Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Hospital Inspection (Unannounced)

Cardiff and Vale University Health Board: Noah's Ark Children's Hospital, Island Ward, Pelican Zone, Owl Ward and Paediatric Critical Care Unit (PCCU)

8 and 9 October 2015

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Introduction

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

HIW's primary focus is on:

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at the Noah's Ark Children's Hospital within Cardiff and Vale University Health Board on the 8 and 9 October 2015. The following wards were visited during this inspection:

- Island Ward
- Pelican Ward
- Owl Ward
- Paediatric Critical Care Unit (PCCU).

Please note that for the remainder of this inspection report we will refer to the Paediatric Critical Care Unit as PCCU for ease of reading.

Methodology

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

feedback is made available to health services in a way which supports learning, development and improvement at both operational and strategic levels.

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

Figure 1

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

- **Quality of the Patient Experience:**
  We speak with patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to inspection.

- **Delivery of Safe and Effective Care:**
  We consider the extent to which services provide high quality, safe and reliable care centred on individual patients.

- **Quality of Management and Leadership:**
  We consider how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also consider how health boards review and monitor their own performance against the Health and Care Standards.

Our team, for the inspection at the Noah's Ark Children's Hospital, comprised of five HIW Inspection Managers (one of whom led and co-ordinated the inspection), two clinical peer reviewers and one lay reviewer.

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

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

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the quality, safety and

effectiveness of healthcare provided and the way which service delivery upholds essential care and dignity.

Context

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

The delivery of NHS primary care services in Cardiff and the Vale of Glamorgan, including general practitioners, community pharmacists, dentists, and optometrists are also the responsibility of the Board. Additionally, it serves 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 Vale University Health Board includes nine hospitals and seventeen health centres.

The Noah's Ark Children's Hospital for Wales (CHfW) is based on the site of the University Hospital of Wales in Cardiff. It provides health care for the children of Cardiff but also provides tertiary services for children across Wales.

Phase One

The building work for Phase One of the Noah's Ark Children's Hospital for Wales began in April 2003. The hospital admitted its first patients at the end of February 2005.

Phase one of the Children's Hospital for Wales brought new, purpose-designed buildings and facilities for children's services such as a new main entrance, atrium and reception. A children's cancer unit is on two floors (Rainbow and Rocket Wards) including an in-patient ward, day care unit, outpatients and full family accommodation. This area is supported by the charity LATCH (which stands for Llandough aims to treat children with cancer and leukaemia with hope).

Phase Two

This section of the children’s hospital has five floors which contain a range of services. The floors are named as follows:

- Ocean Floor (Ground)
- Land Floor (Upper Ground

- Sky Floor (First)
- Space Floor (Second)
- Star Floor (Third)

All the floors are named and colour coded to help children and their families to find their way around the hospital, and all areas have different animal logos to help children, families and staff to identify their location.

Volunteers are present at reception during day time hours to help with orientation and ‘way-finding’ due to the significant increase in square footage and additional departments within the hospital.

Children’s acute services currently have 120 inpatient beds with 102 commissioned for use. With the addition of phase three, children’s acute services will have 146 beds (115 commissioned) which excludes the (28) neonatal intensive care cots and the future admission unit (Seahorse).

Island Ward cares for children with medical conditions. There are 24 bed spaces in this area, all of which are provided in individual rooms.

Pelican Zone cares for children with cardiac and renal conditions. There are six beds available in this area.

Owl Ward is a surgical ward which has 14 beds for day surgery cases, and 28 beds for acute inpatient surgical care. The beds are distributed throughout the ward in a mixture of individual rooms, two bedded and four bedded bays.

PCCU has space to care for 15 critically ill children. Nine beds are for children requiring ITU care, six beds are for children requiring HDU care. WHSSC commissions six of the nine ITU beds.

Summary

We found that patients were treated with dignity and respect. This is because we observed the compassionate approach adopted by staff when speaking to patients and their families and responding to their requests for assistance. We also saw that curtains were closed in multi-occupied ward areas and doors were closed to individual rooms when care and support was being provided.

Patients' families told us that their privacy was well maintained as a direct consequence of the provision of individual rooms. We also received very positive verbal and written feedback in terms of the overall hospital environment; a number of people describing this as '*brilliant*'.

The three ward environments inspected were well maintained and brightly decorated; the emphasis on the environment within PCCU needing to be more clinical in its presentation due to the nature of the service provided.

Arrangements were in place for patients and their families to provide the health board with feedback on their experiences of current services received at the children's hospital.

Overall, we found systems were in place with the aim of protecting patients from avoidable harm and to keep them safe. Each of the four clinical areas we inspected were visibly clean.

Patient records clearly demonstrated appropriate input from members of the multidisciplinary team.

We found that patients had a choice of meals, the quality and presentation of which received favourable comments from patients and their families.

Overall, arrangements were in place for the safe management of medicines. We did however identify some improvements and have asked the health board to take action regarding those matters. We also identified the need for improvement with regard to a number of safety issues, a small number of environmental factors within PCCU and the recording of patient care.

