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, Ward B1

21 and 22 October 2014

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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

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care inspection in Ward B1 Cardiology at the University Hospital for Wales, part of Cardiff and Vale University Health Board on the 21st and 22nd October 2014.

Our inspection considers 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, 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 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 or scheduled hospital treatment, or 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 comprises of nine hospitals and 17 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. The hospital was officially opened in 1971 and is the third largest University Hospital in the UK and the largest hospital in Wales.

Ward B1 is a cardiology ward with two separate wings (North and South). The ward is made of both multiple bedded bays and single cubicles. When necessary additional beds can be used for patients with a range of medical conditions bringing the total up to 35 patients. Several of the additional beds were in use during our inspection. The age of patients admitted to the ward ranges from 16 years and above.

4. Summary

Patients told us they were very satisfied with the standard of care they received and the staff looking after them. We saw staff working to uphold patients' privacy and dignity.

Overall we found that staff were committed to providing good standards of person centred care to all patients. It was also evident that the ward team placed an emphasis on treating patients and their families with respect and dignity.

We saw staff communicating with patients effectively and in a manner they could understand, using recognised communication tools when needed. Consideration needs to be given in relation to making the ward environment as accessible as possible to those with complex and/or sensory needs.

We saw staff being polite and courteous to patients, treating them with respect and protecting their privacy and dignity.

We saw staff encouraging and assisting patients to be independent as far as their condition allowed.

The ward systems and culture in place ensured people were assisted to maintain contact with their loved ones during their stay on the ward.

We found the ward environment to be conducive to allowing people to rest.

We saw staff ensured patients were comfortable. Records showed that staff monitored patients' pain and observations showed staff responded to alleviate pain in a timely way.

Staff provided assistance to people with personal care where required. Due to the physical ward environment some patients experienced difficulties in accessing and manoeuvring around bathroom facilities.

Patients' nutritional needs were assessed and they had access to dietician services where required.

Patients received assistance with eating and drinking where required, although the approach in identifying these patients was not consistent and left room for confusion.

Protected meal times were not consistently implemented and we saw patients disturbed during meals.

Repairs needed in the kitchen environment were impacting on patient access to hot drinks and posed health and safety risks. In addition, patients could not access hot meals outside of regular meal times.

Records indicated and patients told us that they were supported to maintain good oral health.

We saw staff responding to patients requests for help in relation to their toilet needs in a discreet and timely manner.

We saw that appropriate equipment and risk assessments were in place in order to reduce the risk of patients developing pressure sores. Referrals were made to specialist services when required.

We found management on the ward to be visible and supportive, focussed on disseminating learning throughout the staff team. We found the staff team to have a collaborative and person centred approach.

Staffing levels during the inspection were appropriate in meeting patient needs. However, at the time of our inspection there was a reliance on bank and agency staff.

We saw evidence of good, effective multidisciplinary working and patients had access to a range of specialist services.

In order to meet the changing needs of patients, staff required additional training in areas such as dementia/confusion and vulnerable adults.

We found the area for additional beds to be well managed although some of the equipment was not fit for purpose.

We saw that systems were in place to monitor issues associated with the delivery of safe and effective healthcare services. We did however, find two issues of immediate concern. These were in relation to a Deprivation of Liberty Safeguard and the kitchen environment. We asked the health board to provide immediate assurance to ensure patients were appropriately safeguarded. The health board provided sufficient assurance to HIW on 7 November 2014 that the issues had been addressed.

Quality of the Patient Experience

Patients told us they were very satisfied with the standard of care they received and the staff looking after them. We saw staff working to uphold patients' privacy and dignity.

During the course of our inspection patients and their relatives were invited to complete our questionnaires to tell us about their experiences on the ward. These were completed via face to face interviews or returned to us in the post. In total 14 questionnaires were completed in this way by both relatives and patients.

We also observed the care and treatment being provided to help us understand the patient experience. Some patients and their relatives gave us permission to include their comments within this report, some of which are found below.

People told us they felt the ward was clean and tidy. On investigation we found there was only one cleaner on the ward tasked with all cleaning duties and this provided challenges on a ward with a high turnover of patients. However, we found the ward to be adequately clean on inspection (with the exception of the kitchen area which is addressed below) and cleaning audits were in place to monitor cleanliness levels. People also commented about the generally tired condition of the ward and our observations confirmed some disrepair to areas such as paint flaking off walls, around sink areas and worn and uneven flooring. This meant that even when the ward was clean, the environment appeared tired and uncared for. Staff told us the ward was due for refurbishment but this would not be happening imminently.

When asked about the staff looking after them, the large majority of people gave overwhelmingly positive comments. For example:

'very good staff'

'brilliant staff, have a laugh and a joke'

'staff make me feel at ease with pain and discomfort'

'they are superb'

'can't praise the staff enough'

'staff are kind and help with dignity of older patients. (I) witnessed staff really encouraging an elderly patient to eat who says she is eating but isn't'

Several people commented they felt staff were very busy and there was a risk of this impacting on the service they received. For example:

‘yes they do listen but are rushed off their feet’

‘they are good but up against a poor working environment’

People were overwhelmingly positive about the standard of care they received and we observed a high standard of care in practice. We saw staff being polite and courteous to patients and their visitors. Staff protected the privacy and dignity of patients when providing assistance with personal care by closing curtains around bed areas and closing doors to lavatories. Appropriate privacy signs were also being used to further protect patients’ privacy. Patient questionnaires indicated that staff assisted patients with their toilet needs in a sensitive way and we found that staff responded to call buzzers promptly.

