Hospital Inspection (Unannounced)

Surgical Services: Trauma and Orthopaedic care

Bronglais Hospital / Hywel Dda University Health Board

Inspection date: 3 to 5 July 2017

Publication date: 6 October 2017

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@wales.gsi.gov.uk**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-78859-413-4

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

Patient-centred: we place patients, service users and public experience at the heart of what we do

Integrity: we are open and honest in the way we operate

Independent: we act and make objective judgements based on what we see

Collaborative: we build effective partnerships internally and externally

Professional: we act efficiently, effectively and proportionately in our approach.

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of surgical services at Bronglais Hospital, Aberystwyth within Hywel Dda University Health Board on the 3 to 5 July 2017. The following clinical areas were visited during this inspection:

- Pre-operative assessment clinic
- Ceredig ward (a surgical ward for trauma[1], planned orthopaedics and general surgery)
- Day Surgery Unit theatres (including admission areas, theatres and recovery areas)

Our team, for the inspection comprised of two HIW inspection managers, four clinical peer reviewers (a theatre manager, a senior nurse, two anaesthetists and a surgeon) and two lay reviewers. The inspection was led by one of the HIW inspection managers.

Whilst we considered the care provided to patients having different types of operations, we focussed on the trauma and orthopaedic service provided at Bronglais Hospital.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

[1] Trauma surgery is unplanned orthopaedic (bone) surgery.

2. Summary of our inspection

Overall, we found that patients needing trauma and orthopaedic surgery received safe care. Patients told us that they were happy with their care.

We did, however, have concerns about some aspects of care that could pose a risk to the safety and wellbeing of patients. We required the health board to provide HIW with immediate assurance of the action taken to promote patient safety. The health board provided a suitable improvement plan within the agreed timescale.

We also found that patients did not always receive timely and effective care and that key safety steps were not always followed in theatres.

This is what we found the service did well:

- Patients were consistently treated with dignity, respect and compassion by staff teams
- The pre-operative assessment clinic provided a patient focussed service
- Staff made considerable efforts to help prevent patients developing pressure sores
- Effective arrangements were in place for the storage of surgical instruments in theatres.

This is what we recommend the service could improve:

- The handover of information by staff before and after patients' operations
- Ensuring timely access for patients needling trauma surgery
- Ensuring patients are not fasted longer than necessary
- The completion of key safety steps in theatre
- Ensuring a consistent approach for reporting patient safety incidents.

3. What we found

Background of the service

Hywel Dda University Health Board provides healthcare services throughout Carmarthenshire, Ceredigion and Pembrokeshire. It provides acute, primary, community, mental health and learning disability services via general and community hospitals, health centres, GPs, dentists, pharmacists, optometrists and other sites.

Bronglais hospital was built in 1966 and is situated in Aberystwyth, mid West Wales, and serves a wide surrounding area. The hospital is relatively small in size and subsequently results in some patients being referred to hospitals in Carmarthen, Swansea and further afield. The hospital has approximately 150 beds and provides a range of in-patient and out-patient services together with a 24 hour Accident and Emergency department.

In 2016 the hospital performed 111 unplanned hip procedures and 260 planned hip and knee procedures[2]. The National Hip Fracture Database (NHFD)[3] data identifies long waits for patients needing unplanned hip fracture surgery in Bronglais.[4]

The National Joint Registry[5] looks at planned orthopaedic surgery outcomes. Bronglais Hospital is not identified as a concern in their annual report.

---

[2] Data from National Joint Registry and National Hip Fracture Database.

[3] The NHFD looks at frail elderly patients who need unplanned hip surgery (as a marker for all frail elderly patients needing unplanned orthopaedic surgery).

[4] NHFD data - Bronglais hospital. Hours to operation 63.4 hours (May 2017) for unplanned hip fracture surgery. National UK average 32.7 hours. Bronglais hospital is specifically identified in the NHFD 2016 report as one of five hospitals in the UK where fewer than 50% of patients receive surgery on the day or the day after admission with no explanation given.

[5] National Joint Registry 13th Annual report. 2016.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients told us that they had been treated with dignity and respect by the staff teams at the hospital. Patients also felt they had been given enough information about their care and treatment.

We found that improvement was needed around the handover of information by staff before and after patients' operations. We also found improvement was needed to ensure patients receive (trauma) surgery in a timely way.

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the services provided. A total of eight were completed. We also spoke to a number of patients during the inspection. Patient comments included the following:

"Everyone's very caring, nurses brilliant. No complaints"

"Care was good"

"80% happy"

All patients that completed a questionnaire provided positive feedback on their experience during their time in hospital, with just over three quarters of the patients rating their overall experience as excellent, or very good.

Those patients we spoke with on the ward and those attending the pre-operative assessment clinic also provided positive comments on their experiences and the attitude and approach of the staff.

Staying healthy

Pre-operative assessment clinic

Patients having planned surgery were seen in the pre-operative assessment clinic[6] before their operations so their medical conditions and social situations could be considered. Arrangements were described for providing patients and their carers with written and verbal information about how they could help prepare and recover from their operations.

Pre-operative assessment nurses followed standardised guidelines ensuring that all patients had relevant tests before their operations, which took their current health conditions into account. This was to ensure that patients were as fit as possible before their operations. Wherever possible, any tests needed were all done at the same visit for patient convenience.

Patients having planned orthopaedic surgery, for example a hip joint replacement, were also invited to attend the joint school. This aimed to help patients understand what to expect before and after their operations.

Dignified care

During the course of our inspection we found that patients were treated with dignity, respect, compassion and kindness by staff teams. Every patient that gave an answer in a HIW questionnaire felt they had been treated with dignity and respect during their time in hospital.

Pre-operative assessment clinic

We saw clinic staff being kind to patients and treating them with respect, courtesy and politeness. We also saw that consulting room doors were closed when staff were seeing patients, thus helping to promote patients' privacy and dignity.

Ward

Similarly, we saw ward staff being kind to patients. We also saw staff promoting patients' privacy and dignity when helping them with their personal care needs. This was achieved by drawing dignity curtains around bed areas and closing

[6] The pre-operative assessment clinic is led by nurses who assess whether patients are fit enough to have surgery and an anaesthetic.

doors to cubicles, toilets and shower rooms when patients were receiving support with aspects of their personal care.

Theatres

In the operating theatres, we consistently saw patients being treated with dignity when they were awake (in the anaesthetic room and in the recovery area) and asleep[7] (during surgery). Again we saw staff being kind and courteous to patients. Staff promoted patients' privacy and dignity by ensuring doors to anaesthetic rooms were closed during induction (of anaesthetic). Staff ensured patients were not unnecessarily exposed and covered patients when they were awake and asleep, as appropriate to the surgery being undertaken.

Similarly patients in the recovery area were appropriately covered and their dignity maintained.

Patient information and consent

There was a valid process of consenting patient for surgery. Patients said they felt they were given enough information about their treatment options and had sufficient time to make decisions.

Pre-operative assessment clinic

We found that patients who were attending the pre-operative assessment clinic were provided with both verbal and written information about their planned surgery. This included information about the hospital admission process, fasting before surgery (including advice on whether to take prescribed medication) and information about specific types of surgery.

Ward

Directions to the ward were clearly displayed and a colour coded system helped patients and visitors to find their way around. The ward was divided into two wings which were clearly identified. Notice boards were used to display the names of the nurse in charge of each wing. We saw however, that the boards were not fully completed which meant that some patients and/or visitors may not be clear about who was providing their care.

Ward staff confirmed that they involved patients in developing their care and treatment plans.

---

[7] "Asleep" during surgery refers to the time when patients are receiving an anaesthetic.

We looked at a sample of patient records and saw that consent forms for operations had been completed appropriately. These were legible and the use of medical jargon and abbreviations had been avoided. We saw that the appropriate consent form[8] had been used for those patients who were unable to give consent, (for example those patients with memory loss). However, whilst consent forms had been completed, patients' medical records did not always contain details of verbal discussions around treatment, in advance of the operation.

Theatres

We found that patients were provided with the opportunity to ask questions before being taken into the operating theatre.

Overall, patients told us that they could always speak to staff when they needed to, and all patients said that they felt that they had been listened to by staff during their stay. Patients felt that they had been involved as much as they wanted to be in decisions about their care.