Overall, we found that each of the four clinical areas inspected were led by knowledgeable, motivated and passionate individuals who demonstrated a keen sense of purpose regarding the promotion of continuous service improvement. However, the environmental layout associated with one of the wards posed significant challenges in terms of team working and staff skill mix.

We found that the health board placed an emphasis on staff succession planning and we were offered some practical examples of the benefits of this approach in terms of retaining competent and confident staff.

Discussions with a senior member of the medical staff highlighted the management arrangements that have been developed within the Children's Hospital to ensure that staff innovation is embraced and acted upon as far as possible. We were also made aware of the management systems that have been established regarding clinical governance and quality and safety to support the effective delivery of care to patients and their families.

However we identified the need for improvement with regard to staffing levels and bed management arrangements.

During day one of the HIW inspection we found that a number of children within Island Ward did not have identification wristbands in place. This created the potential risk of medication error and/or patient identification error should clinical investigations be required outside of the ward environment. In addition, on examination of one particular set of patient records, we saw that the child in question had a recorded latex allergy. However, there were no supplementary safety measures in place to alert staff to this serious health and safety issue. The ward manager was also unable to initially confirm whether the resuscitation trolley contained latex free equipment to minimise the risk of anaphylaxis in an emergency situation. (HIW has since received confirmation that the resuscitation trolley does indeed contain latex free equipment with the exception of specific airways which are not available in a latex-free form. However in the event that such equipment needed to be used-the risk would be managed through the use of appropriate medication).

The above matter was brought to the attention of the health board at the point of discovery and resulted in an immediate assurance letter being issued by HIW. The purpose of the letter was to seek immediate written assurance from the health board on the action taken to maintain the safety and well being of patients. The response received was considered by HIW. However further information had been requested at the time of writing this report.

<u>Previous Inspections by Healthcare Inspectorate Wales</u>

Healthcare Inspectorate Wales conducted seven dignity and essential care inspections and one follow-up inspection at Hospitals run by Cardiff and Vale University Health Board during 2014-2015. Reports of our findings are available on the HIW website (www.hiw.org.uk)

Whilst this inspection did not revisit any of those clinical areas, it did take account of recommendations previously made. This was to establish whether specific improvement action, described by the health board in response to previous HIW inspection findings, needed to be applied more

widely across the hospitals inspected. At previous inspections, we identified improvement was needed around the following:

- Better recording of patients nutrition and hydration needs
- The completion of care and risk assessment documentation used on hospital wards needed to be consistent
- Staff on some wards required further training around the specific issue of caring for patients who were confused or had dementia
- There were concerns identified about the maintenance and ward environment in some of the older parts of the health board estate
- We did not find any areas for improvement in relation to the recording of patients' nutritional needs and staff training regarding the care of the older person and dementia/confusion was not relevant during this inspection.
- However, we identified that improvement was still needed in respect of the recording of some patients' risk assessments and care plans. Whilst present, they were not used to monitor and evaluate care. In addition, we found elements of improvements needed to the PCCU environment.

We did not find any areas for improvement in relation to the recording of patients' nutritional needs and staff training regarding the care of the older person and dementia/confusion was not relevant during this inspection.

However, we identified that improvement was still needed in respect of the recording of some patients' risk assessments and care plans. Whilst present, they were not used to monitor and evaluate care. In addition, we found improvements were needed to the PCCU environment.

Findings

Quality of the Patient Experience

We found that patients were treated with dignity and respect. This is because we observed the compassionate approach adopted by staff when speaking to patients and their families and responding to their requests for assistance. We also saw that curtains were closed in multi-occupied ward areas and doors were closed to individual rooms when care and support was being provided.

Patients' families told us that their privacy was well maintained as a direct consequence of the provision of individual rooms. We also received very positive verbal and written feedback in terms of the overall hospital environment; a number of people describing this as '*brilliant*'.

The three ward environments inspected were well maintained and brightly decorated; the emphasis on the environment within PCCU needing to be more clinical in its presentation due to the nature of the service provided.

Arrangements were in place for patients and their families to provide the health board with feedback on their experiences of current services received at the children's hospital.

Dignified Care

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

During our inspection we invited patients and/or their parents/relatives to complete a HIW questionnaire to provide us with their views and experiences of the current services provided, the clinical environment and the hospital staff.

Twenty one questionnaires were completed in total, either via face to face interviews or returned to us during the two day inspection. Without exception, the comments received indicated staff were polite toward patients and their families/friends. We also observed staff being friendly, kind and professional toward patients and their families. Our observations were further confirmed through comments provided within questionnaires. A sample of those comments is shown below:

'Everything has been first class'

'Go above and beyond their duty. Nothing is too much trouble for them'

'Staff appear to be more dispersed. Now seems to be more difficult (because of the size). No teamwork as well as they did previously on South Ward'

And

'Play staff are excellent'

'Staff have looked after us. Lots of support, physical and emotional and we are being trained'

'Wonderful establishment'

Additionally, we saw that staff were compassionate in their approach towards patients and their visitors and in all areas we visited; we found staff protecting the privacy and dignity of patients as far as possible. For example doors to single rooms were closed and curtains were used around individual bed areas.

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner. (Standard 4.2)

Comments from patients and parents indicated staff had spoken with them about their own or their child's (where parents provided comments) medical conditions and had helped them to understand the care and treatment to be provided. A small number of parents however told us that there were occasions when nurses and doctors did not introduce themselves prior to speaking with them.

