Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Surgical Services: Trauma and Orthopaedic Care

Princess of Wales Hospital / Abertawe Bro Morgannwg University Health Board / Ward 10 and Main Theatres

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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 the trauma and orthopaedic services[1] at the Princess of Wales Hospital within Aberatwe Bro Morgannwg University Health Board on the 13, 14 and 15 March 2018. The following areas were visited during this inspection:

- Pre-operative assessment clinic
- Ward 10 (trauma surgery ward)
- Main theatre suite

Our team, for the inspection comprised of one HIW Inspector, four clinical peer reviewers (a theatre manager, a senior nurse, an anaesthetist and a surgeon) and a lay reviewer. The inspection was led by the HIW inspection manager and we focussed on the trauma service provided at the hospital.

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

Further details about how we conduct inspections of trauma and orthopaedic surgery can be found in Section 5 and on our website.

[1] Trauma and orthopaedics is an area of unplanned and planned surgery concerned with injuries and conditions that affect the musculoskeletal system (the bones, joints, ligaments, tendons and muscles).

2. Summary of our inspection

We identified areas of noteworthy practice around the care of patients requiring trauma and orthopaedic surgery.

We found, however, that improvement was needed to further promote the safe and effective care of patients admitted with trauma injuries in accordance with national standards.

This is what we found the service did well:

- We saw staff treating patients with respect and compassion
- Patients told us they had been involved in decisions about their care and had been provided with sufficient information
- The pre-operative assessment clinic was well run and patient focussed
- Excellent progress had been made in developing Local Safety Standards for Invasive Procedures based on the national standards
- We saw good practice in relation to the completion of pressure sore risk assessments
- We saw good use of infection prevention and control procedures
- We saw that controlled drugs were managed safely in theatres.

This is what we recommend the service could improve:

- The arrangements to promote timely surgery for patients admitted to hospital with trauma injuries
- Demonstrating that patients had been assessed of their risk of developing a venous thromboembolism
- Compliance with The Five Steps to Safer Surgery, particularly debriefing
- Comments received from ward staff indicated that morale was low.

Our findings in relation to timely surgery and venous thromboembolism prevention resulted in our concerns being 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.

3. What we found

Background of the service

Abertawe Bro Morgannwg University Health Board was formed on 1st October 2009 as a result of a reorganisation within the NHS in Wales and consists of the former Local Health Boards (LHBs) for Swansea, Neath Port Talbot and Bridgend and also the Abertawe Bro Morgannwg University NHS Trust. The Health Board covers a population of approximately 500,000 people.

The Health Board has four acute hospitals providing a range of services; these are Singleton and Morriston Hospitals in Swansea, Neath Port Talbot Hospital in Port Talbot and the Princess of Wales Hospital in Bridgend.

There are a number of smaller community hospitals and primary care resource centres providing clinical services outside of the four main acute hospital settings.

The Princess of Wales Hospital is a district general hospital located on the outskirts of Bridgend in South Wales. It provides a range of acute surgery and medicine services for patients of all ages, including inpatient, outpatient and day services.

The main theatre department consists of a total of six theatres and a recovery area with six bays. There is a designated theatre used to perform unplanned (emergency) trauma and surgical operations and another is used to perform planned (elective) orthopaedic operations.

Unplanned and planned trauma and orthopaedic surgery operating lists run every day between Monday and Friday and is a mixture of all day and half day sessions.

Ward 10 is a 29 bedded ward specialising in trauma and orthopaedic surgery. Patients are usually admitted to the ward via the Emergency Department rather than as planned admissions.

The Princess of Wales Hospital submits data to both The National Hip Fracture Database (NHFD)[2] and the National Joint Registry[3].

[2] The National Hip Fracture Database is a national clinical audit undertaken by the Royal College of Physicians on behalf of the NHS. The data collected is fed back to hospital staff in a number of ways to allow hospitals to track their performance and to facilitate quality improvements. https://www.nhfd.co.uk/

[3] National Joint Registry – 14th Annual report, 2017. This looks at planned orthopaedic surgery outcomes.
http://www.njrreports.org.uk/Portals/0/PDFdownloads/NJR%2014th%20Annual%20Report%202017.pdf

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 were generally satisfied with their care. We saw staff treating patients with respect and compassion and comments from patients also confirmed this.

