance from the health board. The health board has provided HIW with a satisfactory response detailing its actions which can be found at Appendix A.

Patient safety

We observed that the ward used patient information at a glance boards which contained patient information including National Early Warning Scores[16] (NEWS) whether patients had conditions such as diabetes. We scrutinised a sample of patient records and compared the information in them to the information on the patient information at a glance boards. We found that the information on the boards was not up-to-date and therefore was not serving the purpose for which it was in use and may potentially indicate incorrect information about patients.

Immediate assurance recommendation – see Appendix A

Our review of a sample of patient documentation identified that safety scoring of patients in the form of NEWS scores was recorded inconsistently between the patient documentation and the patient information at a glance boards. This indicated that registered nurses did not have a full awareness of the NEWS

[16] National Early Warning Scores (NEWS) is a standardised assessment tool used by healthcare professionals to identify and respond to patients who present with or develop acute illness

status of every patient at a glance, and potentially may not be aware of a changing NEWS score of a patient (as recorded within patient documentation). We also noted that the observation measurements taken and recorded at the bedside by healthcare support workers were not reviewed by registered nurses for a number of hours. This delay in review could lead to inaccurate information being acted upon by registered nurses. Therefore it is important that registered nurses are made aware as promptly as possible, that observation measurements have been updated.

Immediate assurance recommendation – see Appendix A

We asked a number of nurses some basic questions about the patients on the ward and found that all nurses we spoke to had an inconsistent knowledge of the patients. This was compounded by errors in the information on the patient information at a glance boards. For example, the patient information at a glance boards indicated that there were no patients with diabetes on the ward and we had conversations with three separate registered nurses who explained that there were no patients with diabetes on the ward. However, our review of a sample of patient documentation found that there were patients with diabetes on the ward. We found on further investigation that the patients with diabetes were receiving the correct treatment for their conditions.

Immediate assurance recommendation – see Appendix A

Our review of a sample of patient documentation found that a number of Do Not Attempt Resuscitation (DNAR) forms were not fully completed, or reviewed once a patient's condition had changed. We could not identify from the patient documentation if the DNAR forms had been escalated to the consultant orthogeriatrican to be reviewed and updated.

Immediate assurance recommendation – see Appendix A

We found limited evidence of effective mental capacity assessments[17] being undertaken. The ward cared for a large proportion of elderly patients, many of whom had cognitive impairment. Therefore, it would be important to assess mental capacity in line with the principles of the Mental Capacity Act (2005) to determine whether patients had the capacity to consent to their care and

[17] Mental capacity assessments are used to determine whether patients have the capacity to fully understand and consent to their care and treatment. This is defined in the Mental Capacity Act 2005.

treatment. Staff had a limited understanding of the importance of mental capacity assessments. We were informed by staff that the ward doors are locked when they have patients who wander around the ward. Although locking the ward doors can prevent wandering patients leaving the ward, staff did not recognise that this could be considered a potential deprivation of liberty if a patient attempted to leave the ward and was prevented from doing so. In the event that a patient was considered to lack mental capacity and was prevented from leaving the ward, an authorisation under the Deprivation of Liberty Safeguards[18] would be required in order to best take account patient interests.

Immediate assurance recommendation – see Appendix A

Environment

During the inspection we observed that the ward environment and availability of space was a challenge for staff. We found that the amount of space available around the bed areas, particularly in the nine bedded areas, was very limited for both staff to work in and for patients to have space around bed areas. Many of the patients needed to use mobility equipment, such as Zimmer frames, which the areas around the beds could not always accommodate without being cluttered. Staff told us they worked with the space available placing patients who had additional mobility equipment in the beds which had more space available to accommodate the equipment.

We observed that there was an open door to the kitchen area which contained operational commercial ovens. The kitchen area had another access door located on the corridor outside of the ward, but staff told us this door was not used. We observed that the door from the ward to the kitchen area was routinely open and the room unattended during the inspection. We also found that the door to the waste room on the ward, which had a key pad lock on it, was unlocked. This meant that there was a risk the kitchen or waste room could be accessed by unauthorised persons when left unattended.