Improvement needed

The health board is required to describe how it will ensure that staff always introduce themselves to patients and their families ahead of any discussions or clinical interventions.

We looked at a sample of patients' care records. These demonstrated nursing and medical staff and other members of the multi-disciplinary team had spoken to patients (and/or their parents) about their care and treatment.

We saw that information leaflets were available for patients and parents to take home. These provided relevant information on a range of health conditions.

The hospital also provided families who visited the hospital with a leaflet which provided a range of information such as details about car parking, visiting times, staying overnight with children, multifaith services and security issues.

Staff confirmed they could access translation services should these be required to assist them to speak effectively with patients. We also saw that all signs within the hospital were displayed in both Welsh and English and were informed that there were staff available to speak with patients and their families in Welsh in accordance with individual wishes and preferences.

Conversations with ward staff demonstrated that a form of pictorial communication system was used to assist patients and their parents/representatives with limited understanding or use of the English language.

In addition, we were made aware that there were two staff within Owl Ward who were able to communicate with individuals through the use of Makaton[1] if required.

Individual Care

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

We found that patients had a written assessment of their needs to identify their individual care and support requirements.

We saw that each of the four clinical areas inspected had kitchen and some sleeping facilities. These were used at such time when parents were present at the hospital for long periods and/or overnight. However, family members were not currently provided with any means of storing their personal belongings. Discussion with senior managers highlighted that facilities within Phase 3 of the

[1] **Makaton** is a language programme designed to provide a means of communication with individuals who cannot communicate efficiently by speaking.

children's hospital will address this issue. In the interim, the health board was advised to consider practical ways of addressing this issue.

There was a room, within each clinical area seen, where parents and family members could spend some time away from their child's bedside or to speak with medical and nursing staff privately.

The visiting arrangements in all the areas we inspected meant that patients were able to maintain contact with their families and friends, according to their wishes.

We found that care was consistent with the ages of the children in receipt of services. However, discussions with ward managers and other staff revealed that the transition of patients from children's' to adult services needed to be improved.

Improvement needed

The health board is required to provide details of the plans and strategy in place to ensure that children's transition to adult services is efficient and effective and supported by good communication between relevant agencies.

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

We saw that there were suggestion boxes within the wards to enable patients and their families to provide their comments on services received. We were told that all information gathered via this method was discussed at monthly clinical board meetings by a variety of staff. This was with a view to looking at the issues raised and taking action to improve the service wherever possible.

We were also provided with the results of a completed patient/relatives survey undertaken across the children's hospital during August 2015 and found that many positive comments had been made. Issues identified for improvement at that time included the provision of water jugs for parents who remain in hospital with their child and a request that play staff are available at weekends; the health board having taken suitable action in both cases. Results from the September 2015 survey were not available at the time of our inspection.

Senior staff explained that wherever possible staff would try and resolve concerns raised by patients or their representatives at ward/unit level. Where this could not be achieved they were aware of the escalation process to follow so that concerns (complaints) may be considered under the *Putting Things Right*[2] arrangements. However, we could not find any information about the concerns/complaint process on display within Owl Ward. This meant that patients and their relatives may not know what to do in the event that they wished to raise any concerns.

Improvement needed

The health board is required to describe the action taken to ensure that patients, their families and representatives in all areas of the children's hospital are made aware of the arrangements in place for managing concerns in Wales.

[2] *Putting Things Right* are the arrangements for managing concerns (complaints) about NHS care and treatment in Wales.

Delivery of Safe and Effective Care

We found systems were in place with the aim of protecting patients from avoidable harm and to keep them safe. Each of the four clinical areas we inspected were visibly clean.

Patient records clearly demonstrated appropriate input from members of the multidisciplinary team.

We found that patients had a choice of meals, the quality and presentation of which received favourable comments from patients and their families.

Overall, arrangements were in place for the safe management of medicines. We did however identify some areas for improvement and have asked the health board to take action regarding those matters. We also identified the need for improvement to a number of safety issues, a small number of environmental factors within PCCU and the recording of patient care.

Staying healthy

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

We found that signs were clearly displayed in a number of areas across the hospital site which alerted staff, patients and visitors to the fact that it was a smoke free environment. We also saw reference to this issue within the overarching information leaflet made available to families. However, staff within Island Ward told us that they could often smell smoke in a particular area of the ward (room 17) when the windows were open to allow natural ventilation. Family members in one of the other wards we inspected also expressed their concern at the sight of visitors smoking directly outside the main entrance of the Noah's Ark children's hospital.

The above findings contravene Welsh Smoke Free Premises legislation[3] and may also compromise the health and safety of patients, visitors and staff.

Improvement needed

The health board is required to demonstrate the action taken to ensure that the hospital site conforms to current Smoke Free Premises legislation.

Safe care

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

We found that staff at the children's hospital were not using Paediatric Early Warning Scores (PEWS) documentation, to record any deterioration in children's' health status, at an early stage. Early intervention can address problems and can prevent the need to transfer a child to a higher level of care and thus avoid or reduce harm.