Several patients told us they experienced frustrations with procedures off the ward being cancelled and we observed patients voicing these frustrations during our inspection. Although this was outside of the ward’s control, staff had to manage patients’ expectations whilst on the ward, which posed challenges. Patients told us the main impact they felt around procedures being cancelled was missed meals. Patients told us they missed meals in order to have the procedure done and when the procedure was cancelled and they were able to eat again, they were not able to access hot meals. We found that this situation was exacerbated by the kitchen environment and there is further detail provided in the ‘Fundamentals of Care’ section below.

Delivery of the Fundamentals of Care

Overall we found that staff were committed to providing good standards of person centred care to all patients. It was also evident that the ward team placed an emphasis on treating patients and their families with respect and dignity.

Communication and information

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

We saw staff communicating with patients effectively and in a manner they could understand, using recognised tools when needed. Consideration needs to be given in relation to making the ward environment as accessible as possible to those with complex and/or sensory needs.

We saw several examples of staff really taking their time to explain aspects of patients' care and treatment to them. We observed one nurse giving advice and guidance to one person about their diet in a kind, informative and engaging manner. This meant that from our observations, patients were given the time they needed to understand their care and treatment.

There was no hearing loop on the ward to assist staff in communicating with patients with hearing difficulties. There was limited use in the ward environment of tools that would make the environment accessible and user friendly for those with additional and/or sensory needs. Staff told us they were seeing many more people on the ward with complex needs and felt the ward environment should be set up to be as accessible as possible for these people.

Staff showed us some picture cards they used with patients when needed to help communication. One patient did not speak English and we saw staff giving the person choices by physically showing them items to choose from. Staff told us they communicated with the person by using a doctor who spoke the person's language. They had also requested some everyday phrases from the person's daughter and the person also used their own translation tool. We felt assured that staff had access to communication tools and were confident in using them, to assist individual interactions with patients where needed.

We saw lots of useful and up to date information being displayed on the ward walls and patients had access to a wide variety of information leaflets, relevant to cardiac health needs. The cardiology rehabilitation team provided information

to patients on discharge in relation to their condition and any ongoing patient self care advice.

Interactions between staff and multidisciplinary notes in patients' records confirmed that team communication worked well and was effective in ensuring that staff were kept up to date in relation to patient care.

Recommendation

The health board needs to make the ward environment as accessible as possible to those with complex and sensory 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.

We saw staff being polite and courteous to patients, treating them with respect and protecting their privacy and dignity.

We saw staff being polite, courteous and treating people respectfully when assisting them and providing treatment. One notable example of this was when we observed one staff's manner to be particularly kind, patient and compassionate with an elderly patient. People we spoke with gave us examples of how staff maintained patients' privacy and dignity and we saw examples of this in practice.

Staff protected the privacy and dignity of patients when providing assistance with personal care by closing curtains around bed areas and closing doors to lavatories. Appropriate privacy signs were also being used to further protect patients' privacy.

Staff we spoke with were knowledgeable about their professional conduct and duties in relation to respecting people and giving people time to understand their treatment.

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 saw staff encouraging and assisting patients to be independent as far as their condition allowed.

We observed staff encouraging patients to be as independent as their condition would allow, providing assistance where needed. For example, we saw one staff member bringing a bowl of water to a patient so they could wash as they chose and without assistance from staff.

Patients used mobility aids where needed, and were encouraged to mobilise as independently as possible, to allow them to move around the ward freely.

Relationships

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

The ward systems and culture in place ensured people were assisted to maintain contact with their loved ones during their stay on the ward.

The ward had structured visiting hours in place. The ward sister told us these times had been implemented after consultation with patients about their preferred visiting times. This meant that patients had been involved in choosing visiting times that best suited them. Visiting hours were 3:00pm – 7:00pm hours, although we were told the ward could be flexible if a specific need was identified.

There was a spacious and light day room on the ward and it provided an area for patients to spend time with their visitors in relative privacy. However, we did not observe this to be well used during our time on the ward.

The ward sister told us, where necessary, patients could have their family members stay with them overnight in one of the private rooms. This meant that the ward was flexible in ensuring people maintained relationships with their family and received the support they required from them during their stay on the ward.

Rest, sleep and activity

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

We found the ward environment to be conducive to allowing people to rest.

The ward operated a structured visiting time policy and this allowed time for patients to rest during the day. The ward was comfortably warm and noise was minimised to allow patients to rest.

Televisions were not provided in ward areas but a television and other resources were available to use in the day room.

Newspapers were available daily but other than this option, people had to rely upon their own resources to keep entertained.

Patients told us they had access to extra blankets and pillows to help with sleep should they need them.

Ensuring comfort, alleviating pain

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

We saw staff ensured patients were comfortable. Records showed that staff monitored patients' pain and observations showed staff responded to alleviate pain in a timely way.

We found that staff assessed people's pain levels and provided pain relief medication promptly to alleviate pain. We saw this in practice when one patient was experiencing chest pain and staff responded quickly to alleviate the pain.

Patients we asked told us they had been made comfortable. In particular those patients in the additional bedded area told us staff had gone out of their way to settle them in and make sure they were comfortable on their transfer to the ward.