Immediate assurance recommendation – see Appendix A

[18] The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. The safeguards are intended to protect people who lack mental capacity to consent to care or treatment, from being detained when this is not in their best interests and to give people the right to challenge a decision.

We observed that the stockroom was untidy and cluttered and had items of equipment stored in front of shelves or cupboards which would need to be moved in order to access those cupboards and shelves. We also found that items were stacked on shelves at a high level and may pose a risk to staff if they fall.

Recommendation

The health board is advised to review the practice of storing stock and equipment at high level and stacked on shelves within the storage rooms to ensure there is no risk to staff.

Infection prevention and control

We noted that a medication room on one side of the ward was cluttered and had a number of dressing trolleys stored in front of the sharps bin. This meant in order to dispose of any sharps; staff first had to move the dressing trolleys in order to reach the sharps bin.

We also observed an increased risk of infection transmission and sharps injury on the ward. This was because of the incorrect use of treatment trays. We found that nursing staff were routinely carrying treatment trays containing used sharps from patients' bedside to the sharps disposal bin in the medication rooms. Whilst the treatment trays had a dedicated space for a sharps box, no sharps box was evident on the tray and sharps were loose within the trays.

Immediate assurance recommendation –see Appendix A

We observed that staff were regularly using patient transfer platforms to assist patients to the bathroom and shower facilities on the ward. Staff also informed us that they used slide sheets on the ward for turning or moving patients. Scrutiny of a sample of patient documentation found that there was limited evidence to confirm that patients had been individually assessed for use of suitable manual handling products such as the slide sheets and patient transfer platforms.

Recommendation

The health board is advised to ensure that assessments for the use of manual handling aids are recorded within the patient records.

Cleanliness and hand hygiene

We did not undertake a cleanliness spot check during the inspection; however, our general observations of cleanliness practice concluded that the ward was generally clean throughout the inspection.

We found that all sluice, medicine and storage rooms were clean and showed that some of the transforming care practices had started to be implemented to identify cupboard contents. However, the transforming care practices had not yet been fully embedded.

All commodes were suitably cleaned and stored ready for use. However, we found that none of the clean commodes had green tape attached to them in order to indicate that they had been cleaned and were ready for use. This was despite the green tape being available in the sluice room.

Recommendation

The health board is advised to ensure a consistent approach to All Wales Infection Prevention and Control guidelines[19].

Medicines management

Staff we spoke to told us that they were able to access the health board's policies for safe storage, prescription and administration and dispensing of drugs. They explained that the information was easily accessible and stored in a folder in the nurses' office.

The medication room had secure access and for the majority of the inspection access was restricted to nursing personnel obtaining medication for patients. However, on a small number of occasions we observed that the medication room door was left unlocked and unattended which meant that there was a risk that the room could be accessed by unauthorised personnel.

Recommendation

The health board is advised to demonstrate that there are systems in place for ensuring medicines are stored safely and securely.

[19] All Wales Infection Prevention and Control guidelines apply to all NHS staff in Wales and detail infection prevention and control practice/ processes to ensure patients are protect.

Once in the medication room, location of medication was easily identifiable as there were photographs on the front of cupboards displaying the medication contained within them. The controlled drugs cupboards and fridge were locked and we viewed a sample of entries within the controlled drugs record book and found all to be correct.

Patient buzzers

We found that all patients had working buzzers. One patient reported they had previously had a faulty buzzer for seven days but had been provided with a hand bell. Two patients on the ward were calling out for the assistance of a nurse. We found that this was because the patients did not have their buzzers within reach. We passed the buzzers to within reach of the patients and informed the nursing staff that the buzzers had been out of reach.

Recommendation

The health board is advised to remind staff to ensure patients have buzzers within reach at all times in order to alert staff if assistance is required.

In general, patients reported that buzzers were answered in a timely manner, although during the morning of the second day of the inspection, we observed delays in excess of six minutes for patients to have their buzzer call answered.

Immediate assurance recommendation – see Appendix A

6. Next Steps

The health board is required to complete an improvement plan (Appendix B) to address the key findings from the inspection and submit its improvement plan 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 within Ward B6 Trauma and Orthopaedics at the University Hospital for Wales will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/units of the health board.