Discussions with a senior nurse manager indicated that the documentation had been used in the past but had been discarded in favour of other means of recording such aspects of care and treatment. The health board was however advised of the need to re-consider the use of PEWS documentation in the future, to supplement and record the face to face individual patient assessments undertaken by clinical and nursing staff.

We asked staff to provide us with a small number of key policies and procedures and found that they experienced difficulty in locating the information via the hospital intranet (especially with regard to medicines management). This meant that there was the potential risk that staff may not have easy access to up to date and relevant information to help them prioritise and manage real risks relating to patient care and treatment.

[3] Smoke free legislation was introduced in Wales on April 2nd 2007. The legislation banned smoking in most enclosed (or substantially enclosed) public places and aimed to address concerns about exposure to Environmental Tobacco Smoke (ETS). It was also hoped that the ban would increase the impetus of smokers to quit.

Improvement needed

The health board is required to describe the measures taken to ensure that staff working in all clinical areas are able to easily obtain current, relevant information to assist them in their work.

We found that there were occasions when medical staff removed patients' medical records from the wards without communicating this to nursing staff. We were made aware that this issue had arisen on one occasion during the course of our inspection. This meant that there was the potential for the security of patients' records to be weakened and communication between medical and nursing staff was undermined by this practice.

Improvement needed

The health board is required to demonstrate how it will ensure that the whereabouts of confidential patient information is known to all medical and nursing professionals and other relevant staff at all times.

We found that the nurses' station within the Pelican Zone was constructed in such a way that the two computer screens, (and their contents), were clearly visible to whoever entered this area (including patients/families/other members of the public, as well as staff). We also saw that patient records were placed in this area (at times when the nurses' station was unattended) which meant that patients' information could potentially be seen by unauthorised persons. These issues compromised patient confidentiality.

Improvement needed

The health board is required to provide details of the action taken to ensure that the confidentiality of patients' information is maintained within Pelican Zone at all times.

We found that the security monitor within Owl Ward was broken. In addition, discussion with a patient's family member revealed that they had recently discovered an unauthorised person wandering in the ward corridors at 10:00pm. A member of the inspection team also needed to escort two people to a member of staff as they were seen to be wandering within the ward. This prompted further discussion with the ward team who told us that the security monitor had been broken for a short while (as a result of doctors using the monitor to access laboratory results) which meant that they were unable to determine who was requesting entry at any time of day or night. They also acknowledged that people were being granted entry without checking who was making the request to enter the ward and that 'visitors' tended to 'tailgate' their way into the ward. This matter clearly compromised patient safety.

We reported our findings to senior hospital managers who provided a verbal assurance that action would be taken to address this issue promptly.

Improvement needed

The health board is required to fully describe the action taken to ensure that the entry and exit arrangements associated with Owl Ward are made secure. This is for the protection of patients, visitors and staff.

We held conversations with ward managers about the arrangements in place regarding risk management and health and safety and found that safety briefings for all staff were held daily within the Pelican Zone, Island and Owl Wards respectively. This enabled staff to discuss areas of risk associated with the provision of care to patients and their families (this could relate to clinical or environmental factors). The briefing also focussed on any informal concerns or clinical incidents. We were also told that action plans were completed as a result of the safety briefings which meant that staff were enabled to learn lessons from any concerns identified by healthcare staff or raised by patients/ families, thus reducing the risk of similar occurrences in the future.

Welsh Government issues patient safety solutions[4] information which require health boards to take appropriate action where needed to ensure safe services. We found that there were electronic systems in place to communicate the content of safety alerts to staff. This was with a view to ensuring that any action needed, would be taken in a prompt manner.

We discovered that a set of keys (needed to access the contents of a medicines cupboard) in Owl Ward was missing. We also found that a set of keys was broken in the same clinical area. This was discussed with the ward team and remedial action taken on the same day-to change locks and issue a new set of keys.

We held conversations with staff and explored issues relating to the PCCU environment and found the following:

- The room temperature within PCCU was considered to be very low; staff being unable to adjust this to a more comfortable level within which to deliver care

[4] Information on NHS Wales Patient Safety Solutions is available on the Patient Safety Wales website: http://www.patientsafety.wales.nhs.uk/safety-solutions-

- We were informed that the water temperature at the hand wash basins was too hot and estates staff had not been able to resolve this situation

- Staff told us that when the emergency button is pressed at a patient's bedside, the locator panel does not match up with the bed unit. This meant that there were occasions when staff, (who would be required to offer assistance) were unclear as to where, within PCCU, they were needed in an emergency situation. We understood that senior managers were aware of this matter.

Improvement needed

The health board is required to provide HIW with details of the action to be taken with regard to the environmental issues highlighted within PCCU.

Immediate Assurance

During day one of the HIW inspection we found that a number of children within Island Ward did not have identification wristbands in place. This created the potential risk of medication error and/or patient identification error should clinical investigations be required outside of the ward environment. In addition, on examination of one particular set of patient records, we saw that the child in question had a recorded latex allergy. However, there were no supplementary safety measures in place to alert staff to this serious health and safety issue. The ward manager was also unable to confirm whether the resuscitation trolley contained latex free equipment to minimise the risk of anaphylaxis in an emergency situation. (HIW has since received confirmation that the resuscitation trolley does indeed contain latex free equipment with the exception of a small number of specific airways which are not available in a latex-free form. However in the event that such equipment needed to be used- the risk would be managed through the use of appropriate medication).