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.

Staff provided assistance to people with personal care where required. Due to the physical ward environment some patients experienced difficulties in accessing and manoeuvring around bathroom facilities.

We overheard staff carrying out personal care discreetly and appropriately. Patients told us they were given opportunities to shower and wash and patients appeared well cared for.

One patient used an electric wheelchair to mobilise and told us they were not able to access the bathroom to shower independently. This was due to the space available and door width which was too narrow to allow the person to manoeuvre their electric wheelchair inside. They were therefore not able to be as independent as they normally would be in their personal hygiene routines

and required assistance from staff in this respect. One person using a mobility aid told us they had been able to access the bathroom facilities independently. However staff confirmed that where patients required assistance to mobilise, either through staff supporting them to walk or through staff manoeuvring people's wheelchairs, they found it awkward to assist people with the space available in bathrooms.

There was a healthcare assistant on the ward who was trained in specialist foot care. We found one patient had been referred to the orthotic department as they required specialist shoes. This meant patients had access to a specialist foot care service where required.

Recommendation

The physical environment of the ward and people's access to bathroom facilities should be taken into consideration when the ward is refurbished, to ensure facilities are accessible to all.

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.

Patients nutritional needs were assessed and they had access to dietician services where required.

Patients received assistance with eating and drinking where required, although the approach in identifying these patients was not consistent and left room for confusion.

Protected meal times were not consistently implemented and we saw patients disturbed.

Repairs needed in the kitchen environment were impacting on patient access to hot drinks and posed health and safety risks. In addition, patients could not access hot meals outside of regular meal times.

Patients made varied comments about the food but these were mainly positive in relation to the choice and portion sizes offered. We observed a meal time on the first day of our inspection and found the food to be appetising with catering staff offering a range of choices to meet people's individual preferences.

Catering staff told us they experienced problems keeping the food warm due to some electrical points (needed for plugging in the heated food trolley) on the ward not working. However, they were managing this and the food we saw looked hot and no patients complained of cold food. Patients had access to water jugs that were changed twice a day.

We were told the ward had protected mealtimes [1]in place. However we observed several occasions when patients were interrupted during their meals for doctors' rounds, medical tests and procedures. This meant patients were disturbed when trying to eat their meals and could result in them not finishing their meals whilst food was still suitably warm.

We saw that staff assessed patients' nutritional needs using a nutritional risk assessment tool[2] . Where required, patients' food and fluid intake was recorded using All Wales food record charts. We saw a trainee dietician on the ward providing support and guidance in relation to patients' nutritional needs.

We saw a patient nutrition and hydration bed plan which was used by staff to identify those patients with special diets such as diabetic or nil by mouth but this was not fully completed to identify everyone who needed assistance. We were told the Red Tray system[3] was in place to physically identify those patients who needed assistance at mealtimes. However, on investigation, this was not being consistently implemented and staff told us there were not enough red trays to use this approach properly. Staff told us they used a list to confirm which patients required assistance and staff organised between them who would assist each person. We saw that where people required assistance, this was given. However, with two separate systems in place it left the potential for confusion.

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[1] **Protected Mealtimes.** This 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.

[2] **Nutritional assessment** is used to evaluate nutritional status, identify disorders of nutrition and determine which individuals need instruction and/or support.

[3] The **Red Tray system** helps to reduce nutritional risk in hospitals by providing a signal that vulnerable patients need help and support from staff, or has a poor dietary intake.

Patients told us they experienced frustrations when their procedures were cancelled and they were then unable to access a hot meal. Patients also told us they did not always receive hot drinks in the afternoon. On investigation, kitchen staff told us the freezer was broken. This impacted on their time in food preparation because they had to access another ward for supplies and this meant they were not always able to do the hot drinks round. This meant patients were not always able to access hot meals outside of regular meal times, they did not have a choice of certain options such as ice cream and access to hot drinks had been limited. Kitchen staff also advised the seal on the fridge was broken and had been reported but not yet repaired and the dishwasher did not wash crockery and cutlery to a high enough standard so staff were bleaching it in addition to washing. There are further recommendations in relation to the hygiene of the kitchen environment which posed health and safety risks and can be found under 'Delivery of a Safe and Effective Environment' section.

Recommendation

Meal time arrangements should be reviewed in order to improve the patient experience and ensure consistency in approach including; use of the Red Tray system and identification of patients requiring assistance, protected meal times, patients' access to hot meals and drinks and management of kitchen repairs.

Oral health and hygiene

People must be supported to maintain healthy, comfortable mouths and pain free teeth and gums, enabling them to eat well and prevent related problems.

Records indicated and patients told us that they were supported to maintain good oral health.

The records we saw indicated staff were assessing patients' oral hygiene regularly and providing assistance. We saw that the All Wales Health and Hygiene bundle[4] was being used to assess patients' oral health needs.

[4] **Bundles** are All Wales or Health Board wide agreed interventions and approaches to specific areas of health care. These ensure consistent evidence based nursing practice.

Patients told us they were able to clean their teeth and dentures as regularly as they wanted to.

Toilet needs

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

We saw staff responding to patients' requests for help in relation to their toilet needs in a discreet and timely manner.

Toilets on the ward were adequately clean and appropriately equipped with toilet paper and hand washing facilities to reduce cross infection. Privacy signs were in use when patients accessed bathroom facilities.