Patients confirmed through a questionnaire:

- That they received instructions on which medications they could take, and which medications they could not take before coming into hospital.
- That staff explained everything that would happen to them during the operation they were going to have, and it was explained in a way they could understand.
- That the anaesthetist came to see them to explain how they would be put to sleep or control their pain.
- That they were visited by a member of staff after the operation who explained how their operation went.

[8] Consent Form 4 is used for treatment in best interests for patients aged 16 years and over who lack the capacity to consent to examination or treatment. http://www.wales.nhs.uk/governance-emanual/patient-consent

Communicating effectively

We looked at the handover of patients' information between staff teams and saw that a standardised approach was not always used. This meant that key patient information may not be shared as it should.

Ward to Theatre

The handover of patients from the ward to theatres did not consistently involve a verbal handover. This practice does not meet the expected standard of care (especially in the context of non urgent surgery[9]). Patients who were about to undergo operations were left in theatre with a pre-operative handover checklist and medical record. It is important theatre staff are verbally told about any relevant medical issue immediately before a patient undergoes surgery. A completed VTE risk assessment did not always accompany the patient at this point (see section - Delivery of safe and effective care).

Staff working in the wards and in theatres mostly told us that the process of ensuring patients were ready for theatre was very effective. However a quarter of theatre staff said that it was often the case that patients were not ready.

Theatre to Recovery

After patients had their operations, we saw that a verbal handover took place between theatre staff and recovery staff. Whilst most essential information was shared, this was not done in a standardised way and no checklist was used. Sometimes this meant key aspects of information were missing.

Patient communication

Overall, most patients told us that they were always able to speak to staff in their preferred language. Some of the patients who were Welsh speakers told us they could sometimes speak to staff in Welsh. However, almost two thirds of patients said that not all of the staff that treated them introduced themselves the first time they came to provide them with care[10].

---

[9] Standard 5 - Handovers and information transfer. National Safety Standards for Invasive Procedures. 2016.

[10] "Hello my name is…" is a campaign which encourages staff to introduce themselves.

Improvement needed

The health board must make arrangements to ensure effective handovers of patient care information take place throughout the surgical pathway.

Timely care

A high proportion of theatre staff told us that they experienced daily or weekly restrictions to patient flow through theatres. Numerous reasons were given by theatre staff. The main reasons were:

> *"Lack of beds, patients not ready on wards. No X-ray available"*
>
> *"Waiting for pre-assessments to be done. Clinical commitments of surgeons prevent timely starts"*
>
> *"Patients unable to go to [post-operative] wards - they often remain in recovery for many hours post-op"*

Approximately one in 10 patients are cancelled for an orthopaedic procedure in Bronglais[11] with staff telling us that they saw cancellations on a daily to weekly occurrence. Staff told us that the lack of beds caused most cancellations and this is supported by the Bronglais hospital theatre data.

The hospital's theatre was able to run an operating list when it planned to nearly all the time[12] across the two elective theatres.

We found that the patient's social issues which needed to be resolved before discharge were not fully addressed before patients underwent planned surgery. This meant patients could sometimes stay in hospital for longer than need be after their operation. Staff told us that for planned surgery, social issues could be better identified and communicated from pre-operative assessment clinic. Although this is an issue which also affects patients undergoing unplanned

[11] Bronglais hospital theatre data shows a cancellation rate for orthopaedic procedures of 7 to 13% from January to May 2017. This compares with a national average of 28% for trauma and orthopaedic care in Wales (Source: Operating Theatre 2016 - national benchmarking project).

[12] Bronglais hospital theatres confirmed a sessional rate uptake of over 97% (of the two elective theatres). This compares with a national average for Wales of 84%.

surgery, it was appreciated that resolving social issues before unplanned operations happens is not always within the health board's control.

Trauma surgery

We found the systems in place which ensure timely unplanned trauma surgery for elderly frail patients were not reliable and delays were common[13]. The system which aimed to fast-track patients from the emergency department to the trauma ward was not effective when the ward was at maximum bed capacity (which often occurred). We found there was no ring-fenced bed for elderly frail patients needing trauma surgery. As a result patients would often wait longer than the recommended four hours[14] - either in the emergency department or in a temporary area[15]. We discussed this with senior managers who said they were keen to improve this situation and were working towards providing a higher level of care in the temporary holding area and also considering introducing a ring-fenced bed for elderly frail trauma patients on the ward, so that patients get effective care in the right place.

We found there were long delays for patients before they underwent unplanned trauma surgery. The system for prioritising trauma patients on the emergency list was not clear and there was no dedicated trauma operating list at any point. We found this meant elderly trauma patients' surgery would be delayed as other types of unplanned surgery were taking place. We were told that the trauma surgeons could find it difficult being available to operate because they had other work commitments and that dedicated time to operating on trauma patients would improve this situation. We spoke to senior theatre management staff who were responsive and said they already had plans to implement dedicated trauma operating so that patients do not wait as long for trauma surgery.

We found that it was not always consistent or clear how patients were prioritised for unplanned surgery. There was no daily trauma meeting of the multidisciplinary care team to discuss new trauma patients who needed operating on. There was no overall display of what unplanned operating needed

[13] The NHFD recommends patients receive hip fracture surgery on the day or the day after admission. The current national UK average that patients wait for surgery is 32 hours. Bronglais hospital NHFD data shows waiting time at 62 hours (June 2017). 33% of patients receive surgery on the day or the day after admission (NHFD annual report 2016).

[14] The NHFD annual report 2016 shows 43% of hip fracture patients reach the orthopaedic ward within 4 hours.

[15] This temporary admission area was called the clinical decision unit and is a short stay area.

to take place in the theatre each day and the list arrangements for unplanned surgery did not consider the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Classification of Intervention[16]. Consequently, we could not be reassured that urgent trauma surgery for the frail elderly patient was prioritised ahead of less urgent general surgery. Conversations with senior theatre management had already identified improvement was needed around this area.

We looked at the system which ensured timely discharge for patients. Overall we found that delayed discharges often occurred when patients needed placements in nursing homes or packages of care involving district nurses - which was often the case for frail elderly patients needing trauma surgery. We were told this was a continual challenge for the health board as these factors are not always within the health board's control.

Improvement needed

The health board should make arrangements to ensure that relevant information around patients' home circumstances, which could affect their discharge home following surgery, is obtained and shared with relevant staff in a timely manner. This is with the aim of preventing delays in patient discharge as far as practicable.

The health board must make arrangements to ensure the timely admission of patients from the emergency department onto the trauma ward.

The health board must make arrangements for reducing the time it takes for elderly trauma patients to undergo surgery.

The health board must make arrangements to ensure a clear system for prioritising patients and listing patients for unplanned surgery.

[16] The NCEPOD Classification of Intervention (2004) - this is used to classify how urgent surgery is, so operating is based on and changes in response to clinical urgency.

Individual care

Planning care to promote independence

Multidisciplinary trauma care

Frail elderly patients who sustain a fracture as a result of a fall, can have complex medical conditions which need to be improved before their unplanned surgery. Such patients need care from many specialist teams and not just surgery on the broken bone.

At Bronglais hospital a dedicated peri-operative care doctor and trauma nurse delivered essential care to elderly and high risk patients needing surgery[17]. This meant complex medical issues were improved significantly before and after surgery. We were told this sometimes meant that patients needing trauma surgery would wait longer for surgery as their conditions were being optimised, or they were waiting for a post-operative bed which offered a higher level of care[18] which was good practice. We were told the main reason patients took a long time to undergo unplanned trauma surgery was due to the limited trauma theatre capacity (as described earlier under section - Timely care).

We were told the physiotherapy team were available seven days a week but did not always help mobilise trauma patients the day after surgery (at the weekend) routinely (as is expected in a hip fracture programme). This may explain why only one in two patients who have undergone hip fracture surgery are given help to get out of bed the following day[19].

When patients underwent surgery for their hip fracture, we found the overall system for ensuring all patients have a standardised recommended operation to be very effective. All hip fracture surgeons had adopted the same standardised approach to fixing a hip fracture, which means all patients receive the same high level of care and errors relating to equipment are less likely. In particular all hip fractures are cemented, a total hip replacement is performed if necessary

---

[17] NHFD live performance data for Bronglais hospital shows 100% of patients receive an orthogeriatric assessment prior to hip surgery (May 2017).

[18] This higher level of care is a form of critical care and involves close nursing and doctoring for higher risk patients.