The above matters were brought to the attention of the health board at the point of discovery and resulted in the issue of a HIW immediate assurance letter. This was to seek assurance regarding the action taken to improve and promote patients' health safety and welfare. HIW has since received a response from the health board. However further information had been requested at the time of writing this report.

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

Examination of a sample of two to three records in each of the four clinical areas inspected served to demonstrate that appropriate paediatric risk assessment documentation was completed by staff. The records also generally showed that action was taken by staff where appropriate to prevent children from developing pressure and tissue damage. However, one of the records we looked at did not include the details of the actual equipment provided for the patient. During a later conversation with one of the nurses we found out that a pressure relieving mattress and cushion had been provided, therefore we suggested that this information be added to the patient's record.

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

Discussion with two housekeeping (domestic) staff revealed that they were often unable to complete cleaning duties within their hours of work. In addition, they told us that the work they were unable to complete was often not addressed by the next shift either. Staff told us that this situation existed because the floor space in the children's hospital was much larger than they had responsibility for in previous accommodation. In addition, all wards now have individual patient rooms, so cleaning duties took much longer to complete and their hours of work had not increased. This issue had the potential to impact negatively on required infection prevention and control standards. HIW did however note that all areas inspected appeared visibly clean and domestic staff were seen to be present at various times of the day.

We were provided with copies of recent cleanliness audits across each of the four clinical areas inspected (otherwise known as credits for cleaning) and saw that the areas concerned were largely compliant. However, one ward manager acknowledged the challenge they faced in meeting the required standards for hand washing due to the pressure of work experienced by the staff team and current staff deficits.

Improvement needed

The health board is required to provide detail of the action to be taken to ensure that standards of cleanliness and hygiene are upheld in all areas of the hospital. This is with a view to ensuring that patients and staff are protected from infection as far as possible at all times.

We saw that there were sufficient sinks, paper hand towels and alcohol gel in all clinical areas inspected. We were told that infection control 'link nurses' were in place within ward areas to help support staff in maintaining required standards of hygiene. Staff also told us that they had received training in relation to infection prevention and control; updates being provided on a regular basis.

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

We found that patients' individual nutritional needs were assessed and planned for, and parents were encouraged and supported to assist their child with eating and drinking where required. However, one (breastfeeding) parent who spoke with us stated that they had not initially been made aware that they could have been provided with regular meals by the hospital to maintain nutritional needs in accordance with agreed local procedure. As a result many hours had been spent with her child without food or drink and there was a need to rely on relatives to bring food into the hospital. The health board therefore needs to consider ways of ensuring that, in future, parents are aware of this measure of support in a more timely way.

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

We identified a number of areas where medicines management needed to be improved. These were:

- Fridge temperatures were being recorded within the Controlled Drugs Book (Island Ward) which is an inappropriate use of this legal document. We were told by a member of staff that this was being done as a result of a memorandum received from the dedicated pharmacist. We also found an inconsistent approach to recording

daily fridge temperatures. Some areas were using a separate list whilst another area was not recording fridge temperatures at all

- Oxygen was not being recorded as a prescription drug on patients' medication administration records (MARs) in each of the four areas inspected. There were arrangements in place to track such treatment on children's records in paediatric intensive care, albeit that we were informed that such recording was due to be improved in the near future
- Saline (flushes) for intravenous use were not being recorded on the MARs
- Prescriber's signatures were illegible on MARs in all four areas inspected. Given that contact bleep numbers changed regularly and all-Wales MAR charts do not make any provision for staff to print their names, the health board is required to ensure that clinical staff who have prescribing responsibilities ensure that their signature is legible
- We found that in instances where staff were undertaking daily stock checks/audits of controlled drugs, they were not making a separate entry to record their check on individual pages. Rather, they were making one summarised entry in the CD book to indicate that all drugs had been checked. This was a contravention of the health board policy

Improvement needed

The health board is required to provide HIW with a description of the action taken to address each of the five areas for improvement identified with regard to medicines management.

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

We found that staff in each of the four areas inspected had an understanding of the All Wales Child Protection procedures. There were also safeguarding link nurses in place as a means of supporting staff to ensure that correct procedures were followed.

We saw that there was a whistleblowing policy in place to enable staff to raise any concerns they may have in a confidential manner and were also able to

confirm that staff felt confident in approaching their ward manager or other senior staff if they became aware of any allegations of abuse.

Conversations with staff revealed that there were well established arrangements in place with regard to multi-agency working and discharge planning.

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems. (Standard 2.9)

We saw that a range of medical equipment and devices were available to staff, all of which appeared to be visibly clean. The equipment also contained labels which showed that they had been serviced and maintained as required.

Effective care

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

Examination of a sample of patient records across four clinical areas served to confirm that staff overall placed an emphasis on ensuring that patients were safe and protected from unavoidable harm.

We found examples whereby Welsh speakers were able to use the Welsh language to express themselves.

The above standard was otherwise not explored.