The health board's improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing dignity and essential care inspection process.

Appendix A

Dignity and Essential Care: Immediate Assurance Improvement Plan

Hospital: University Hospital of Wales

Ward/ Department: B6 Trauma and Orthopaedic

Date of inspection: 22 and 23 July 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
Delivery of the Fundamentals of Care			
The delivery of the Fundamentals of Care Standards was variable and we were not able to confirm that these standards were being achieved for every patient all of the time. For example, a patient was found to have received inadequate oral care and another required more appropriate continence care than they had been receiving.	Additional Senior Nurse "spot check" audits based on FOC to be undertaken on B6	Senior Nurse	w/c 18th Aug 2014
	Oral Care profile to be raised with all nursing staff	Ward Sister	w/c 18th Aug 2014
	Roll out of continence bundle ongoing and remaining staff to receive updates.	Ward Sister	w/c 18th Aug 2014
	Additional continence equipment obtained.	Ward Sister	w/c 18th Aug 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
We found a patient in need of oral care which we escalated to the nurse in charge of the ward. It was not possible to ascertain whether the need for mouth care for this individual had been assessed, or any such care had been provided, as the patient's care plan did not include any record of assessment or delivery of care.	Rollout of oral care bundle.	Ward Sister	w/c 8th Sept 2014
Buzzers were taking a long time to be responded to. When timed, responses were routinely taking 6 minutes. (We do not normally time buzzer response, but the team was sufficiently concerned to do so during this inspection).	Staff to be reminded that it is important to respond to call bells in a timely manner and even if direct care cannot be given at that time that this is explained to the patient.	Ward Sister	w/c 18th Aug 2014
	Responsiveness to call bells to be audited regularly.	Ward Sister, Senior Nurse, Practice Nurse Facilitator	w/c 8th Sept 2014
Quality of Management, Leadership and Staffing			
Medical Leadership: There was no evidence of clear medical leadership and our review of a sample of patient records identified that patients did not have a clear multi-professional plans of care.	Repeat patient note audit in three months to check that patients are being reviewed by medical staff regularly and have a clear plan of care.	Lead/Senior Nurse/ Consultant Ortho-geriatrician	Nov 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
Communication between medical staff and the nurse in charge was limited. During a medical round we observed the nurse in charge of the ward was not present to ensure effective coordination of any changes to patient care plan and discharge arrangements.	An auditable process for ward round handovers is put in place.	Ward Sister	w/c 18th Aug 2014
Professional Nursing Accountability: Patients were allocated to registered nurses and no registered nurse had more than seven patients in accordance with the Chief Nursing Officer (CNO) for Wales guidance for adult medical and surgical ward nurse staffing.	No further action required.	n/a	n/a
Whilst there was a nurse in charge of the ward, we observed ineffective organisation and control of the nursing team and limited prioritisation of the workload amongst nursing staff and within the multi-disciplinary team.	Ward Management team identification posters displayed.	Ward Sister	Completed
	Nurse in charge of shift notice displayed.	Senior Nurse	Completed
	Deputy ward sister assigned to each team, overseen by Ward sister.	Ward Sister	Completed
	Staffing allocation each shift reflective of patient needs balanced against the responsibilities of being visibly the	Ward Sister	Completed