[19] NHFD data for Bronglais hospital shows 58% of patients are mobilised out of bed the day after surgery (NHFD annual report 2016) and 100% of patients receive a physiotherapist assessment (May 2017).

for young patients and the equipment for performing a total hip replacement is the same kit for performing one half of a hip replacement[20]. The approach adopted by the surgeons accounts for the above average performance here in the National Hip Fracture Database[21].

Approximately one in 10 patients who have a hip fracture have no surgery and are treated conservatively[22]. We were told this is because Bronglais hospital has a higher proportion of elderly frail patients who were not suitable for an operation and the focus should be on making the patient comfortable instead. This reason does not fully account for a non-operative rate that is nearly five times higher than the national average of 2.2% reported by the NHFD.

Improvement needed

The health board must make arrangements to improve the performance within an elderly trauma patient programme relating to: mobilising patients after surgery and reducing the non-operative rate of hip fracture care.

People's rights

We found that peoples' rights were promoted within each of the clinical areas we inspected.

We found that arrangements were in place to protect peoples' rights to privacy and saw staff treating patients with compassion and kindness. We also found that the spiritual care needs of patients were respected and considered when planning care and treatment.

We saw that patients could be accompanied by their relatives or carers throughout their patient journey (including the pre-operative assessment clinic and ward).

[20] The surgical term for half a hip replacement is a hemiarthroplasty - it involves replacing the end of the femur (leg bone) but not the hip socket.

[21] NHFD live performance data for Bronglais hospital shows 100% of hip fractures are cemented when necessary, 33% of patients receive a total hip replacement (June 2017).

[22] NHFD live performance data for Bronglais hospital shows 11% of hip fracture patients have non-operative management (June 2017) (compared with an UK national average of 2.2%).

Listening and learning from feedback

The health board had arrangements in place for patients to provide feedback about the service. These arrangements were in place within each of the areas we inspected and included an annual patient satisfaction survey as part of the health board's annual audit activity. In addition, the health board's process for responding to concerns (complaints) was in keeping with 'Putting Things Right', (the arrangements for handling concerns about NHS care in Wales).

However patients were not always aware of how to provide feedback or raise a complaint. Most patients said they had not been asked to feedback their views about their care and most patients also told us that they had not been told how to raise a concern or make a complaint.

Improvement needed

The health board must make arrangements to promote awareness amongst patients and their carers of how they may provide feedback about their experiences.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The health board was aware of the need to review practice in response to the publication of the National Safety Standards for Invasive Procedures (NatSSIPs).

We sought immediate assurance from the health board on the action taken to promote aspects of patient safety both on the ward and in theatre. The health board provided this assurance within the agreed timescale.

Staff made considerable efforts to help prevent patients from developing pressure sores. Overall, arrangements were in place for safe medicines management. We found some improvements could be made to help reduce cross infection on the ward. Patients were often fasted for longer than necessary. Most patients were happy with how their pain was managed after surgery.

We found that key safety steps were not always performed well in theatres.

Safe care

Managing risk and promoting health and safety

Pre-operative assessment clinic

We found the pre assessment clinic to be clean and tidy. We did not see any obvious environmental hazards to the safety of staff or patients

Ward

We found the ward to be clean and generally well maintained. It was obvious that there was a lack of sufficient storage on the ward for equipment. The main corridor was being used to store equipment such as hoists, trolleys and monitoring equipment. We also found the sluice to be cluttered. The lack of storage presented potential trip hazards to patients and staff.

Theatres

We saw that theatres had a risk register which identified areas of risk and actions which needed to occur. All such information was appropriately kept up to date.

At the time of our inspection the operating theatre capacity had been reduced. This was because the main theatres were being refurbished so all operations were being performed in the Day Surgery Unit (DSU) theatres[23]. These arrangements had been subject to a risk assessment by the health board, which acknowledged that emergency surgery, which could not wait,[24] may need to occur outside of an operating theatre, if a theatre was not available.

Staff told us that the anaesthetic room had been used to perform emergency operations on more than one occasion at times when all theatres were in use. Whilst this was in keeping with the health board's risk management arrangements, we were not provided with evidence that those operations (performed outside of an operating theatre) were reported as patient safety incidents (using the national incident reporting system[25]). In addition, senior managers were unaware that the operations had taken place in the anaesthetic room. We were therefore not assured that the risk management strategy in place was robust.

Almost all staff said they were supported by their colleagues to report serious incidents, yet almost three quarters of theatre staff told us they rarely or never received feedback from the reported incidents. The health board must make arrangements to address this to promote shared learning.

Transfer of patients

We saw that patients who had undergone major and minor surgery (involving cases needing general anaesthesia and sedation) were not being transferred between the operating theatres and recovery areas with supplementary oxygen

---

[23] The day surgery theatres comprised a total of three operating theatres. The new general theatres will offer two new operating theatres when the refurbishment is complete. This refurbishment started in August 2016.

[24] The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) would classify this type of surgery as "immediate". The NCEPOD Classification of Intervention. 2004.

[25] National Reporting and Learning System (NRLS) for reporting of patient safety incidents. This is a mandatory national reporting system which contributes to patient safety.

being administered. Patients were though, administered oxygen in the recovery area after the transfer had been made.

This was not in accordance with published standards[26]. We therefore notified senior staff of our findings and sought assurance that patients would be transferred safely from the operating theatre to the recovery area in accordance with known safety guidelines.

Our concerns regarding the above issue were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board should make arrangements to review the storage of equipment on the ward and take action as appropriate to reduce the risk of injury to patients and staff.

The health board must make arrangements to promote a consistent approach for the reporting of patient safety related incidents and shared learning.

Preventing pressure and tissue damage

We found that ward and theatre staff made considerable efforts to help prevent patients from developing pressure sores and tissue damage.

Ward

We looked at a sample of patients' records and saw pressure sore risk assessments had been completed. This supported the findings from national

[26] The Association of Anaesthetists of Great Britain & Ireland - Recommendations for standards of monitoring during anaesthesia and recovery. 2015.

The Royal College of Anaesthetists. 4th National Audit Project of The Royal College of Anaesthetists and The Difficult Airway Society - Major complications of airway management in the United Kingdom. March 2011.

audits.[27] We saw that care plans explained what each patient needed to prevent pressure sores and that staff regularly checked patients' skin for signs of pressure damage and helped patients to move. A tissue viability nurse was available to support the ward team.

We were able to confirm that pressure relieving mattresses and moving and handling equipment were available for the patients with a high risk of developing pressure sores.

Theatres

We looked at the arrangements to safely position patients who were undergoing surgery and requiring general anaesthetic (where patients were unable to move themselves). We saw staff using appropriate moving and handling aids to transfer patients safely and in a coordinated manner. Staff also safely positioned patients and used gel pads to protect patients' limbs from pressure damage during operations.

Falls prevention

We found efforts were made to reduce the risk of patient falls on the ward. We identified improvement was needed, however, around written care plans in respect of falls.

Ward

Senior ward staff told us that considerable work was being done around falls prevention. They explained that audit activity had identified an increased number of falls within the ward. They had implemented an improvement plan to help reduce the number of patient falls and told us this work was ongoing. [28]

We looked at a sample of patients' records and saw that falls risk assessments had been performed. A falls care plan was not always started in response to the risk assessment. On one occasion we found a falls care plan put in place after a fall (when it should have been in place before the fall).

---

[27] This finding supports the NHFD pressure ulcer data which shows 0% of frail elderly patients suffering hip fractures are reported as suffering a pressure ulcer. This reflects good care in particular.

[28] The NHFD live performance data currently shows 100% of patients who suffer a broken hip have a falls assessment performed. Data also shows that 5.6% of hip fracture patients suffer a inpatient fracture (this is a measure which is used to monitor falls). May 2017 data.

Mobility aids were readily available to help patients walk around safely. We saw ward staff assist patients in mobilising safely. A physiotherapy team helped patients become more mobile after their surgery. As described earlier this did not always happen at weekends.

Infection prevention and control

Clinical areas were clean and necessary equipment was available to prevent the spread of infection. Improvement was identified, however, around the ward organisation which mixes patients having planned joint surgery with those having trauma surgery and abdominal surgery. This creates a risk of cross infection.

Ward

We saw that the ward was clean and cleaning schedules ensured this. Hand washing facilities and personal protective equipment (PPE) such as disposable gloves and aprons were used appropriately. We also saw there were arrangements for patients to be nursed in isolation if a particular infection risk was present.