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

We found a number of aspects of record keeping that needed to be improved as follows:

- Examination of the content of a sample of patient records revealed that staff were not always recording the pressure relieving equipment that was to be used to support patients following the completion of risk assessment documentation. Discussion with staff and observation of what was in place demonstrated that necessary steps had been taken. However, staff recording in this regard needed to be improved (as already mentioned on page 21 of this report)

- We saw that daily patient and assessment documentation was not always completed (e.g. previous history and other key information were absent). Staff also told us that there were often occasions when patient admission assessments and review documentation were not completed due to staff deficits. Structured care plans were in place, however, HIW could not find any evidence that patients' individual needs were monitored and evaluated alongside their use.

- HIW team members who examined patient documentation found that there was an over reliance on the use of patient hand over sheets to determine daily care to be delivered as opposed to staff making their own individual assessment and updating records accordingly, during the course of their work

- We found that nurses were signing their recorded entries, but were not always printing their name or designation (this applied in each of the four areas inspected)

- Doctors' signatures were seen to be present within patient records; however, senior doctors were not recording their designation (within the sample seen during the inspection). The health board is therefore required to describe how it will ensure that this matter is addressed in accordance with GMC-Good Practice Guidance

Improvement needed

The health board is required to describe the action taken to ensure that all patient records are maintained in accordance with legislation and clinical standards guidance.

Timely care

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

No concerns were reported to the inspection team around the timeliness of care provided during our inspection.

Quality of Management and Leadership

Overall, we found that each of the four clinical areas inspected were led by knowledgeable, motivated and passionate individuals who demonstrated a keen sense of purpose regarding the promotion of continuous service improvement. However, the geographical area associated with one of the wards posed significant challenges in terms of team working and staff skill mix.

We found that the health board placed an emphasis on staff succession planning and were offered some practical examples of the benefits of this approach in terms of retaining competent and confident staff.

Discussions with a senior member of the medical staff highlighted the management arrangements that have been developed within the Children's Hospital to ensure that staff innovation is embraced and acted upon as far as possible. We were also made aware of the management systems that have been established regarding clinical governance and quality and safety in support of the effective delivery of care to patients and their families.

However we identified the need for improvement with regard to staffing levels and bed management arrangements.

Staff, resources and staff training

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

We found that nurse staffing and skill mix within the Children's Hospital was recognised as a priority for Executive Directors and senior managers. More specifically, discussions with health board representatives demonstrated their acknowledgement that the number of nurses would need to be increased to

work in this area due to patient acuity ratios[5], the larger floor space, and in some cases, the complicated layout of clinical areas. Staffing issues were however compounded by decisions that were yet to be taken in respect of the South Wales Programme[6]. For example, we were informed that it had not been possible to realise the benefits of plans to consolidate regional children's (paediatric) services across a reduced number of district general hospitals. This was due to difficulties in achieving the required pace of the change across South Wales and because a number of qualified paediatric nurses, (who had previously been employed within the NHS outside of Cardiff) had chosen to pursue alternative career paths such as health visiting, instead of taking up employment at the Noah's Ark Children's Hospital.

Ward managers and senior managers were able to describe the current emphasis on recruiting more paediatric nurses and registered nurses via a UK and European recruitment drive; some staff having already been employed as a result of this initiative. Consideration was being given to the skill mix of staff within the wards to ensure the most effective way of delivering care to patients and their families. We were also told that whilst recruitment of paediatric nurses was proving to be difficult, (as it is for other health boards in Wales), staff retention was good.

We found that the health board placed an emphasis on staff succession planning and were offered some practical examples of the benefits of this approach in terms of retaining competent and confident staff.

Conversations with staff demonstrated that there were no Nurse Practitioners (NPs) associated with Island or Pelican wards respectively. They also told us that recent funding which had become available to the health board for NPs had been diverted to adult services.

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[5] Patient acuity. This is one of the methods that can be used to identify the extent of patients' needs alongside the allocation of nursing staff and the long-range projection of budget.

[6] The South Wales Programme is made up of the five South Wales health boards – Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys – working with the Welsh Ambulance Service to create safe and sustainable hospital services for people living in South Wales and South Powys. The programme's work has been led by frontline clinicians – doctors, nurses, midwives and therapists – with the aim of providing high quality and safe specialist hospital services which improve the care of the sickest and most seriously injured patients.

We held discussions with members of the ward teams about the demands they faced in terms of service delivery and found that they were often unable to take their meal breaks at reasonable times during their working day. We also observed that the provision of appropriate staffing levels within two of the four areas inspected (Island and Owl Wards respectively) was particularly challenging either due to the complexity of care provided or the need for regular observation of patients for the purpose of their care and safety.

The geography of Owl Ward posed particular challenges regarding the deployment of staff due to its layout. Conversations with staff in the same area further revealed feelings of isolation and the difficulties they faced in terms of supporting patients with effective, timely discharge arrangements together with making bed spaces available to children who required admission for in-patient and day surgery. This was due to the known staff deficit.