HIW Finding	Health Board Response	Responsible Officer	Timescale
	nurse in charge of the ward.		
The ward sister was part of the nursing numbers looking after a heavy caseload resulting in them being unable to provide effective focus towards organising the nursing team or nursing work on the ward.	Consideration being given to options of Ward sisters being supervisory to CNO staffing allowing greater oversight, support and supervision of team and work.	Clinical Board/Lead/ Senior nurses	w/c 8th Sept 2014
	Staffing allocation each shift reflective of patient needs balanced against the responsibilities of being visibly the nurse in charge of the ward.	Ward Sister	Completed
The ward is a challenging environment due to the size and long distance between nursing stations and patient bay areas. There were periods when we observed that nursing staff were not routinely visible in the patient bay areas.	Introduction of intentional rounding to enable regular scheduled review of all patients even when constant presence in a bay is not possible.	Ward Sister	w/c 11th Aug 2014
We observed that six staff appeared to be on break at the same time during the morning, reducing the number of staff on the floor to provide continuous patient care and observation of patient areas.	All staff have been told that taking breaks in the clinical area will not be tolerated and that they are to challenge any staff member not adhering to this standard.	Ward Sister	w/c 11th Aug 2014
	The new arrangement for the management of staff breaks to be made clear to staff and clearly display this on the staff allocation board.	Ward Sister	w/c 11th Aug 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
	Regular audits to check the compliance of the above will be conducted initially weekly to ensure adherence to these actions.	Senior Nurse	w/c 11th Aug 2014
We observed a heavy reliance on health care support workers to maintain observations and safety scorings, for example National Early Warning Scores (NEWS). It was found that it may be some hours before the trained nurses reviewed the observations to amend care as necessary.	Registered nursing staff to be reminded via a letter of their professional responsibilities under the NMC code of conduct that they are responsible for any tasks delegated to another person.	Clinical board/Lead/ Senior nurses	w/c 11th Aug 2014
	Registered nursing staff to be reminded via a letter that they have a responsibility to regularly review observation charts and ensure they document their review of the recordings.	Clinical board/Lead/ Senior nurses	w/c 11th Aug 2014
	Registered nursing staff to be reminded via a letter that they have a responsibility to regularly review all nursing documentation and to sign to say that this has been carried out.	Clinical board/Lead/ Senior nurses	w/c 11th Aug 2014
	Introduction of intentional rounding to enable regular scheduled review of all patients by the registered nurse this will result in prompt action and escalation where indicated within given individualised parameters and ensuring appropriate escalation if required.	Ward Sister	w/c 11th Aug 2014
	Additional training to Health Care Support Workers in relation to documentation and escalation of patient status.	Practice Development Nurse	w/c 25th Aug 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
	Regular audits to check the compliance of the above will be conducted initially weekly to ensure adherence to these actions.	Senior Nurse	w/c 11th Aug 2014
We observed one instance of a deteriorating patient being recognised by the peer reviewers and the registered nurses had not recognised the urgency of assessing the patient themselves and acting on/involving medical opinion and providing a heightened level of observation to the patient. We escalated our concerns regarding the patient to the ward sister.	Registered nursing staff to be reminded via a letter to reinforce that they use the SBAR document currently available on the ward when escalating patients who are of concern.	Clinical board/Lead/Senior nurses	w/c 11th Aug 2014
	Additional training to Health Care Support Workers in relation to documentation and escalation of patient status	Practice Development Nurse	w/c 25th Aug 2014
	Medical staff to be reminded of the importance of noting in the medical record where they have been requested to review a patient (as opposed to it being a routine review of the patient).	Consultant Ortho-geriatrician	w/c 11th Aug 2014
Culture: We recognised a need for more support and clear leadership within the ward and the team from both a nursing and medical leadership perspective.	Consideration being given to options of Ward sisters being supervisory to CNO staffing allowing greater oversight, support and supervision of team and work.	Clinical board/Lead/ Senior nurses	w/c 8th Sept 2014
	Senior Nurse to undertake clinical support shifts on ward and complete daily spot check audit based on FOC.	Senior Nurse	w/c 8th Sept 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
The ward team require more open and joined up communication between health care support workers and registered nurses and between nursing, medical staff and therapy staff.	An auditable process to record safety briefing occurrence in the presence of registered nursing and unregistered nursing staff.	Senior Nurse	w/c 18th Aug 2014