The ward arrangements meant patients from different surgical specialties could be nursed together on the ward[29]. We found it was possible for patients who had undergone planned hip or knee joint surgery to share a multi bedded bay with patients who had undergone bowel surgery or trauma surgery. Many hospitals make arrangements to ensure patients with different needs are not nursed together for infection control reasons and to deliver care most relevant to the patient group. This is particularly important in regard to planned hip and knee joint surgery to avoid cross infection from other types of surgery.

Senior ward staff explained that patients were assessed on admission for their risk of infection and action taken to minimise this. However there was no effective system which clearly separated the distinct patient groups which have different needs.

[29] Trauma surgery, planned orthopaedic surgery and general surgery could be found mixed in the same bays on Ceredig ward (the main trauma admissions ward).

Theatres

The operating theatres, anaesthetic rooms and recovery were clean and tidy. PPE and hand washing precautions were followed appropriately. Not all staff however had adopted a 'bare below the elbows'[30] approach.

Staff observed a strict aseptic approach when opening instrument sets. Similarly a strict aseptic approach was followed when patients' skin was cleaned prior to their surgery.

Overall, we saw that there were arrangements in place to deter staff from entering theatres unnecessarily. Doors to theatres were kept closed when in use and floor markings indicated areas where staff should not walk during surgery.

There were safe systems for the transfer, tracking, decontamination and storage of surgical instruments. In particular the storage area for instrument sets was particularly organised and clean. The trays were stored on appropriate shelving and stacked singularly, thus avoiding damage to their outer wraps which could compromise their integrity.

Certain extreme temperatures and humidity can compromise tray integrity therefore a temperature controlled and monitored tray room is viewed as best practice this was in place and the temperatures were recorded on a daily basis.

Improvement needed

The health board must make arrangements to ensure ward arrangements minimise the risk of cross infection between different surgical patient groups (trauma patients, elective orthopaedic patients and general surgery patients).

Nutrition and hydration

Fasting before operations is an essential safety process patients must undertake. The period of fasting should meet certain minimum periods whilst equally not be unnecessarily long. We looked to see if there was an effective fasting system.

[30] Healthcare workers should ensure their hands do not become contaminated and being 'bare below the elbows' promotes this.

For safety, patients should not drink for at least two hours before planned surgery. Half of the patients we asked said they had gone for between 4 and 8 hours without a drink while one patient told us they went more than 8 hours without a drink.

Overall, not all staff working in theatres felt there was an effective system in place that ensured patients were not deprived of fluids for longer than necessary. This supports what patients told us.[31] The fasting system ensures patients are safely fasted but does not ensure they are not fasted for too long.

After an operation, patients are usually encouraged to resume eating and drinking soon after surgery. However, a third of the patients we asked, told us that they hadn't been able to eat and drink when they needed to post-operatively.

Patients were asked how the hospital could improve the care or service it provided. The majority of comments we received were about hospital food. Specific patient comments about the food included:

> *"Services okay. Food rubbish"*
>
> *"Sandwiches are of appalling quality. Vegetables (including potatoes) were poor"*

Improvement needed

The health board must make arrangements to ensure that patients are not fasted for unnecessary long periods of timeInsert improvement here. If more than one improvement in this section, include these within the same table.

The health board should make arrangements to review the quality of meals in response to patient feedback.

Medicines management

Overall, we found suitable arrangements were in place for the management of medicines.

[31] 40% of theatre staff felt that the system in place meant patients were deprived of fluid for longer than is necessary.

Ward

On the ward medicines were stored safely and appropriately in lockable cupboards or fridges.

Controlled Drugs (CDs), which have strict and well defined management arrangements, were stored securely. CD records described the type and amount of drugs received, administered and returned to pharmacy. It was not always clear however, where stock balances from previous CD records had been obtained. The health board may wish to review those arrangements so that a clear audit trail exists.

We looked at a sample of drug charts and saw that these had been completed appropriately. We found that staff administered medication to patients in a safe way.

Theatres

We saw that medicines (including Controlled Drugs) were stored securely in cupboards or fridges in an organised manner. We found that intravenous drugs and local anaesthetics could be stored together. Intravenous drugs and local anaesthetics should be stored separately to avoid local anaesthetics being administered intravenously (which is a safety issue)[32] [33]. CD records in theatres did not make a record of the amount of Controlled Drug which was wasted (and not given to the patient).

We found there was a robust and safe system in place which ensured that residual anaesthetic drugs were flushed from every patient's cannula after surgery. This was a very positive aspect of patient safety as it prevented residual anaesthetic drugs accidentally being administered when other drugs were administered through the same intravenous device later.[34]

Regular checks of Controlled Drugs had not been conducted by pharmacy staff on the ward or in theatres. This was raised with senior staff who agreed that

---

[32] In this case bupivacaine (a long acting local anaesthetic) was being stored with intravenous medication.

[33] Patient Safety Notice: The safe storage of medicines: Cupboards. PSN 030. April 2016.

[34] Patient Safety Notice: Residual anaesthetic drugs in cannulae and intravenous lines. PSN 014. July 2015.

pharmacy should be involved. There were a number of points described above which the health board should address.

Improvement needed

The health board must make arrangements:

- for the appropriate and safe storage of intravenous and local anaesthetic drugs in theatres to promote patient safety
- to ensure staff adhere to the health board's policy for the recording of wasted drugs (i.e. not administered to patients)
- for checks of Controlled Drugs in accordance with the health board's policy

Safeguarding children and adults at risk

We found that the health board had arrangements in place for safeguarding children and adults at risk.

Discussions with the ward staff demonstrated that they had a good understanding of safeguarding issues. However, senior staff explained that they experienced difficulties in establishing where to correctly direct safeguarding referrals on occasions. This was due to health services cross-boundary issues. The health board should, therefore, explore the reasons for this and take action as appropriate.

Improvement needed

The health board should make arrangements to ensure that safeguarding referrals are directed correctly and efficiently to relevant safeguarding teams.

Blood management

In theatres there was a system in place which made blood products available to patients in a timely manner, whilst minimising wastage of blood. However, we identified improvement was needed with regard to the documentation of blood product administration within the ward.

Ward

We looked at a sample of patient records and identified that two patients had received blood transfusions whilst on the ward.

The documentation said that both patients had received two units of blood. The documentation demonstrated that all appropriate safety checks had been conducted for each patient prior to them receiving one unit of blood. The documentation did not demonstrate that the required bedside safety checks had been conducted prior to each patient receiving a second unit. Both patients had their observations recorded before, during and after the transfusion and there was no evidence that patient harm occurred.

We notified senior staff about this safety issues and were provided with a verbal assurance that action would be taken to reduce the likelihood of this occurring again. Initially, senior staff had assessed the incidents as not reportable via the health board's electronic reporting system. However, following further discussion between the HIW inspection team and senior managers, these incidents were reported with consideration to undertaking a formal review of both incidents in accordance with the health board's policy.

Our concerns regarding the above issue were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Theatres

Theatre staff described the blood management system in use within theatres which ensured blood was available to patients in a timely and effective manner. Unused blood products could also be returned to minimise wastage.

There was a major haemorrhage system in place, which aimed to ensure that patients who suffered significant bleeding during surgery, received blood products immediately, as a priority.

Medical devices, equipment and diagnostic systems

The ward and theatres had equipment to meet the care needs of patients.

Ward

The ward had a range of equipment to meet the care needs of patients on the ward. We saw that moving and handling equipment, monitoring equipment and pressure relieving mattresses were readily available.

We saw some medical equipment and re-chargeable batteries that had labels showing they were due or overdue servicing checks. This equipment was not

being used at the time of our inspection, but ward staff should assure themselves that this equipment is safe to use when it is needed.

Equipment and medication for use in the event of a patient emergency (collapse) were available.

Theatres

The theatres and recovery areas had a range of equipment for delivering care. Specialist moving and handling equipment was available for safely transferring obese patients having operations. Some staff told us that more equipment was needed for the safe handling and positioning of patients in theatres.

Staff confirmed that spare operating and anaesthetic equipment was available to help prevent operations from being cancelled in the event of equipment failure.

Arrangements were described for training staff on the use of surgical equipment. Arrangements were also described for the regular servicing and repair of equipment used in theatres.

Equipment and medication for use in the event of a medical emergency were available in theatres. However, the difficult airway trolley containing equipment for managing airway emergencies was kept inside one of the operating rooms, so was not immediately accessible to other areas in theatre. This emergency equipment should be kept in a more central location so that it can be accessed at all times and by all theatre staff in the event of an emergency. This was addressed before the end of the inspection.