We identified that improvement was needed so that patients with trauma injuries had their surgery in a timely way. We found that delays were having a negative impact on patients' wellbeing. This resulted in HIW requiring the health board to provide an immediate improvement plan in accordance with our immediate assurance process.

The pre-operative assessment clinic was well run and patient focussed.

Most patients felt they had been involved in decisions about their care and been provided with sufficient information before and after their operations.

During the inspection we distributed HIW questionnaires to patients and carers on Ward 10 to obtain their views on the services provided. A total of 11 completed questionnaires were returned. We also spoke to patients and their carers during the course of our inspection.

Just over a half of the patients that completed a questionnaire rated their overall experience as excellent or very good. Patients provided some positive comments in the questionnaires, but also told us that in their opinion a shortage of staff on the ward was having an impact on the care provided. Patient comments included the following:

> *"Staff are always willing to help. Most seem very knowledgeable. Access to various staff groups has been very good. Good input from Occupational Therapists, physios, medical team. Sisters on the ward are very helpful"*

"Considering the staff shortages, I have felt that they have given the care that they were able to do. If they had a full complement of staff then more could have been done to make my husband's stay more bearable"

"Staff are always busy which occasionally means you have to wait for certain care. More staff at peak times would help the staff to provide the care they want to provide"

"More nursing staff to give the care that they want to as they all seem to feel they wish they could do more because of the staff shortage"

Patients were asked in the questionnaires how the hospital could improve the care or service is provides; comments given by patients included:

"More money for staff & equipment"

"The biggest improvement could be the food provided to the patients as my husband has been in for quite sometime and the same menu is dished up weekly"

We also distributed HIW questionnaires to staff working on the ward and within theatres, inviting them to provide their views on the quality of care provided to patients undergoing surgery. Comments from staff are included throughout the report.

Staying healthy

Pre-operative assessment clinic[4]

Patients waiting for planned joint replacement surgery attended the pre-operative assessment clinic before their surgery. Following an assessment, clinic staff would arrange investigations as necessary to determine whether identified medical conditions required further treatment prior to patients' surgery. Arrangements were described to assess and manage patients who

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

had conditions that may place them in a high risk category[5] for surgery. Clinic staff confirmed that advice and support was available to help patients stop smoking.

Ward

We saw that a range of health promotion material and information about local support groups was displayed near the ward entrance for patients and carers to read.

Dignified care

Every patient that gave an answer in the HIW questionnaires felt that they had been treated with dignity and respect during their time in hospital.

During the course of our inspection we saw many examples of staff being kind and compassionate to patients. We saw staff treating patients with respect, courtesy and politeness at all times.

Ward

We saw dignity curtains were drawn around beds within the bays, and doors to cubicles were closed when staff were helping patients with their personal care. We found that staff spoke in soft tones wherever possible to avoid their conversations with patients being overheard. Shared toilet and washing facilities were designated single gender and clearly marked as such using dementia friendly signage. These arrangements helped promote patients' privacy and dignity.

Whilst there were simple locks on the toilet doors (and a small indicator to show the facilities were in use) we found that these were not being used effectively to prevent staff or patients inadvertently opening the doors. The use of privacy signs would help to further promote patients' privacy and dignity when using the toilet or washing facilities.

[5] High risk pre-operative assessment clinics are important for high risk patients to make a better decision about their surgery. Higher levels of care can be organised for after the operations (if need be).

Theatres

Staff protected patients' privacy and dignity by ensuring doors to anaesthetic rooms were closed during induction (of anaesthetic). We also saw that staff made efforts to keep patients covered so that they were not unnecessarily exposed during their surgery.

Similarly we saw patients in the recovery area were appropriately covered and their dignity was maintained. Privacy curtains could be used to provide a higher level of privacy in this mixed gender area.

Improvement needed

The health board is required to provide HIW with details of the action taken to further promote patients' privacy and dignity when they are using toilet or washing facilities on Ward 10.

Patient information

Patient information and consent[6]

Almost all patients that completed a questionnaire told us that they had been involved as much as they wanted to be in decisions about their care, and that they had been given enough time to make choices about all aspects of their care.

Only one patient who completed a questionnaire told us they felt that the people close to them (for example, their friends, family or carers) had not been involved in all aspects of their care as much as they wanted them to be.