	An auditable process for ward round handovers is put in place that records the MDT decisions made, the actions required and that the actions have been carried out.	Ward Sister	w/c 18th Aug 2014
The above issue was compounded by an absence of clear plans of care for each individual patient.	Repeat patient note audit in three months to check that patients are being reviewed by medical staff regularly and have a clear plan of care.	Lead/Senior Nurse/ Consultant Ortho-geriatrician	Nov 2014
	An auditable process for ward round handovers is put in place.	Ward Sister	w/c 18th Aug 2014
Delivery of a Safe and Effective service			
We observed that patients were not the focus of attention. This was because the ward was disordered and there was a lack of organisation of the staff resource. This was compounded by ineffective communication between nursing, medical staff and therapy staff.	Repeat patient note audit in three months to check that patients are being reviewed by medical staff regularly and have a clear plan of care**.**	Lead/Senior Nurse/ Consultant Ortho-geriatrician	Nov 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
Safety scoring of patients in the form of National Early Warning Scores (NEWS) were recorded inconsistently between the patient records and the patient information at a glance boards. Registered nurses did not have a full awareness of the NEWS status of every patient at a glance, and potentially may not be aware of a changing NEWS score.	Review information captured on the Patient at a Glance boards.	Ward Sister	w/c 18th Aug 2014
Our review of documentation found a number of Do Not Attempt Resuscitation (DNAR) forms not fully completed, or reviewed once a patient's condition had changed.	Internal audit of all forms carried out and results cascaded to all medical staff.	Senior/Lead Nurse	Completed 24th July 2014
	Following above audit all DNAR forms were reviewed and updated by the Consultant Orthogeriatrican.	Medical staff	Completed 25th July 2014
	Additional focus to be applied to DNAR form completion and regular review within the Junior medical Staff induction process.	Medical staff	w/c 4th August 2014
	Re audit of completion and review to be undertaken in the 3 months.	Senior/Lead Nurse	Completed November 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
We found limited evidence of effective Mental Capacity Act assessments being documented clearly in patient records.	Internal audit of all forms carried out and results cascaded to all medical staff. Following above audit all patient medical records were reviewed for Mental Capacity Act assessments evidence. Audit results were communicated to Consultant Orthogeriatrican and as result theses were updated by the Consultant Orthogeriatrican where appropriate.	Senior/Lead Nurse Medical staff	Completed 24th July 2014 Completed 25th July 2014
	Additional focus to be applied to Mental Capacity Assessment completion and regular review within the Junior medical Staff induction process.	Medical staff	w/c 4th August 2014
	Re audit of completion and review to be undertaken in the 3 months.	Senior/Lead Nurse	Completed November 2014
The patient information at a glance board contained patient information (such as NEWS scores and patients with diabetes) which was not up-to-date.	Review NEWS information captured on the Patient at a Glance boards.	Ward Sister	8th Sept 2014
	Strengthen reporting of patients with diabetes to more effectively communicate to the team.	Ward Sister	11th August 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
Some of the nurses we spoke to had an inconsistent knowledge of the patients on the ward. The above two issues were highlighted by the patient information at a glance board indicating there were no patients with diabetes and our conversations with three separate registered nurses who explained there were no patients with diabetes on the ward. However, our review of patient documentation found that there was a diabetic patient on the ward.	All registered nurses have been reminded that they have a responsibility to ensure that they are fully appraised of the patients they are looking after such as their diabetes status.	Ward Sister	4th August 2014
Ward Environment: We observed an open door to the kitchen area which contained operational commercial ovens was constantly open during the inspection. We also found the door to the waste room which had a key pad lock on it to be unlocked. We found no systems in place to mitigate these environmental risks to patients.	Ward kitchen protocols raised and challenged with Catering Manager and further risk assessment and appropriate action taken in light for potential risk to wandering patients.	Catering Manager	4th August 2014
	The issue of the waste room doors has also been discussed with facilities and facilities staff reminded that the doors need to remain locked at all times if they are not attended.	Facilities Manager	4th August 2014
	Feedback to corporate Health and Safety team regarding potential Health and Safety Issues.	Lead/ Senior Nurse	11th August 2014
	Formal risk assessment to be undertaken and added to Ward/ Directorate Risk register.	Ward Sister	11th August 2014