Effective care

Safe and clinically effective care

During the course of this inspection, we looked at the following:

- The National Safety Standards for Invasive Procedures (NatSSIPs)
- The Five Steps to Safer Surgery
- Venous thromboembolism (blood clot) prevention
- Intravenous (IV) access on the wards
- Peri-operative hypothermia management
- Pain management.

The National Safety Standards for Invasive Procedures (NatSSIPs)

Senior managers were aware of the need to review practice in response to the publication of the National Safety Standards for Invasive Procedures (NatSSIPs)[35]. NHS health boards in Wales are required to implement work by 28 September 2017.

Senior managers confirmed that a lead person had been identified and work had started to develop Local Safety Standards for Invasive Procedures (LocSSIPs) based on the NatSSIPs.

The Five Steps to Safer Surgery

We looked at how the Five Steps to Safer Surgery[36] [37] were performed within the three operating theatres. The five steps are Briefing, *Sign in, Time Out, Sign Out* (the three steps of the WHO Surgical Safety Checklist[38]) and Debriefing.

We saw that Briefing[39] usually occurred, though it was not always performed routinely using a standardised format and attended by all the relevant operating team members. We did see some examples of very good briefing - with all team members attending, a standardised format being followed and a record of the briefing being displayed in the operating theatre.

We saw that the *Sign In*[40] was always clearly performed. The *Time Out*[41] and *Sign Out*[42] were not always clearly performed. When they were performed, they did not always meet the required standard.

---

[35] National Safety Standards for Invasive Procedures (NatSSIPs) refers to the implementation of surgical checklists, based on the Safe Surgery Saves Lives and initiative established by the World Alliance for Patient Safety. The checklists are required to be in place across all NHS services by September 2017.

[36] National Patient Safety Agency - The Five Steps to Safer Surgery. 2010.

[37] Standards 7, 8, 9, 12 and 13 (Safety briefing, sign in, time out, sign out, debriefing respectively) – National Safety Standards for Invasive Procedures. NHS Wales.

[38] World Alliance for Patient Safety. WHO Surgical Safety Checklist. 2008.

[39] Briefing is where the operating team meets to share their safety concerns and discuss patients individually as a team for the first time.

[40] Sign In refers to the first safety check which is performed when the patient immediately arrives in theatre.

We saw the *Sign In* being performed clearly in all the operating theatres. Whilst the *Sign In* involved at least two people involved in the procedures, an anaesthetist was not always involved in the *Sign In* for procedures performed under a general anaesthetic.

We saw some very good examples where the *Time Out* was performed well with all operating team members involved. We also saw other examples where the *Time Out* was not performed well with some team members not actively participating (this was because they were talking to other members of the team or completing other tasks). In addition, noise and interruptions were not minimised and sometimes elements of the WHO checklist were not read aloud.

Similarly we found very good examples where the *Sign Out* was clearly performed and involved all operating team members. We also saw examples where the *Time Out* was not performed at all.

Our findings around the use of the WHO checklist meant that we could not be assured that robust patient safety systems were being consistently applied in theatres. Responses from theatre staff who completed a questionnaire supported our observations around the use of the WHO checklist.

Theatre staff confirmed that debriefing[43] did not occur at the end of each operating session. As no debriefing occurred after operations had finished, there was no clear mechanism for identifying what had gone well and what needed to be improved on a daily basis.

Improvement needed

The health board must make arrangements to ensure that the standards for the Five steps to Safer Surgery are met.

---

[41] Time Out refers to the final safety check which is performed before the operation starts.

[42] Sign Out refers to the safety check which is performed immediately after the operation. It checks the right procedure has been performed, that items (such as swabs and needles) have not been left in the patient and checks that everyone knows if there has been a problem.

[43] Debriefing is the fifth and final step of the essential five steps to safer surgery. After operating has finished the operating team meets to discuss what went well and what needs to be improved. Anything important is written down and fed into the local safety network so staff in theatres learns from mistakes and good practice is shared. Debriefing also contributes towards creating a safety culture.

Venous thromboembolism (blood clot) prevention

Whilst there was a system in place to assess patients' risks of developing a venous thromboembolism (VTE), (also commonly referred to as a blood clot) the system needed improving. This was because we found it was possible for a patient to undergo an operation without having had a VTE risk assessment on the ward after surgery (despite several checkpoints on VTE care along the theatre pathway in theatres).

Ward

We looked at a sample of patient records and found that most (but not all) patients had their individual risk assessed for developing a venous thromboembolism[44]. None of the patients concerned, however, had a reassessment of their risk recorded at 24 hours. The patients we considered had undergone surgery and should have had an assessment on admission and a reassessment completed at the 24 hour time point[45].

We saw that where anti embolism stockings had been prescribed, the patients' drug charts had not been signed by nursing staff to show they had been applied and checked.

Theatre

We were told that all patients should be risk assessed for developing blood clots before theatre. However this system was not robust as patients could be transferred from wards to theatres without a completed risk assessment.

As part of the *Time Out*, we saw that a check was performed by theatre staff as to whether treatment to reduce blood clots had been undertaken. We saw that this check ensured VTE prevention treatment was given during surgery. The check did not ensure VTE risk assessments were complete and that prevention treatment was prescribed after surgery.

We saw that patients received mechanical measures for VTE prevention during the intra-operative phase.

---

[44] Blood clots are known as venous thromboembolisms. Preventing blood clots is an important part of surgical care.

[45] National Institute for Health and Care Excellence (NICE) – Venous Thromboembolism: reducing the risk for patients in hospital. CG 92. Latest update June 2015.

Improvement needed

The health board must make arrangements to ensure that VTE risk assessments are consistently completed.

Intravenous (IV) access on the wards

Arrangements were in place so that patients could have intravenous (IV) fluids and medications in accordance with their identified needs.

Ward staff told us that doctors, nurse practitioners and some ward nurses were able to insert intravenous devices so that fluids and medication could be given through the veins (IV). This meant IV access was available to patients during the day and night without delay. We saw that care bundle documentation was being used to promote good care of IV devices.

Peri-operative hypothermia management

Equipment was available to help prevent and manage patients with peri-operative[46] hypothermia[47]. We found patients' temperatures were not always recorded at the recommended frequency in theatres.

Ward

We looked at a sample of patients' care records and saw that all patients had their temperatures checked in the pre-operative phase. The records showed that most of the patients had their temperatures checked at the recommended frequency (every four hours) in the post-operative phase on the ward.

Theatres

From the records we saw that most patients had their temperatures checked during the intra-operative phase. Checks were not always performed at the required frequency. After the operation, when patients were in the recovery area we saw that their temperatures were checked frequently.

[46] Peri-operative refers to the periods around an operation. These are the pre-operative phase (before the operation), intra-operative phase (during the operation) and post-operative phase (after the operation).

[47] Hypothermia (getting too cold) can occur during operations and can cause problems such as infected wounds, blood clots, more blood loss and pressure sores and it can take longer for patients to wake up from anaesthesia.

Equipment was available both in theatres and the recovery area to actively warm patients identified as being too cold.

Improvement needed

The health board must make arrangements for minimising the risk of peri-operative hypothermia which includes intra-operative temperature checks for all patients.

Pain management

Acute pain service

We found that some improvement was needed around aspects of pain management.

There was no dedicated pain team based at the hospital. Ward staff said that they would call a doctor (who was available day and night) should they have concerns about a patient's pain. Staff told us that there was sometimes a delay in patients with acute pain, having their pain relief reviewed. Staff confirmed they had access to enough equipment to administer pain relieving infusions.

We saw that staff had recorded patients' pain scores and administered pain relief appropriately. Ward staff also had the use of pain assessment tools for patients who may not be able to let staff know that they were in pain (for example if they had difficulties with communication).

We saw staff in recovery treating patient's pain appropriately. Patients would only be transferred back to the ward once they were comfortable.

Patients were asked whether they had requested extra pain relief medication since their operation. Of those patients who told us that they had, the majority waited less than 10 minutes after they had requested extra pain relief before they got it.

The majority of patients who completed a questionnaire felt that they had been given enough pain medication, with only one patient feeling that they hadn’t been given enough.

Hip fracture pathway

For patients with hip fractures we found that there were arrangements in place for patients to receive an initial nerve block as a means of pain relief, but that this did not always happen for all patients. Additionally, there was no system

ensuring a second nerve block is considered for these patients when in theatre (during the intra-operative phase).[48]

Improvement needed

The health board must make arrangements for the effective pain relief to all patients at all points along the surgical patient pathway (pre-operative, intra-operative and post-operative phases).