Patients were asked a series of questions in the questionnaire about the quality of information provided to them by staff both before and after their operation or procedure. One patient told us:

> *"There needs to be much better and clearer information. I did not know my op could be delayed for 2-3 weeks"*

[6] Consent is the process of informing a patient about the treatment options and starts well in advance of the operation. It is not just the signing of a consent form.

Of those patients that could remember before their operation, each told us that staff explained everything that was going to happen to them during the operation or procedure they were going to have. Similarly, the same patients told us that the anaesthetist had came to see them before the operation to explain how they would be put to sleep for their surgery or control their pain.

After the operation, all but one of the patients who completed a questionnaire indicated that they were visited by a member of staff who explained to them how their operation went. Most patients told us that they felt they had been given enough information about all aspects of their care during their stay in hospital. Patients also confirmed that they had been given enough information on what to do once they were at home, for example, how to look after any wound they may have, and confirmed that a member of staff had discussed any needs they may have at home after the operation, such as help with mobility or home adaptations.

Patients waiting for planned joint replacement surgery attended the pre-operative assessment clinic before their surgery. Clinic staff confirmed that patients were provided with verbal information about their surgery and we saw copies of patient information booklets. These contained helpful information for patients due to have planned joint replacement surgery.

When deemed fit for surgery, patients waiting for planned joint replacement surgery could attend a joint school, where they were provided with information about their surgery. Nurse practitioners run the joint school and explained that they were responsible for obtaining valid consent from patients. This allowed patients enough time to ask questions and make a decision on whether to proceed with their joint replacement surgery. Patients and their carers were offered the opportunity to use an interactive online service that provides general information on the risks and benefits of surgery. This aims to enhance and facilitate the consent process, and improve patients' understanding of the risks of surgery and its implications

Communicating effectively

Handovers of care

We found that the handover of patients from the ward to theatres did not involve a verbal handover of relevant patient information. This practice did not meet the expected standard of care (especially in the context of non urgent surgery). Theatre staff confirmed that patients were collected from wards by theatre staff (healthcare support workers) who would check the pre-operative handover

checklist[7] on the ward. Patients were then escorted to theatre and either taken directly to the anaesthetic room or would wait at the theatre reception.

A structured handover form was used that prompted theatre staff to check the following, the patient's identity, weight, known allergies, the surgical procedure to be performed, that the operation site was clearly marked and the patient's fasting status.

We observed the handover of three patients and confirmed that patients had been prepared for transfer to theatres from the wards. We identified, however, that not all relevant documentation accompanied patients to theatre. The medication chart for one patient was not present at the time of handover and a completed venous thromboembolism[8] (VTE) risk assessment did not accompany any of the patients.

Ward staff and almost all theatre staff agreed that there was an effective staff handover process in place at the hospital that ensured the continuing delivery of safe and effective care to patients. Almost all ward staff who completed a HIW questionnaire felt that the process in place for ensuring that patients are ready for surgery is effective. Theatre staff told us (in completed HIW questionnaires) that patients often arrive in theatre well prepared and with everything in place for their operation. Our findings suggest, however, that improvement was needed around completeness of care documentation accompanying patients to theatres.

After patients had their operations, we saw that a formal handover of relevant patient information took place between theatre staff and recovery staff. This handover included both surgical and anaesthetic information. Whilst most essential information was shared, the post-operative handover did not include all the information recommended by the National Safety Standards for Invasive

[7] A pre-operative checklist is used by hospital staff to check that patients have been suitably prepared for their operations.

[8] Blood clots are known as venous thromboembolisms or deep vein thrombosis (DVTs). VTE prevention is an important part of surgical care (especially for hip and knee surgery).

Procedures (NatSSIPs)[9]. No formal checklist was used. This meant key aspects of information were not consistently discussed, for example target range for physiological variables and VTE prophylaxis.

Patient communication

All patients that completed a questionnaire told us that they could always speak to staff in their preferred language; this included patients whose preferred language was English and patients whose preferred language was Welsh.

Most patients that completed a questionnaire said that all of the staff that treated them introduced themselves the first time they came to provide them with care.

Patients seemed to be positive about their interactions with staff during their time in hospital. Around two thirds of patients that completed a questionnaire told us that they could always speak to staff when they needed to, and the majority of patients said that they felt that they had been listened to by staff during their stay.

Improvement needed

The health board is required to provide HIW with details of the action taken to demonstrate that:

- a verbal handover of patients from the ward to theatres takes place
- all relevant documentation accompanies patients to theatres
- the post-operative handover includes all information set recommended by the NatSSIPs.