We were told there were no patients on the ward requiring a continence assessment, but the All Wales bundle[5] to assess people's continence needs was used when required. We noted the ward stocked continence products should patients require these.

Patient questionnaires indicated and our observations confirmed that staff answered calls for assistance promptly meaning that patients did not have to wait unnecessarily to use the toilet.

Preventing pressure sores

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

We saw that appropriate equipment and risk assessments were in place in order to reduce the risk of patients developing pressure sores. Referrals were made to specialist services when required

The ward had pressure relieving mattresses in place to reduce the risk of patients developing pressure sores. The monitoring records we saw indicated

[5] **Continence bundle** is a tool which enables all nurses in Wales to assess the continence needs of their patients, audit the care provided and offer patients the opportunity to give feedback.

staff regularly checked patients' skin for signs of pressure damage. This meant that recording systems and equipment were in place to try to prevent patients from developing pressure sores.

We saw that the All Wales Pressure Ulcer SKIN bundle was in use[6]. We saw that appropriate referrals were made to the tissue viability services if needed for further specialist input.

[6] **SKIN bundles** requires documented nursing intervention at least every two hours in the following areas to reduce likelihood of damage; **S**urface – ensure patient is on the right mattress, cushion, there are no creases or wrinkles, **K**eep moving- encourage self movement, reposition patient and inspect skin, **I**ncontinence- meet patient's toileting or continence need, **N**utrition – keep well hydrated, meet patient's nutritional needs.

Quality of Staffing, Management and Leadership

We found management on the ward to be visible and supportive, focussed on disseminating learning throughout the staff team. We found the staff team to have a collaborative and person centred approach.

Staffing levels during the inspection were appropriate in meeting patient needs. However, at the time of our inspection there was a reliance on bank and agency staff.

We saw evidence of good, effective multidisciplinary working and patients had access to a range of specialist services.

In order to meet the changing needs of patients, staff required additional training in areas such as dementia/confusion and vulnerable adults.

Staffing levels and skill mix and professional accountability

At the time of our inspection the management structure on the ward was made up of one ward sister and a deputy. The ward team also consisted of medical staff, registered nurses, two student nurses, healthcare support workers and ancillary and housekeeping staff.

On both days of our inspection there were five registered nurses and two healthcare support workers. This meant that staffing arrangements met the Chief Nursing Officer for Wales guidelines for safe levels of staffing. At the time of our inspection one additional healthcare support worker had been organised due to a patient requiring additional supervision. This meant that staffing was flexible according to the care needs of patients. We found staffing levels and skill mix to be suitable to meet the needs of the patients during our inspection.

The ward frequently used bank and agency staff and on the first day of our inspection, two from the five registered nurses and two healthcare support workers were bank staff. The agency and bank nurses we spoke with told us they had been shown around the ward and felt confident to ask the staff team if they were unsure of anything. Staff told us they felt pressure in meeting people's needs at times with the staffing levels in place and with the reliance on bank and agency staff. This was because agency nurses could not undertake all clinical duties that regular nursing staff could perform due to the specialist nature of some of the care provided on the ward.

The Senior Nurse told us the high levels of agency and bank staff on the ward were due to unique pressure the ward was facing at that particular time with staff sickness and four staff leaving at the same time. The Senior Nurse

advised us that three new nursing staff had been recruited but the recruitment process had taken three months to get these staff in post. They were due to start in the coming weeks. We discussed this with Board members at the feedback session and they shared frustrations regarding the All Wales recruitment process. They advised this was a priority at Board level and they were reviewing how they recruited new staff.

We found the ward sister and senior nurse both to be visible on the ward and they provided support and direction to the staff team. We found that the staff team as a whole worked well together, had a patient centred perspective and supported each other to meet the care needs of patients.

The ward sister told us and senior nurse confirmed that since the vacancies in August 2014, the ward sister was not consistently able to work on a supernumerary basis in order to complete all non-clinical duties. This meant she was unable to devote enough time as required to undertake management duties fully.

Recommendation

The health board to continue to review the recruitment processes in place to ensure vacancies on the ward can be filled as quickly as possible to reduce reliance on bank and agency staff.

The ward sister needs to have protected supernumerary time for their management and non clinical duties.

Effective systems for the organisation of clinical care

We found that the type of patients admitted to the ward over the years had changed significantly. The ward was part of the cardiac tertiary centre, admitting patients from hospitals throughout South Wales with a wide range of heart conditions, requiring a wide range of care and treatment. In addition to this, the ward also had seven additional beds which were opened when needed for use by patients with a wide range of care and treatment needs outside of cardiology. This meant that the ward admitted patients with a broad range of medical conditions, requiring careful management and a coordinated multi disciplinary team approach.

There were 12 consultants linked to the ward and we witnessed good communication and strong multidisciplinary team working. We found evidence both on the ward and in patient's notes of the involvement of a diabetic specialist nurse, dietician, discharge liaison officers, cardiac rehabilitation team and specialist diabetic nurse. Staff we spoke with had good and up to date

knowledge of the people they were caring for and patients' care plans had been updated when there was a change to their care and treatment.