Quality Improvement, Research and Innovation

Bronglais hospital anaesthetic department has not yet achieved an Anaesthesia Clinical Services Accreditation (ACSA)[49] status. We were told that implementing the standards for ACSA were at an early stage and there was no fixed timescale for the anaesthetic department to undergo a review by the Royal College of Anaesthetists to achieve this.

We found that Bronglais Hospital had effective arrangements for sending data to the National Hip Fracture Database (NHFD) which is a mandatory national audit for improving trauma care for the frail elderly patient. The NHFD Annual Report 2016 shows that Bronglais hospital submitted 92% of eligible hip fracture cases for inclusion in the NHFD. This was above the Wales average of 90.3%. Senior management showed good awareness of the hospital's live performance metrics in the NHFD and had recently focussed on improving the hip fracture pathway. Senior management were well aware that the timeliness for hip fracture patients was a particular area to improve.

The hospital also submitted 98% of procedures to the National Joint Registry (2016) which is a mandatory national audit for planned orthopaedic care.

Record keeping

Our findings in relation to record keeping (patients' ward and theatre notes) have been described throughout the report. As previously indicated, we looked at a range of relevant assessment tools, checklists and monitoring charts that

[48] Information from the NHFD for May 2017 indicates that 77.8% of patients with a broken hip at got the necessary nerve block before theatre at Bronglais Hospital.

[49] Anaesthesia Clinical Services Accreditation (ACSA) - this is an externally accredited quality improvement initiative from the Royal College of Anaesthetists promotes patient safety and ensures achievable standards of perioperative care are met.

had been completed by staff. As a result, we saw good examples of record keeping, in the form of food and drink monitoring charts and some risk assessments.

We identified however, that improvements could be made around the completeness of some records, such as VTE assessments and blood transfusion documentation. Additionally, not all records we saw had been completed in accordance with professional standards for record keeping. For example, entries made did not always include a date, time or signature of the person making the entry.

Improvement needed

The health board must make arrangements to promote record keeping practise that is in accordance with professional standards for record keeping.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

A management structure was in place with lines of reporting and accountability. Comments from staff, however, indicated that they were unsure of the lines of reporting. We required the health board to provide immediate assurance of the action taken to ensure staff were aware of the management arrangements, to promote timely patient care.

We saw that clinical audit activity took place on the ward and in theatres.

The number and skill mix of staff working in the areas we inspected appeared suitable to meet the needs of patients. We did see that the ward used a significant amount of bank and agency staff to cover shifts.

We identified that improvement was needed around staff training.

Governance, leadership and accountability

Ward

During our inspection we established that a ward manager, supported by a deputy, had responsibility for day to day management and leadership within Ceredig Ward.

Senior staff described a system of clinical audit activity and we were provided with evidence that these audits had been completed. We saw minutes of meetings which demonstrated that audit findings and areas for improvement had been shared with staff, and actions generated.

Theatres

We established that the day to day management of theatres and recovery areas was the responsibility of a designated coordinator, supported by a team leader. There was however, no overall on-site theatre manager in post at the time of our inspection.

We saw that audit activity had taken place. These included audits around fasting, infection prevention and control (including hand washing and surgical site infection), record keeping and patient consent. Findings from audit activity were not displayed to show staff and visitors what audits had been done and what action had occurred as a result. Arrangements should be made to display this information.

Management arrangements

A structure that included both on-site and off-site working arrangements was described. During our conversations with staff, it became apparent that they were either unsure of the lines of reporting or felt disempowered to make day to day decisions in response to situations that occurred on the hospital site. This appeared to be having a negative impact on timely and effective decision making.

Our concerns regarding the management arrangements were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Staff and resources

Workforce

Pre-operative assessment clinic

The pre-operative assessment clinic was nurse led and the team consisted of both registered nurses and a healthcare support worker. Effective team working was described and demonstrated. We found a patient focussed and committed team.

Ward

The number and skill mix of staff working on the days of our inspection appeared to be sufficient. Senior staff explained that they used a significant number of agency and bank staff to provide adequate staffing cover on the ward and our observations confirmed this. We saw staff working effectively as a team.

Theatres

During the inspection the skill mix of theatre staff was found to be safe.

Staff questionnaires

During our inspection we distributed HIW questionnaires[50] to staff working in theatres, recovery and the ward.

A number of concerns and issues were raised by staff about the current working environment at the hospital. It was clear from the comments that staff felt the service would benefit from additional staff. Theatre staff also referred to the need for a greater senior management presence at the hospital. The completed questionnaires further highlighted issues around a lack of beds at the hospital. Comments received included:

> *"There is a problem with staff shortages which affect morale in the department"*

> *"My immediate managers … are supportive, but I find that the higher managers are less visible and supportive as based in a different hospital"*

Almost all staff felt that they were given enough support from their work colleagues to deliver safe and effective care. Despite some of the workforce concerns raised by staff, over three quarters of staff felt patient safety was not at risk and that they were given enough support by management to carry out their role effectively.

However, some staff raised concerns about senior management not being based at the hospital:

> *"Service delivery managers are not based in this hospital. … Managers should be based on site - senior staff on site have no authority to make decisions"*

> *"We have no clinical band 8 [at Bronglais] and therefore we need to contact managers in Withybush to authorise cancellations or any management issues"*

[50] In total 36 staff questionnaires were completed.

Training

Most staff on the ward felt they had sufficient opportunities to attend training relevant to their role. However over a third of theatre staff said they were rarely given access to training required to maintain their professional competence.

In theatres a third of staff said they had not been involved in a multidisciplinary training session and that it only occurs approximately only once per year. Training towards implementing the National Safety Standards for Invasive Procedures had not yet occurred (ahead of the implementation date of September 2017). This kind of training is only one factor towards creating a safety culture in theatres.[51]

Discussions with the training lead for theatres revealed recent progress had identified what training had been completed and what was needed for theatre staff. We were told by theatre staff that theatre workforce shortages meant staff did not have access to training as service delivery was prioritised.

Improvement needed

The health board must make arrangements for staff to attend training (at appropriate intervals) relevant to their roles.

[51] NHS Wales. National Safety Standards for Invasive Procedures 2016. Standard 3.1.4 - "Multidisciplinary teams that work together should train together with a focus on human factors, effective communication and openness".

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Hospital: Bronglais Hospital

Ward/department: Pre-operative Assessment Clinic, Ceredig Ward and Theatres

Date of inspection: 3 - 5 July 2017

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
To promote patient safety and foster a consistent approach to learning from patient safety incidents, the health board is required to inform HIW of the action taken to ensure that: • staff responsible for administering blood products complete all the appropriate safety checks and document these in accordance with the health board's policy on administering blood products • a consistent approach is taken by staff for the reporting of blood product related	Standard 2.8	Ward Sister and Senior Nurse Manager immediately ensure only the All Wales Blood transfusion prescription forms are available on the ward. Ward Clerk will check weekly that only the All Wales blood transfusion forms are available on the ward. Ward Sister will ensure all RNs are aware of the appropriate safety	Senior Sister / Senior Nurse Manager Senior Sister / Senior Nurse Manager Senior Sister / Senior Nurse	7th July 2017 7th July 2017 21st July 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
incidents.		checks and documentation when administering blood products. All RNs on Ceredig ward will demonstrate they have read and understood the UHB Transfusion Policy. Both RNs involving in administering the blood will be booked on Blood transfusion update training. Blood transfusion training records and competencies will be checked for all RNs on Ceredig ward to demonstrate competency. Senior Nurse Manager for Ceredig will carry out weekly spot checks of compliance with the blood transfusion policy weekly for 6 weeks and spot check thereafter.	Manager Senior Sister / Senior Nurse Manager Senior Sister / Senior Nurse Manager Senior Sister / Senior Nurse Manager Senior Nurse Manager	 21st July 2017 21st July 2017 21st July 2017 21st August 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Letter to all clinical areas in Scheduled Care reminding staff of the need to comply with the HB transfusion policy and the need to Datix report any blood transfusion incidents. Spot checks of compliance with the blood transfusion policy will be undertaken across all acute hospital areas. All staff will be made aware of the process for reporting incidents related to blood products on the Datix system.	Head of Nursing Scheduled Care Hospital Heads of Nursing / Head of Nursing Scheduled Care Senior Sister / Senior Nurse Manager	11th July 2017 30th July 2017 21st July 2017
The health board is required to provide HIW with details of the action taken to promote patient safety at times when patients are transferred from the operating theatre to the recovery area. More specifically, HIW requires assurance with regard to the availability and administration of	Standards 2.1 and 2.6	A letter will be disseminated to all clinical staff in Theatre, DSU and Anaesthetics across the UHB reminding them of their responsibilities to comply with evidence base.	Medical Director / Director of Nursing, Quality and Patient Safety	14th July 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
supplementary oxygen to patients whenever necessary.		Spot checks of practice in all Theatres will be carried out.	Service Delivery Manager / Senior Nurse Manager Theatre and DSU	30th July 2017
The health board is required to provide HIW with details of the action to be taken to promote the provision of safe and timely patient care, to include the following: • how staff working across the health board are made aware of the correct lines of reporting applicable to the areas in which they work/have responsibility • the arrangements in place to empower staff to make decisions in a timely way.	Governance, leadership and accountability and Standard 7.1	Scheduled Care structure to be disseminated to all Triumvirate teams and clinical teams in Scheduled Care. All staff within Scheduled Care will be reminded of their line management and escalation arrangements. Review of the Emergency Pressures and Escalation Procedure to be reviewed on each hospital site and communicated as appropriate. Specifically ensure standard operating procedures are in place for all escalation areas across all	General Manager / Head of Nursing Scheduled Care Service Delivery Managers Deputy CEO	12th July 2017 21st July 2017 11th August 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		hospital sites.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **JOE TEAPE**