[9] National Safety Standards for Invasive Procedures (NatSSIPs) refers to the implementation of surgical safety systems and processes. Implementing the standards is expected by all NHS services by September 2017.

http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/NatSSIPs%20WALES%20%28FINAL%29%20September%2020161.pdf

Timely care

Whilst the majority of theatre staff that completed and returned a questionnaire felt that the theatre scheduling in their theatre was very or fairly well organised, more than a third told us that no time at all is factored into their daily work plan for them to adequately prepare for each theatre list.

A high proportion of theatre staff that completed a questionnaire told us that they experienced daily or weekly restrictions to patient flow in their theatres. Numerous reasons were given by theatre staff for the main reasons for the restrictions to patient flow:

> *"Patients not adequately prepped for theatre. Bed shortages. Staffing problems"*
>
> *"No beds! Not enough staff!"*
>
> *"Communication failure to have all docs/tests/investigation completed on time"*

Although theatre staff told us staff shortages was often a reason for restrictions to patient flow, most theatre staff felt that operations were rarely (less than once a month) cancelled or delayed in their theatre because of staffing issues. However, theatre staff told us that it was more common that operations were cancelled or delayed in their theatre because of bed availability issues; almost all theatre staff that completed a questionnaire told us that cancellations or delays occurred daily or weekly.

We considered the arrangements for reviewing and planning timely care and treatment for those patients admitted to hospital following trauma injuries. We did this by attending two trauma meetings, speaking to relevant staff and exploring the arrangements for trauma operating list scheduling. We also considered the care of patients whilst in theatre.

From our findings, we could not be assured that efficient systems were in place to promote the effective and timely care of trauma patients requiring surgery. The systems in place may also have put patients at risk of avoidable harm.

Senior staff confirmed that trauma meetings were held each morning. At the meetings we attended, we saw that an orthopaedic consultant, non consultant orthopaedic doctors and a trauma nurse practitioner were present. We were told that other members of the multidisciplinary team (for example, theatre coordinator and anaesthetist) did not routinely attend the daily trauma

meetings. Reasons for this included, staff not being asked to attend, competing work commitments and a lack of staff.

We saw that the following was discussed and agreed at the meetings:

- The management of patients recently admitted with trauma injuries
- If patients required surgery; the operation required, its urgency and who will perform the operation
- The order of the trauma operating list.

Given that they did not attend the trauma meetings, anaesthetists responsible for anesthetising patients on the trauma operating lists were not present to advise on anaesthetic suitability.

An orthogeriatrican, who could provide useful input into the care of frail elderly patients, was not employed at the hospital. This meant that whilst patients' orthopaedic care needs were considered at the trauma meeting, their medical care needs were not appropriately considered.

Whilst the priority of patients was discussed at the meetings, we found that frail elderly patients with hip fractures were not always prioritised highly. One of the half day (morning) dedicated trauma operating lists was allocated for patients requiring upper limb surgery. Patients with hip fractures would be prioritised on the dedicated (afternoon) list running the same day. Given that, together, a trauma operating list runs all day, it may be more beneficial for frail elderly patients to be prioritised so that their surgery was scheduled for the morning rather than the afternoon.

We found that ahead of each trauma meeting a trauma operating list was generated. We were told that an anaesthetist used the list to assess patients prior to theatre. Following the trauma meeting, however, we found this list may be changed. This meant that anaesthetic staff may assess patients who may not be listed for surgery. Similarly there may be a delay in them assessing those patients confirmed as being on the list for surgery. This could result in the start time of the trauma list being delayed. During our inspection a patient already scheduled for surgery was then assessed by the anaesthetist as being too unwell for surgery. We were told that it took considerable time for the anaesthetist to treat the patient and obtain suitable input from the medical team. This delayed the start time of the trauma operating list that day.

Staff explained that dedicated trauma operating lists run five days a week. These were made up of three all day and two half day operating lists. There was no designated theatre for trauma surgery that could be used out of hours

and at weekends. Rather, patients requiring trauma surgery would be scheduled on the CEPOD[10] (unplanned) list. This meant that patients needing surgery as a result of trauma injuries did not always receive timely care[11].