HIW Finding	Health Board Response	Responsible Officer	Timescale
	Re- audit of compliance.	Lead/ Senior Nurse	November 2014
Sharps Management and Infection Prevention and Control: We observed an increased risk of infection transmission and sharps injury. This was because of the incorrect use of treatment trays. Nursing staff were observed carrying treatment trays containing used sharps from patient's bedside to the sharps disposal bin in the sluice room. Whilst the treatment trays had a dedicated space for a sharps box, no sharps box was evident on the tray and sharps were loose within the tray instead.	Stock levels to be reviewed and maintained to prevent running out of resource.	Ward Sister	4th August 2014
	Compliance in the use of appropriate trays and sharps bins at all times where sharps are used outside of the treatment room.	Ward Sister	4th August 2014
	Re-audit in 3 months.	Senior Nurse	November 2014
	Spot check audit to be undertaken as part of the Senior Nurse on going clinical observations.	Senior Nurse	4th September 2014

Appendix B

Dignity and Essential Care: Improvement Plan

Hospital: University for Wales Hospital

Ward/ Department: B6 Trauma and Orthopaedic

Date of Inspection: 22 and 23 July 2014

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
8	The health board must ensure staff adhere to the All Wales NHS Dress Code, principle 5, which requires all staff to wear identification at all times which is clearly visible.	Ward sister to ensure that The all Wales NHS dress code is discussed as part of the twice daily safety briefing undertaken on the ward. Senior Nurse/Lead Nurse to undertaken spot check audits	Ward sister Senior nurse/Charge Nurse	Completed Monthly
	Delivery of the Fundamentals of Care			
We made a number of findings in relation to the delivery of the fundamentals of care for which we requested immediate assurance from the health board. The health board have provided HIW with a satisfactory response detailing their actions which can be found in Appendix A.				

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
10	The health board is advised to review the availability of suitable communication aids on the ward.	Ward sister to ensure that all signage on the ward is bilingual Senior nurse will arrange for the purchase of a loop hearing system for use across the Directorate	Ward sister Senior nurse	December 2014 December 2014
10	The health board is advised to ensure that information provided to patients on the ward is accurate.	Ward sister to ensure that all clocks and orientation boards located on the ward display the correct date, day and time	Ward sister	Completed
11	The health board is advised to ensure that patients are communicated with in a way that enables them to receive and respond to the information given.	Ward sister to ensure that the nursing team promptly identify communication needs and ensure that the most appropriate method of communication is utilised	Ward sister	Completed
11	The health board must ensure that patients receive full information about their care in a language and manner sensitive to their needs.	Information regarding how to access to language line needs to be shared with the ward team; this information will be laminated and added to the computer desktop on the ward. In addition to this information on how to contact sign language companies will also be available in this way. This will be rolled out across the Directorate	Ward sister	Completed
12	The health board is advised to ensure that	The importance of confidentiality and privacy to	Ward sister	Completed

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
	patient confidentiality and privacy are respected as far as possible, especially in hospital wards, public areas and reception areas.	be reinforced to nursing staff		
12	The health board is advised to ensure that patient dignity and privacy must be protected at all times.	Ward sister to ensure that bilingual 'do not disturb' signs are in place for use for all bed areas to ensure that the curtains are kept closed during times where privacy and dignity is required.	Ward sister	November 2014
12	The health board is advised to consider the use of the current patient day room and that the room is a suitable environment for patients.	Since the visit the day room has been refurbished and equipped with new furniture, TV, music system and books to encourage patients and relatives to utilise this facility. Arrangements will be made for the company to remove the photocopier and place it somewhere more suitable	Ward sister	December 2014
14	The health board is advised to ensure that there is an adequate stock of linen and pillows at all times to meet patients needs	The ward sister will carry out a spot check audit of the stock of pillows and linen will arrange for additional stock to be ordered	Ward sister	Completed
15	The health board is advised of the need to ensure that patients' level of discomfort, pain or distress is regularly assessed and recorded. Results of decisions can then be recorded for the continuity of patient care.	Since the visit education and training has been undertaken with regards to documentation in particular with reference to evaluating patient care and responding to the findings. Evaluating pain was used as an example. The impact of	Lead nurse/senior nurse	December 2014