One nurse told us about several delayed (non-cardiac) discharges but when we looked into these, there were exceptional circumstances that had led to delays and they appeared to be the exception rather than the norm. The Discharge Liaison Nurse told us and patient records confirmed that discharges were managed with multidisciplinary input. There was a cardiac rehabilitation team based on the ward which provided support and guidance to people about self care on discharge. This meant patients had access to support to try to avoid any recurrence of their condition and re-admission.

We found the bay with the additional seven beds to be well managed and efforts were made to make patients feel a part of the ward. For example, regular staff were rotated to work in this additional bay to try to ensure some continuity of care for patients. Patients in this area told us they felt staff had gone the 'extra mile' to accommodate them. Some of the equipment in the additional bay was not fit for purpose. For example several Patient Orientated Medication System (POMS) lockers were not lockable and therefore not able to be used.

Recommendation

The heath board and ward needs to review the use of equipment in the additional bay to ensure it is fit for purpose and meets the needs of patients.

Training and development

Staff told us they were supported to access mandatory training and the staff we spoke with were knowledgeable about their clinical roles and responsibilities. We were told about a new initiative being trialled in the Cardiothoracic Directorate whereby the Practice Educator had taken the initiative to become skilled to deliver some elements of mandatory training through team sessions, on the ward. This idea had won the first 'Grand Idea' scheme within the Health Board. This meant that staff were being supported to receive ongoing training in innovative ways that limited the time taken out of their roles on the ward.

The senior nurse told us all staff were offered and had completed the Cardiac Foundation Course. She also told us about six hour training programmes that had been developed to cover both mandatory and additional topics such as health and safety, record keeping and the Fundamentals of Care. She advised this would be offered to the new starters who were due to begin employment

within the coming weeks and they would also be supernumery for two weeks to allow adequate time for induction.

Due to the nature of the ward changing, additional training needs for staff had been identified such as dementia training, Deprivation of Liberty Safeguards[7] (DOLS) and vulnerable adults. The Senior Nurse confirmed that this training was under development.

Staff told us they felt well supported in their roles. However, the statistics for compliance with staff having up to date performance and development reviews (PDRs) in place was 50 per cent. We were told this was due to the ward sister's reduced supernumerary management time as a result of staff sickness and vacancies.

Recommendation

Staff on the ward to receive training in dementia/confusion, vulnerable adults and DOLS in order to meet the changing needs of patients on the ward.

Staff should have timely access to PDRs to identify any practice issues and for support and development in their roles.

Handling of complaints and concerns

We held discussions with the ward sister and senior nurse and found that patients and their relatives were encouraged to discuss care and treatment with ward staff through daily face to face contact. Patients told us they felt able to raise concerns with staff and would ask if they wanted to make a complaint.

We were told that over the last three years there had been two formal complaints made at ward level, the most recent of which had prompted a review of the patient's case. The senior nurse 'walked' us through how this had been dealt with and it was evident that lessons had been learnt from the complaint.

We saw staff meeting minutes which showed learning was disseminated throughout the staff team on a regular basis in relation to complaints, concerns

[7] When a person lacks the mental capacity to make decisions about the care or treatment they need, legislation called **The Deprivation of Liberty Safeguards (DoLS)** has to be followed to ensure that people are not unlawfully deprived of their liberty.

and wider ward issues. We felt assured that there was a culture in place whereby staff were encouraged to learn from any concerns that patients and their families raised.

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 saw that systems were in place to monitor issues associated with the delivery of safe and effective healthcare services. We did however, find two issues of immediate concern. These were in relation to a Deprivation of Liberty Safeguard and the kitchen environment. We asked the health board to provide immediate assurance to ensure patients were appropriately safeguarded. The health board provided sufficient assurance to HIW on 7 November 2014 that the issues had been addressed.

Risk management

Incidents

We found that ward based clinical incidents were reported using a paper system. An electronic system to make the management of incidents easier and more streamlined was under development. Incidents were followed up by the ward sister and learning disseminated through staff meetings.

Risk assessments in patient care

Staff used core patient risk assessment booklets in order to assess the individual risks patients faced. We found these to be up to date and clear plans were in place about how to manage risks to patients. We observed staff working to keep people safe so we were assured that risk assessments followed through to safe practice in patient care.

Policies, procedures and clinical guidelines

We held discussions with the ward sister and staff. As a result of this it became evident that they were able to obtain a range of guidelines and policies which supported aspects of their patient activity (via the ward computer).

We scrutinised policies in relation to medication management and Deprivation of Liberty Safeguards (DOLS). We saw that staff had access to detailed information in relation to making an application for DOLS authorisation and had used this in practice recently. However, staff had not received training to ensure DOLS procedures were followed appropriately and followed up. A recommendation in relation to DOLS has been made in the section below.

Effective systems for audit and clinical effectiveness

We held a discussion with the ward sister and senior nurse in relation to clinical audits and found that there were suitable systems and processes in place to check aspects of the quality of patient care. Specifically, we saw that checks were being undertaken regularly regarding pressure sores and infection prevention and control. We were told audits were also carried out on documentation, falls and medicines management. The results of audits and any changes to practice on the ward were shared with staff on an ongoing basis and specifically at regular staff meetings. This meant staff were aware of the ward's performance and engaged in learning from these audits, which could be used to further improve patient care.

We saw that initiatives from the 1000 Lives campaign[8] were being used, such as safety crosses displayed on the ward wall to make highly visible the incidence of avoidable adverse events. This meant the ward had considered and implemented a system in order to make the whole team aware of avoidable events.