Job role: **DEPUTY CEO / DIRECTOR OF OPERATIONS**

Date: **14TH JULY 2017**

Appendix C – Improvement plan

Hospital: Bronglais Hospital

Ward/department: Pre-operative Assessment Clinic, Ceredig Ward and Theatres

Date of inspection: 3 – 5 July 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must make arrangements to ensure effective handovers of patient care information take place throughout the surgical pathway	3.2 Communicating effectively	2 Surgical Inpatient Pathway Meetings have been held on 19th May and 28th July with Ceredig Ward and Theatre staff. A schedule of monthly meetings will be put in place. An Observational audit of handover from ward to Theatre will be evidenced monthly for 3 months to ensure this is	Rita Stuart SDM / David Harrison SNM Scheduled Care BGH David Harrison SNM Scheduled Care	Action complete 12th September 2017 31st January 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		embedded in practice		
		The handover between Theatre and recovery will be standardised by agreeing a set of criteria for handover	Diane Knight, SDM Theatre	30th October 2017
		Staff have been reminded via a letter to introduce themselves to patients	Mandy Nichols-Davies Head of Nursing Scheduled Care	Action complete 18th September 2017
		An audit as part of a quality improvement initiative will be conducted on Ceredig Ward to establish if staff introduce themselves.	David Harrison, SNM Scheduled Care; Sian Hopkins, Quality Improvement Team	30th October 2017
		The outcomes of the audit outcomes will be shared at ward meetings and the Scheduled Care Quality, Safety,	David Harrison, SNM Scheduled Care	31st December 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Experience meeting. We will launch the #Hello my name is... campaign on Ceredig Ward following the initial audit We will re-audit patient's experience of staff introductions to ensure this is embedded in practice	David Harrison, SNM Scheduled Care; Sian Hopkins, Quality Improvement Lead David Harrison, SNM Scheduled Care; Sian Hopkins, Quality Improvement Lead	31st December 2017 31st March 2018
The health board should make arrangements to ensure that relevant information around patients' home circumstances, which could affect their discharge home following surgery, is obtained and shared with relevant staff in a timely manner. This is with the aim of preventing delays in patient discharge as far as practicable.	5.1 Timely access	Conduct a review of information collected at pre- assessment and actions taken to ensure patient's social care needs are identified and communicated. The Red to Green initiative has been implemented on Ceredig Ward at BGH in July 2017. The Red to Green initiative	Helen George, SNM DSU, PAC, Pain David Harrison, SNM Scheduled	30th November 2017 31st December

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must make arrangements to ensure the timely admission of patients from the emergency department onto the trauma ward. The health board must make arrangements for reducing the time it takes for elderly trauma patients to undergo surgery. The health board must make arrangements to ensure a clear system for prioritising patients and listing patients for unplanned surgery.		will be further rolled out in all our Trauma and Orthopaedics Wards. Data from Red to Green is being collected. We will analyse the data to identify reasons for delays and identify solutions to barriers. Monitor length of stay and reasons for delays to ensure that no delays are attributable to poor assessment and planning Implement a pre alert for fracture NoF to ensure that the hospital is aware of a patient coming in and is able to promptly respond to the patient assessment and identify and prepare a bed in the most appropriate ward The principle of ring fencing a trauma bed will be embedded within the escalation and site management principles in the same way as stroke bed etc. To aim to retain a protected bed at	Care David Harrison, SNM Scheduled Care David Harrison, SNM Scheduled Care Lydia Davies, SDM T&O; Mohammed Yaqoob, Clinical Lead T&O Hazel Davies, General Manager BGH; David Harrison, SNM Scheduled Care	2017 30th October 2017 30th November 2017 31st January 2018 30th September 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		levels 1-3 of escalation. Finalise and implement the trauma database (this will hold a visible to the MDT Trauma dashboard based on NCEPOD classification) to reduce the time it takes for elderly patients to undergo surgery and to prioritise patients for surgery	Diane Knight, SDM Theatre	31st December 2017
The health board must make arrangements to improve the performance within an elderly trauma patient programme relating to: mobilising patients after surgery and reducing the non-operative rate of hip fracture care	6.1 Planning Care to promote independence	Physiotherapists to put in place a mobilisation plan for elderly trauma patients on Ceredig Ward in week and at weekends	David Harrison, SNM Scheduled Care; Annette Snell, Ortho Geriatrician; Susan Griffith, Head of Physiotherapy	30th September 2017
		Nursing staff on Ceredig Ward to be reminded at handover and in ward meetings of their responsibility to mobilise patients and implement the	David Harrison, SNM Scheduled Care; Sue Dolman, Senior	30th September 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		mobilisation plan	Sister Ceredig	
		Retrospective review of NHFD to determine if the non operative rate of hip fracture in BGH is a trend	Lydia Davies, SDM T&O; Mohammed Yaqoob, Clinical Lead T&O	31st December 2017
		NHFD meeting will monitor and scrutinise reasons for non operative treatment of hip fractures	Lydia Davies, SDM T&O; Mohammed Yaqoob, Clinical Lead T&O	31st December 2017
The health board must make arrangements to promote awareness amongst patients and their carers of how they may provide feedback about their experiences.	6.3 Listening and Learning from feedback	A simple patient information sheet has been implemented to tell patients who is looking after them and how to get information or raise concerns.	David Harrison, SNM Scheduled Care	Action complete 18th September 2017
		Patient feedback forms and a feedback box have been implemented to provide an opportunity to provide real time feedback to help us understand what	David Harrison, SNM Scheduled Care; Sue Dolman, Senior	30th November 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		patients think of the ward and their care. The ward sister and Senior Nurse will review these weekly. This will be shared at Ceredig ward meetings and the Scheduled Care Quality, Safety, Experience meetings.	Sister Ceredig	
		The Ward Sister undertake a daily walkabout of patients to seek feedback and resolve any concerns	Sue Dolman, Senior Sister	Action complete 18th September 2017
		Ceredig Ward will conduct the Health and Care Standards Patient Survey monthly for 6 months. The Ward Sisters and Senior Nurse will review findings and evidence appropriate action. This will be shared at Ceredig ward meetings and the Scheduled Care Quality, Safety, Experience meetings.	David Harrison, SNM Scheduled Care; Sue Dolman, Senior Sister Ceredig	31st March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Putting Things Right leaflets are available in the day room and stock will be checked weekly by the Ward Clerk Identify other opportunities to proactively seek patient feedback and utilise the support from the Assistant Director Patient Experience	David Harrison, SNM Scheduled Care; Sue Dolman, Senior Sister Ceredig David Harrison, SNM Scheduled Care; Sue Dolman, Senior Sister Ceredig	Action complete 12th September 2017 30th October 2017
Delivery of safe and effective care				
The health board should make arrangements to review the storage of equipment on the ward and take action as appropriate to reduce the risk of injury to patients and staff. The health board must make arrangements to promote a consistent approach for the reporting of patient safety related incidents and shared learning.	2.1 Managing risk and promoting health and safety	The Senior Nurse Manager and Asst Site Operations Manager, Estates have done a full walkabout to review storage and equipment on Ceredig to identify improvement opportunities. Findings from the walkabout will be recorded, an action plan developed and	David Harrison, SNM Scheduled Care; Elfyn Jones, Asst Site Operations Manager Estates David Harrison, SNM Scheduled	Actioned 18th September 2017 31st December