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
		this training will be monitored as part of the senior nurse/lead nurse spot check audits		
16	The health board is advised to demonstrate that documentation is fully completed and reviewed in accordance with the All Wales Nutritional Care Pathway.	The UHB fundamentals care group are currently undertaking a project looking at fluid balance chart completion with the view to develop standard operating principles for use across the UHB. There will be an education and training element to support this project. There is representation from Trauma and Orthopaedics in this group	Practice development nurse	Ongoing
18	The health board is advised to ensure that patients are offered the opportunity to either to wash their hands or use hand wipes prior to eating their meals in accordance with their wishes and in keeping with the Fundamentals of Care.	Ward sister to liaise with Dietetic staff to request their assistance in ensuring that prior to assisting patients with their meal they will ensure that they have had the opportunity to wash their hands. This will also be reinforced to the nursing staff. The Directorate is also Investigating the option of utilising volunteers to support mealtimes	Ward sister	Completed
19	The health board is advised to ensure that all care given is documented within the patient records.	The education and training that has been provided emphasised the importance of accurate record keeping. Documentation is also included in the spot check audits undertaken by the lead and Senior nurse.	Lead nurse/senior nurse	December 2014
19	The health board is advised to ensure that patients' toilet and bathroom facilities are clear from unnecessary clutter and equipment.	The clutter identified during the visit refers to broken condemned items which were reported to estates for collection after the visit. This is	Lead nurse/senior nurse	Completed

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
		still on going due to staff shortages in that department. Senior nurse/lead nurse to escalate		
20	The health board is advised to ensure that the All Wales continence bundle is used consistently	An education package has been developed and the All Wales continence bundle is currently being rolled out on B6. This education will involve looking at assessing patients and appropriate use of continence products	Practice development nurse	Completed
20	The health board is advised to demonstrate that patient dignity is maintained at all times.	Ward sister to ensure that 'do not disturb' signs are in place for use for all bed areas to ensure that the curtains are kept closed during times where privacy and dignity is required.	Ward sister	November 2014
	Quality of Staffing Management and Leadership			
We made a number of findings in relation to the quality of staffing, management and leadership for which we requested immediate assurance from the health board. The health board have provided HIW with a satisfactory response detailing their actions which can be found in Appendix A.				
	Delivery of a Safe and Effective Service			
We made a number of findings in relation to the delivery of a safe and effective service for which we requested immediate assurance from the health board. The health board have provided HIW with a satisfactory response detailing their actions which can be found in Appendix A.				

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
28	The health board is advised to review the practice of storing stock and equipment at high level and stacked on shelves within the storage rooms to ensure there is no risk to staff	The storage room has since been de-cluttered, storage space on the ward is restricted however the ward have organised their storage so that items that are used the least are stored at the top of shelving unit	Ward sister	Completed
28	The health board is advised to ensure that assessments for the use of manual handling aids are recorded within the patient records	The education and training that has been provided emphasised the importance of accurate record keeping. Documentation and risk assessment completion is also included in the spot check audits undertaken by the lead and Senior nurse.	Lead nurse/senior nurse	December 2014
29	The health board is advised to ensure a consistent approach to All Wales Infection Prevention and Control guidelines	The green tape is now used for all commodes after they have been cleaned. This will be checked during the spot check audits undertaken by the Lead and senior nurse	Lead nurse/senior nurse	December 2014
29	The health board is advised to demonstrate that there are systems in place for ensuring medicines are stored safely and securely.	Ward sister to reinforce importance of ensuring that the treatment room door is locked at all times. Lead nurse/Senior to undertake spot check audits using Safe and Secure Handling of Medicines Audit tool	Ward sister Lead nurse/senior nurse	Completed December 2014
30	The health board is advised to remind staff to ensure patients have buzzers within reach at all	Intentional rounding has been introduced on the ward since the visit. Senior Nurse/Lead Nurse to undertaken spot check audits regarding the		

Page Number	Finding	Health Board Action	Responsible Officer	Timescale
	times in order to alert staff if assistance is required.	time taken to answer call bells. Recently an patient survey was undertaken regarding toileting needs and this area had a positive response. This positive response was also identified recently during an observation of care undertaken by medical students.		

Health Board Representative:

Name (print): .....

Title: .....

Signature: .....

Date: .....