We were informed that where there was a current shortfall in staff requirements across the children's hospital; every attempt being made to cover the situation through the use of established nurse bank arrangements and in some cases by external agency nurses. We were also told that staff across the paediatric wards/units, were expected to work and provide support across all areas on a regular basis at this time. Examination of staff rotas in each of the four clinical areas visited confirmed the efforts being made to ensure that there were enough staff with the right skills to meet the complex, changing needs of patients. However, the above findings indicated that there were times when this may not be fully achieved.

Improvement needed

The health board is required to describe how it will ensure that there are sufficient staff available in all wards within the Children's Hospital to meet patients' needs at all times.

We found that there were suitable handover arrangements at the beginning of each work shift in each of the four clinical areas inspected, to enable the sharing of patient information with all nurses and other relevant members of the ward team.

Governance, leadership and accountability

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

We held a discussion with members of the children and women's clinical board[7] and were able to confirm that their lead roles and responsibilities were clearly defined. This assisted with enabling board members to focus on supporting the delivery of services to children in ways that met their needs. Such conversations also revealed that the board negotiated and co-operated well with staff within the clinical areas inspected as well as external agencies associated with the provision of care to children.

We found, however, that senior nurse and ward management leadership time was eroded by the need to undertake bed management duties. This resulted in individuals' being unable to drive innovation and support ward teams in the way they would have wished. This was particularly evident within Owl Ward. Whilst we were able to confirm that the care and treatment provided in each of the four areas was good at the time of our inspection (and received many positive comments from patients and their families in this regard), the health board must take prompt action to remedy the above situation. This is because there is a risk that the provision of an effective service will be rendered unsustainable due to the current bed management arrangements.

Improvement needed

The health board is required to describe how it will ensure that bed management arrangements are revised so that senior nurses and ward managers are enabled to lead, manage and support staff teams to maintain a positive ethos and outcomes for children.

Staff training and development

Conversations with ward managers indicated that all new staff were supported to become familiar with what was expected of them during a defined period of induction. We also received direct, positive feedback about their induction from three members of staff.

Generally, we found that staff were able to attend regular and relevant training. This was to ensure they had a wide range of communication and therapeutic skills to complete their work. However, we found that training compliance within

[7] The children and women's clinical board comprises a Clinical Director, Lead Nurse, Senior Nurse, a Head of Operations and Delivery, an assistant Directorate Manager and Head of Therapies for acute services. Their role is to ensure that everyone works together in the interests of children in receipt of care.

Owl Ward needed to be improved as staff were experiencing difficulty in securing release from their clinical duties to attend training sessions. This was as a result of the volume of work associated with the ward and prevailing staff deficits. We were made aware that five new staff had recently been recruited to the ward which may serve to alleviate the situation. A further three qualified staff are to be recruited in the near future.

Discussions with members of the four staff teams indicated that there was an effective planned system in place for staff rotation across the children's wards. This was in addition to those times when staff were requested to work in areas other than their designated wards to address unforeseen staff absence/sickness. This meant that the health board was able to deploy its competent workforce in an organised and flexible way for the benefit of patients and their families.

We were able to establish that the health board had introduced the role of education practitioner in the PCCU. Ward managers considered input from this role to be effective in terms of supporting the workforce to complete their work in a confident and competent way. There were no substantive practice educator posts on either the medical or surgical wards. Given that five new staff had recently joined the ward team, the health board was advised of the need to consider the practical assistance those individuals may need, as well as the wider staff team.

Improvement needed

The health board is required to describe the action to be taken to ensure that newly recruited and established members of ward teams are provided with support from practice development practitioners.

We were informed that the health board was encouraging staff to work with them by offering financial and practical support to complete relevant Master's degree modules regarding paediatric care.

Discussions with ward managers revealed that there was an established system in place for the completion of staff appraisals and we were provided with documentation that related to this process. That meant there was a formal mechanism in place to consider whether previous training had been effective. Appraisals were also considered to be a useful forum for identifying future staff training needs. One ward manager did however acknowledge that their schedule of appraisals was not up to date as a result of staff in their area having to work in other wards that were short of staff.

We found that staff were confident and able to raise any concerns with the ward manager and other senior staff, on an informal basis.

During the course of this inspection, staff in each of the four clinical areas visited, were invited to complete a HIW staff questionnaire. Fourteen completed questionnaires were returned.

Eleven of the fourteen staff stated that the training they had completed whilst working for the health board had helped them to do their job more effectively, or deliver a better patient experience.

One member of staff stated that they didn't feel involved in decisions that were made about changes introduced to their department. However 12 out of 14 staff indicated that the organisation was either 'always supportive' or 'usually supportive' of them during the course of their work.

Without exception, staff who completed questionnaires recorded that they were satisfied with the care that they gave to patients and none had personally experienced any form of discrimination at work in the past 12 months.