Improvement needed	Standard	Service action	Responsible officer	Timescale
		progress reported through Ceredig ward meetings and the Scheduled Care, Quality, Safety, Experience meetings.	Care; Sue Dolman, Senior Sister Ceredig	2017
		Non essential equipment in corridor to be removed and SNM Scheduled Care and SSr Ceredig to monitor daily and address inappropriate storage concerns as they arise	Elfyn Jones, Estates; Dawn Jones, Hospital Head of Nursing	Action complete 12th September 2017
		Storage of surplus beds will be addressed once the identified library store has been refurbished	David Harrison, SNM Scheduled Care; Sue Dolman, Senior Sister Ceredig	31st March 2017
		Risk assessments to be completed to evidence the environmental review and safeguards put in place to mitigate risk	Mandy Nichols-Davies, Head of Nursing,	30th September 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		to patients particularly at risk of falls	Scheduled Care	
		Standards for Datix incident reporting to be disseminated via a letter to Theatre and ward staff form the Head of Nursing Scheduled Care	Mandy Nichols-Davies, Head of Nursing, Scheduled Care	Action complete 18th September 2017
		All Theatre and ward staff reminded to use NHS Wales email address when reporting incidents on Datix (to receive feedback)	Diane Knight, SDM Theatre	Action complete 18th September 2017
		Themes from incidents and lessons learned to be a regular feature on Theatre meeting agenda to be evidenced through team meeting minutes		30th September 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must make arrangements to ensure ward arrangements minimise the risk of cross infection between different surgical patient groups (trauma patients, elective orthopaedic patients and general surgery patients).	2.4 Infection Prevention and Control (IPC) and Decontamination	Principles for the placement of patients on Ceredig Ward to be drafted and implemented	David Harrison, SNM Scheduled Care; Sue Dolman, Senior Sister Ceredig	30th September 2017
		The Hospital Site Team will adhere to the infection prevention and control principles when allocating beds on Ceredig Ward.	Dawn Jones, Hospital Head of Nursing	Action complete 12th September 2017
		All patients will be discussed at bed meetings to ensure that Infection Prevention and Control issues have been considered	Dawn Jones, Hospital Head of Nursing	Action complete 12th September 2017
		Exceptions in compliance to be Datix incident reported and monitored by the	David Harrison, SNM Scheduled Care; Sue	31st March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Senior Nurse Manager	Dolman, Senior Sister Ceredig	
The health board must make arrangements to ensure that patients are not fasted for unnecessary long periods of time. The health board should make arrangements to review the quality and availability of meals in response to patient feedback.	2.5 Nutrition and Hydration	Data from the recent fasting audit to be fed back to clinical teams A letter to clinical teams reminding them of the principles for fasting patients and to Datix incident report if trauma patients are cancelled or to be disseminated Health Board Fasting Policy to be finalised and implemented	Helen George SNM DSU, PAC and Pain Mark Henwood, Clinical Director Scheduled Care, Mandy Nichols-Davies, Head of Nursing Scheduled Care Helen George, SNM DSU, PAC and Pain	30th October 2017 Action complete 18th September 2017 31st January 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		A follow up Fasting audit to be conducted within 6 months of implementation of the revised policy	Helen George, SNM DSU, PAC and Pain	31st July 2018
		The Hospital Head of Nursing and Catering Manager do a weekly survey of patients of patient experience of meals. They will continue to audit 4 patients weekly across all inpatient areas. Any improvement opportunities identified will be actioned accordingly.	Dawn Jones, Hospital Head of Nursing; Adrian Smith,	Action complete 18th September 2017
The health board must make arrangements: for the appropriate and safe storage of intravenous and local anaesthetic drugs in theatres to promote patient safety	2.6 Medicines Management	Separate the storage of intravenous and local anaesthetics drugs	Diane Knight, SDM Theatre	30th September 2017
		Implementation of the All Wales Theatre Controlled Drug Register	Diane Knight, SDM Theatre	31st December 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
to ensure staff adhere to the health board's policy for the recording of wasted drugs (i.e. not administered to patients) for checks of controlled drugs in accordance with the health board's policy		Every location where CDs are stocked will have the 3-6 monthly check undertaken by Pharmacy in accordance with the Health Board Medicines Policy	Delyth Simons; Acute Clinical Pharmacy Lead Geraint Morgan, County Lead Pharmacist	31st March 2018
The health board should make arrangements to ensure that safeguarding referrals are directed correctly and efficiently to relevant safeguarding teams	2.7 Safeguarding children and adults at risk	A Global email will be disseminated to remind staff that the Health Board adult safeguarding team are the single point of contact for advice and support regarding safeguarding concerns and / or referrals. The flowchart for adult safeguarding referrals will be updated and uploaded to the Health Board Intranet Site. Adult safeguarding training in the Health Board will reinforce that the Health Board adult safeguarding team are the single point of contact for advice and	Nicola Edwards, Head of Safeguarding Nicola Edwards, Head of Safeguarding Nicola Edwards, Head of Safeguarding	Action complete 12th September 2017 30th September 2017 30th October 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		support		
The health board must make arrangements to ensure that the standards for the Five Steps to Safer Surgery are met. The health board must make arrangements to ensure that VTE risk assessments are consistently completed. The health board must make arrangements for minimising the risk of peri-operative hypothermia which includes intra-operative temperature checks for all patients. The health board must make arrangements for the effective pain relief to all patients at all points along the surgical patient pathway (pre-operative, intra-operative and post-operative phases).	3.1 Safe and Clinically Effective care	Letter to Theatre staff reminding them of the importance of the Five Steps to Safer Surgery Audit of compliance to be completed monthly for 3 months Existing VTE risk forms to be reviewed with a view to amalgamating VTE risk assessment forms to be kept with drugs charts Monitor and respond to Health Board VTE Risk assessment compliance audit results	Mark Henwood, Clinical Director Scheduled Care Diane Knight, SDM Theatre Annette Snell, Othogeriatrician Clinical Staff; Sue Dolman, Senior Sister Ceredig Mark Henwood, Clinical Director Scheduled Care; Mandy Nichols-Davies, Head of	30th September 2017 31st January 2018 31st March 2018 Action complete 18th September 31st March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
			Nursing, Scheduled Care	
		Audit of recording temperatures during the intra operative stage of surgery	Brian Campbell, Consultant Anaesthetist	30th October 2017
		An audit of pain scores and pain control has been conducted on Ceredig and Rhiannon and will be repeated monthly for 6 months	David Harrison, SNM Scheduled Care	31st March 2018
		The outcome of the audit will be discussed with the multidisciplinary team and at ward meetings and action plans developed as appropriate.	David Harrison, SNM Scheduled Care; Sue Dolman, Senior Sister Ceredig	28th February 2018
		A review of pain management across the Surgical patient pathway will take place with the multi-disciplinary team through the Surgical Patient Pathway meeting to	David Harrison, SNM Scheduled Care; Rita Stuart, SDM	31st March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		ensure patient's needs for pain relief are met		
The health board must make arrangements to promote record keeping practise that is in accordance with professional standards for record keeping.	3.5 Record keeping	Letter to reiterate the standards of record keeping to be issued to nursing and medical staff in Scheduled Care	Mark Henwood, Clinical Director, Scheduled Care; Mandy Nichols-Davies, Head of Nursing Scheduled Care	30th September 2017
Quality of management and leadership				
The health board must make arrangements for staff to attend training relevant to their roles.	7.1 Workforce	Training Needs Analysis to be completed and used to inform the identification and commissioning of appropriate training for Theatre staff	Andrew Poole, Practice Development, Theatre BGH	30th October 2017
		Theatre staff in PADRs to be reminded of their responsibilities to identify own training needs and maintain continuing professional development	Diane Knight, SDM Theatre	31st March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Format for multidisciplinary team learning to be finalised and training sessions arranged on audit days	Andrew Poole, Practice Development, Theatre BGH	31st March 2018

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Mandy Nichols-Davies

Job role: Head of Nursing Scheduled Care

Date: 18th September 2017