Patient safety

Safeguarding vulnerable adults

Staff we spoke with were aware of their responsibilities to report potential abuse and how they would go about doing this. The senior nurse advised us that specific vulnerable adults training was under development.

We found the closing and locking device on the doors to the main ward did not work. This meant that ward doors were left continually open. This had the potential to pose risks to vulnerable patients, either through them potentially wandering off the ward or by access to the ward by unauthorised persons.

One patient on the ward was subject to a Deprivation of Liberty Safeguards authorisation. We found the organisation of the person's file to be disorganised and both staff and ourselves were unable to swiftly lay our hands on the information we required. The DOLS authorisation consisted of the referral from

[8] **The 1000 Lives Campaign** aims to improve patient safety and increase healthcare quality across Wales.

the ward but staff could not produce official documentation to confirm the DOLS authorisation in place. The paperwork we found in relation to the DOLS stated that it should be reviewed on 22 September 2014 and staff could not produce official documentation to confirm that this had happened.

Kitchen environment

On inspection of the kitchen environment we found environmental and health and safety concerns relating to hygiene. We found work surfaces and appliances to have crumbs and food debris both on the surfaces and within crevices of appliances such as the oven. We also found that the flooring, which reached part way up the wall to create a skirting board, had come away from the wall and there were large bits of food and dirt in this gap which could not be reached to clean away. We found that the freezer was not working, the seal of the fridge was broken and were told that the dishwasher did not clean adequately, requiring catering staff to use bleach to ensure cutlery and crockery were safely cleaned. This posed health and safety and infection control risks. We have asked the Health Board to provide us with immediate assurance that these issues will be rectified and managed.

Recommendation

We asked the health board through an immediate assurance letter to address the issues outlined in relation to the kitchen environment. The health board provided sufficient assurance to HIW on 7 November 2014 that the issues had been addressed.

The closing and locking mechanism on the ward doors should be activated to safeguard vulnerable patients.

We asked the health board through an immediate assurance letter to ensure the person concerned was being lawfully deprived of their liberty and appropriate DOLS procedures had been followed. The health board provided sufficient assurance to HIW on 7 November 2014 that the issues had been addressed.

Medicines management

Staff told us they had access to the health board's medication policy via the hospital's intranet system. This allowed staff to check they were adhering to safe storage and handling procedures for medicines used on the ward. A

pharmacist based on the ward provided support and expert advice on the safe use of medicines and we saw them offering advice and guidance both to staff and patients throughout the inspection.

The ward operated a system whereby each person's named nurse was responsible for the administration of their medicines. Patient's medicines were kept in individual locked cupboards next to their beds and staff kept the keys. We noticed in the facility for the additional seven beds, some patient's medicines were stored in the treatment room due to the lack of keys or broken locks for people's individual lockers. Equipment in the seven bedded bay has been addressed under the 'Leadership and Management' section of this report. Throughout the inspection, medicines were stored securely and appropriately.

We observed staff administering medicines and found them to be knowledgeable and competent. However, we noted on several patients Medication Administration Records (MAR) that there were gaps in recording. This meant that we could not be assured medicines had been administered appropriately or at all in these cases. We raised this with the senior nurse and ward sister who agreed to address this and advised us that there was currently a focus on work around medication management audits and learning from this.

There was a flow chart in place to assess whether patients were able to self medicate. However, in practice, patients were limited in being able to do this as staff kept the keys for people's individual lockers to ensure medicines were locked away and stored securely. We were told that if someone self medicated, the nurse provided access to the medicines for them and locked them away after use.

Documentation

Patient Assessment

We looked in detail at four patients' care plans and notes relating to their care and overall found the documentation to be of a high standard. 'B1 Cardiology Essential Nursing' care plans were in place and up to date and there was evidence of the evaluation of the care provided. These were used in conjunction with core patient risk assessment booklets. When we asked one patient, they told us they had been involved with putting together their care plan.

We saw that where patients were assessed as requiring input from a specialist, appropriate referrals were made, for example, to a wound specialist. We also saw multidisciplinary entries in patients notes which indicated the involvement of doctors, a dietician and diabetic specialist nurse and ensured patients' holistic health needs were being addressed.

In several cases we noted that the Blood Sugar Monitoring (BM) charts had been photocopied and the copies were of a poor standard. The print was very small and in conjunction with very poor photocopying it made it difficult to read, which could impact on how results were read and interpreted and could increase the risk of error.

Nurses told us that nursing notes were sometimes left until the end of their shift to update due to the pressures on the ward. We also saw many illegible medical staff signatures and one nursing plan was not signed. This meant that incidents were not always captured in real time and could not always be traced back to the person who wrote the entry to ensure accountability.

We saw that venous thromboembolism (VTE) risk assessment documentation was not routinely completed for patients. It was apparent that risk assessments had been undertaken for some patients as they were receiving clexane (which is used to stop blood clots forming within the blood vessels) but the appropriate documentation had not been completed. We understand that it is the policy of the health board to undertake VTE assessment on all patients and document the result in the patient's medication chart.

Recommendation

Nursing notes should be updated contemporaneously in line with best practice guidelines to ensure any issues are captured and dealt with in real time. All care plans and record entries should be signed and signatures should be legible.

VTE assessments should be consistently completed with all patients and appropriate recording of the assessment should be documented to provide evidence of managing the associated risks to safeguard the patient.