Key governance arrangements

The Clinical Director associated with the children and women's clinical board described the arrangements established to encourage staff innovation and monitor all aspects of quality and safety and clinical governance. This was with a view to continually improving the service provided as far as possible. The following were examples of such arrangements:

- The establishment of a staff forum, (which met nine times per year for a period of three hours each time), was a vehicle for encouraging any member of staff to come forward with any quality improvement ideas. As a result, discussions were taking place to screen patients (on admission) for the presence of MRSA[8], where there has been a history of this in the past. This is with a view to treating the children concerned, whilst protecting others
- Monthly quality and safety meetings take place where agreement has been reached in terms of a rolling programme of regular audits (checks) on key aspects of service such as infection prevention and control and the response to safety alerts. A lead person has been identified to take responsibility for the programme

[8] MRSA is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections. http://www.nhs.uk/conditions/MRSA/Pages/Introduction.aspx

- Clinical governance meetings enable discussions to take place with regard to Quality and Safety and Patient Experience as well as clinical incidents/medicines management and infection control issues
- Morbidity and mortality information[9] is examined monthly with a view to identifying any lessons to be learned
- Regular discussions take place between members of the clinical board and community and other secondary care staff as a means of identifying areas of service for improvement
- Two clinical leadership fellows have been appointed to look at service provision for those children with long term conditions and the interface between primary and secondary care. This is with a view to ensuring the service provided to children is as effective as possible

[9] Morbidity information relates to patients' sickness and long term health conditions and mortality information relates to patient deaths.

Next Steps

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

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

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

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

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

Appendix A

Hospital Inspection: Improvement Plan

Hospital: Noah's Ark Children's Hospital

Ward/ Department: Island Ward/Pelican Zone/Owl Ward/PCCU

Date of inspection: 8 and 9 October 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
Page 11	The health board is required to describe how it will ensure that staff always introduce themselves to patients and their families ahead of any discussions or clinical interventions. Health and Care Standard 4.2			
Page 13	The health board is required to provide details of the plans and strategy in place to ensure that children's' transition to adult			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	services is made more efficient and supported by good communication between relevant agencies. Health and Care Standard 6.2			
Page 14	The health board is required to describe the action taken to ensure that patients, their families and representatives in all areas of the children's hospital are made aware of the arrangements in place for managing concerns in Wales. Health and Care Standard 6.3			
	Delivery of Safe and Effective Care			
Page 16	The health board is required to demonstrate the action taken to ensure that the hospital site conforms to current Smoke Free Premises legislation. Health and Care Standard 1.1			
Page 17	The health board is required to describe the measures taken to ensure that staff working			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	in all clinical areas are able to easily obtain current, relevant information to assist them in their work. Health and Care Standard 2.1			
Page 17	The health board is required to demonstrate how it will ensure that the whereabouts of confidential patient information is known to all medical and nursing professionals and other relevant staff at all times. Health and Care Standard 2.1			
Page 17	The health board is required to provide details of the action taken to ensure that the confidentiality of patients' information is maintained within the Pelican Zone at all times. (This is in relation to the position and design of the nurses' station) Health and Care Standard 2.1			
Page 18	The health board is required to fully describe the action taken to ensure that the entry and exit arrangements associated with Owl Ward are made secure. This is for the protection of patients, visitors and staff. Health and Care Standard 2.1			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Page 19	The health board is required to provide HIW with details of the action to be taken with regard to the environmental issues highlighted within PCCU. Health and Care Standard 2.1			
Page 21	The health board is required to provide detail of the action to be taken to ensure that standards of cleanliness and hygiene are upheld in all areas of the hospital. This is with a view to ensuring that patients and staff are protected from infection as far as possible at all times. Health and Care Standard 2.4			
Page 23	The health board is required to provide HIW with a description of the action taken to address each of the five areas for improvement identified with regard to medicines management. Health and Care Standard 2.6			
Page 24	The health board is required to describe the action taken to ensure that all patient records			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	are maintained in accordance with legislation and clinical standards guidance. Health and Care Standard 3.5			
	Quality of Management and Leadership			
Page 28	The health board is required to describe how it will ensure that there are sufficient staff available in all wards within the Children's Hospital to meet patients' needs at all times. Health and Care Standard 7.1			
Page 29	The health board is required to describe how it will ensure that bed management arrangements are revised so that senior nurses and ward managers are enabled to lead, manage and support staff teams to maintain a positive ethos and outcomes for children. Health & Care Standards, Part 2 Page 8)			
Page 30	The health board is required to describe the action to be taken to ensure that newly recruited and established members of ward			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	teams are provided with support from practice development practitioners. Health & Care Standards, Part 2 Page 8)			

Health Board Representative:

Name (print): .....

Title: .....

Date: .....

Appendix B

Results of Patient Survey

During the course of this inspection, patients and their families were invited to complete a HIW questionnaire in order to obtain their views of services received, the clinical environment and staff.

Twenty one questionnaires were completed during the inspection. All parents agreed that the wards were clean and tidy. All but one family agreed that there were sufficient activities available on the ward for their children.

One parent disagreed with the statement that they were able to stay with their child overnight, but did not provide any additional information as to why this was the case.

Responses received within twenty completed questionnaires highlighted that staff were always polite to them and their family. In addition, no parent disagreed with the statement that staff had helped them to understand their child's medical condition.

One respondent stated his/her preference to communicate in a language other than English/Welsh had not been addressed by staff. However, we found that all respondents who wished to communicate with staff through the use of Welsh were able to do so.

One parent reported that they did not know their child's named nurse and four parents reported that they did not know their child's consultant.

All parents were positive about the care and treatment their child had received from staff, offering a rating of 8 to 10 (from a scale of 0 to10).