Ward Management

We found that patients' medical notes were easily accessible by staff as they were kept on an open sided trolley in the staff area. However we saw nursing folders were left in various places, in the patient's room and sometimes on the trolley which led to staff having to search for these. This meant that staff were not always able to find and access these notes quickly and easily. These were not kept at the end of patients beds as was usually the practice on the ward because there were a lack of holders.

Recommendation

The ward should review how nursing notes are stored and consider holders being used at the end of patient beds to ensure notes are kept safely and easily accessible.

Diabetes Care

The ward had access to diabetic specialist nurses to act as a local point of contact and share best practice on diabetes care. Staff confirmed they had received training on diabetes management which was regularly updated.

We looked at two diabetic patient records and found that their diabetic needs were being managed appropriately. Diabetes nursing care plans were in place in order to assess people's needs and manage their condition. We saw that appropriate referrals had been made, where needed, to a dietician and diabetic specialist nurse.

Hypo-boxes[9] containing equipment and medication to treat a diabetic emergency were available on the ward and clearly visible.

There were arrangements in place for patients to self manage their diabetes but in some cases these were limited. In the additional bedded area not all patients had access to lockable cupboards to store their medications so were reliant upon staff to bring their medicines, including insulin, from the treatment room.

As noted under the 'Documentation' section above, blood sugar monitoring charts were poorly photocopied which presented a risk to results being incorrectly interpreted. This has been addressed under the recommendations for that section.

[9] A **hypo box** provides staff with all the relevant equipment to treat a diabetic emergency as well as guidelines for the effective management of that emergency.

5. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit their 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 B1 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: Improvement Plan

Hospital: University Hospital for Wales

Ward/ Department: B1

Date of Inspection: 21 and 22 October 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
	None identified			
	Delivery of the Fundamentals of Care			
9	The health board needs to make the ward environment as accessible as possible to those with complex and sensory needs.	➢ Outcome of HIW, ICN and environmental audits escalated and communicated to Clinical Board and Assistant Nurse Director for Quality & Safety ➢ Clinical Board Nurse discussing decoration and refurbishment of the ward to a standard to support patients with sensory loss and complex patients without or	Senior Nurse Clinical Board Nurse	Achieved 23rd October 2014 Complete by April 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		fluctuating mental capacity. To be included in bathroom refurbishment as indicated below		
12	The physical environment of the ward and people's access to bathroom facilities should be taken into consideration when the ward is refurbished, to ensure facilities are accessible to all.	➢ Outcome of HIW, ICN and environmental audits escalated and communicated to Clinical Board and Assistant Nurse Director for Quality & Safety ➢ Preliminary decision made by END, Assistant Director for Estates and SpS Clinical Board Nurse to include B1 in the next bathroom refurbishment programme	Senior Nurse Clinical Board Nurse	23rd October 2014 Date to be finalised- expected to be early 2015
14	Meal time arrangements should be reviewed in order to improve the patient experience and ensure consistency in approach including; use of the Red Tray system and identification of patients requiring assistance, protected meal times, patients' access to hot meals and drinks and management of kitchen repairs.	➢ Re – review current protected meal time practices on B1 ➢ Revisit key principles of protected meal times with all staff, to understand exceptions due to nature of the ward/speciality/emergencies ➢ Ensure practice is communicated to all disciplines, patients and relatives to support and understand re-implementation ➢ Set up a meeting with operational services	Sister/Deputy Sister Sister/Deputy Sister Sister/Deputy Sister/Senior Nurse	Completed November 2014 Completed November 2014 Completed November 2014 Completed

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		reiterate with catering principles and their roles/responsibilities ➢ Liaise with operational services for adequate supply of red trays, reiterate to catering staff the correct use of red trays in conjunction with B1 patient nutritional plan	Senior Nurse Senior Nurse	November 2014 Completed November 2014
	Quality of Staffing Management and Leadership			
18	The health board to continue to review the recruitment processes in place to ensure vacancies on the ward can be filled as quickly as possible to reduce reliance on bank and agency staff.	➢ Clinical Board and UHB are looking at streamlining recruitment process to ensure timely robust recruitment plans are in place ➢ New Director for HR has commenced with specific remit for recruitment. Clinical Board Nurse is leading for the profession on task and finish group. Plan for 3 one stop shop recruitment events	Director for HR/CB Nurse	Review April 2015 3 dates arranged for Jan 2015
18	The ward manager needs to have protected supernumerary time for their management and non clinical duties.	➢ Review current constraints to implement change – sickness/vacancies/unavailability of temporary staffing for non commissioned additional capacity ➢ To ensure Ward Sister has expected	Senior Nurse Senior Nurse	Completed November 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		management time 7.5 hrs per week		Completed November 2014
19	The heath board and ward needs to review the use of equipment in the additional bay to ensure it is fit for purpose and meets the needs of patients.	➢ Non- commissioned area – Equipment was provided short term to meet urgent capacity demand. Immediate action – un-lockable POMs boxes reported to Works & estates for new locks ➢ Medicines stored safely within treatment room until work is completed ➢ Future plan – to permanently open the beds as part of the Cardiac expansion plan, all required equipment will be purchased as part of the implementation	Sister/Ward Receptionist Sister/Ward staff Senior & Lead Nurse	Completed October 2014 Completed October 2014 February 2015
20	Staff on the ward to receive training in dementia/confusion, vulnerable adults and DOLS in order to meet the changing needs of patients on the ward.	➢ Immediate actions- Dols team contacted to reassess the patient and support ward with relevant documentation. Patient reassessed and Dols discontinued ➢ Review of educational needs of B1 staff re: DoLs process ➢ Training sessions arranged for B1 staff to familiarise themselves with DoLs process.	N.I.C on B1/ Ward Sister Ward Sister/Senior Nurse Ward Sister/Lead Nurse	Completed 22/10/14 Completed 23/10/14 Ongoing sessions

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		Dates (13th Nov 14, 20th Nov 14 and 4th Dec 2014)		arranged
		➢ Link nurse identified to develop resource folder and facilitate staffs awareness and understanding	Ward Sister	Dec 2014
		➢ Ward meetings arranged with B1 staff to feedback HIW findings and actions required. Summary of findings displayed to all staff	Ward Sister/ Senior Nurse	Completed / Ongoing discussions and engagement
		➢ HIW inspection and actions discussed in CB nursing board, consultant meeting, Cardiothoracic Sisters meeting, Directorate Management meeting	CB Nurse, Senior Nurse, Clinical Director	Completed Oct 2014, ongoing feedback in forums of actions
		➢ Review educational needs with the Dols process within the whole of the Cardiothoracic Directorate. To share learning, establishment of directorate link nurses etc.	Ward Sisters/ Senior Nurse/Practice Educator	January 2015
		➢ To develop support mechanisms throughout the clinical Board to maintain competence and understanding of the	CB Nurse, Senior & Lead Nurses	January 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		DoLs process		
20	Staff should have timely access to PDRs to identify any practice issues and for support and development in their roles.	➢ Review current constraints to implement change – sickness/vacancies/unavailability of temporary staffing for non commissioned additional capacity ➢ Utilise Deputy Sister short term non clinical role to prioritise PADR completion ➢ Revisit the current team leaders staff allocation and give time for them to complete ➢ Practice Educator to provide updated PADR training sessions to the team leaders	Sister/Senior Nurse Deputy Sister Sister/Deputy Sister Practice Educator	Completed November 2014 Completed November 2014 January 2015 January 2015
	Delivery of a Safe and Effective Service			
24	We asked the health board through an immediate assurance letter to address the issues outlined in relation to the kitchen environment. The health board provided sufficient assurance to HIW on 7 November 2014 that the issues had been addressed.	➢ The kitchen will receive a deep clean. Cleaning will be monitored via the Credits for Cleaning monitoring tool. Joint inspections will be carried out with nursing staff and operational services.	Operational Services Manager Operational Services Manager	Completed November 14th

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		➢ Flooring in kitchen will be replaced (costs are currently being obtained by estates department) Operational Services Manager to review the kitchen environment and follow up if there is any work outstanding by 14th November 2014.		February 2015
24	The closing and locking mechanism on the ward doors should be activated to safeguard vulnerable patients.	➢ Escalated to directorate and Clinical Board team ➢ Urgent request to security to action work required and activate doors ➢ Request accepted awaiting date of completion which is dependent on the company availability	Senior Nurse Lead Nurse Security	January 2015 January 2015 January 2015
24	We asked the health board through an immediate assurance letter to ensure the person concerned was being lawfully deprived of their liberty and appropriate DOLS procedures had been followed. The	➢ Immediate actions- Dols team contacted to reassess the patient and support ward with relevant documentation. Patient reassessed and Dols discontinued	N.I.C on B1/ Ward Sister	Completed 22/10/14

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	health board provided sufficient assurance to HIW on 7 November 2014 that the issues had been addressed.			
26	Nursing notes should be updated contemporaneously in line with best practice guidelines to ensure any issues are captured and dealt with in real time. All care plans and record entries should be signed and signatures should be legible.	➢ Re – review current documentation practices on B1 ➢ Revisit key principles of expected standards of documentation/ real time with all staff, to understand their roles and responsibilities ➢ Provide and example of good practice to support compliance ➢ Monitor and audit documentation monthly to ensure compliance	Sister/Deputy Sister Sister/Deputy Sister Sister/Deputy Sister Sister Practice Educator	Completed November 2014 December 2014 December 2014 December 2014 (ongoing)
26	VTE assessments should be consistently completed with all patients and appropriate recording of the assessment should be documented to provide evidence of managing the associated risks to safeguard the patient.	➢ Discuss poor compliance at Cardiothoracic Consultants meeting, Directorate management meeting ➢ Discuss with Consultant Quality & Safety lead to raise non compliance and develop	Senior Nurse Senior/Lead Nurse	Completed October 2014 December

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		plan to increase compliance and communication to the ward medical team ➢ Develop a regular programme of audit to monitor compliance with VTE assessments	Quality & Safety Consultant lead/ Cardiothoracic Clinical Director	2014 End Jan 2015
27	The ward should review how nursing notes are stored and consider holders being used at the end of patient beds to ensure notes are kept safely and easily accessible.	➢ Review of bedside holders currently available on B1 ➢ Plans in place to purchase outstanding equipment	Sister/ Ward receptionist Sister/Ward receptionist	December 2014 December 2014

Health Board Representative:

Name (print): .....

Title: .....

Signature: .....

Date: .....