Consideration was given to those patients who could not have their surgery due to lack of operating capacity. A plan to identify extra capacity was agreed, such as that made available should another operating list finish early or using the CEPOD list. During our inspection, however, this additional capacity did not materialise and a patient had their operation cancelled two days in a row. We identified that this delay impacted negatively on the patient's wellbeing.

We also saw that a patient who required surgery for a fractured neck of femur had their operation postponed (due to a lack of equipment) and then subsequently cancelled (due to a lack of operating capacity). We were told that essential equipment required to perform the surgery was not readily available. In this case, the patient had been sent for, before a check of the equipment needed had been completed. The patient arrived in the main theatres only to return to the ward whilst efforts were made to obtain the equipment from a neighbouring hospital. This had the potential to impact negatively on the patient's wellbeing. This situation may have been avoided if the theatre coordinator/staff had been in attendance at the trauma meeting that morning. Alternatively, improved communication between the orthopaedic team and the theatre team may also have avoided this.

As previously described, a written trauma operating list was generated ahead of the morning trauma meetings. This was subject to change following the meeting and depending on circumstances during the day. Staff confirmed that theatre lists were uploaded and updated on the theatre electronic information management system to provide a 'live' version of the list. Ward staff told us that they could not access this system. This meant that staff relied on a written list that may change. During the course of our inspection, we found that changes to the operating list were not always effectively communicated to ward staff. This

[10] The National Confidential Enquiry into Patient Outcome and Death (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.

[11] NHFD data (2017) for the Princess of Wales Hospital shows 41.5% of patients with a fractured hip had surgery on the day of, or the day after admission.

appeared to cause confusion and resulted in conflicting information being conveyed to patients regarding the timing of their operations.

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

Individual care

Planning care to promote independence

Multidisciplinary trauma care

As previously described, there was no orthogeriatrician employed at the Princess of Wales Hospital at the time of our inspection. This meant that frail elderly patients needing orthopaedic surgery did not routinely have specialist medical input in accordance with best practice[12]. Patients with acute medical conditions could be reviewed by general medical doctors through referral arrangements between the orthopaedic and medical teams within the hospital. This, however, did not replace the specialist input to patient care that can be provided by an orthogeriatrican.

A team of trauma nurse practitioners were employed and coordinated the care of patients admitted with trauma injuries. This included arranging the input of other members of the multidisciplinary team as appropriate. There was no standardised care pathway for patients admitted to hospital with a hip fracture. A standardised pathway would help promote a consistent and agreed approach for the effective assessment, treatment and care of patients admitted to hospital with a fractured femur. We were told that this was being developed by the trauma nurse practitioners.

[12] The NHFD has encouraged hospitals to appoint orthogeriatricians – specialists in the care of such people when they are admitted with hip fractures and other orthopaedic problems. These doctors help to make sure that patients are as fit as possible before their operation, support them following surgery and lead the rehabilitation team.

When patients underwent surgery for their hip fracture, we found the overall system for ensuring all patients have a standardised recommended operation to be 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.

We found arrangements were in place for referring patients for physiotherapy. We were told physiotherapists were available seven days per week. This helped ensure that patients were assessed and mobilised early after their operations[13]. Occupational therapists also provided input to help ensure patients were suitably prepared and ready for discharge.

Not all patients required mobility support after their procedure, but of those patients that did, only one patient told us that they had not been given enough support with mobility issues since their operation.

Improvement needed

The health board is required to provide HIW with details of the action taken to appoint an orthogeriatrician.

People's rights

We found that arrangements were in place to protect peoples' rights to privacy and saw staff treating patients with compassion and kindness. We also saw that patients could maintain contact with their friends and family whilst in hospital.

Listening and learning from feedback

Patients were asked what they thought about the care they had received during their stay in hospital, for example through patient questionnaires. Whilst some patients that completed a HIW questionnaire said that they had been asked, more than a half of patients said that they hadn't been asked for their views about the care they had received during their stay in hospital.

[13] NHFD data (2017) for the Princess of Wales Hospital shows 59% of patients are mobilised out of bed the day after surgery and 65.9% of patients receive a physiotherapist assessment.

Patients were asked whether they would know how to make a complaint[14] if they weren't happy about the care they had received during their stay in hospital. Just over a half of patients that answered the question said they would not know how to make a complaint.

The health board had arrangements for patients to provide feedback on their experience of being in hospital. Patients could complete a comment card and also provide views via the health board's website.

Improvement needed

The health board is required to provide HIW with details of the action taken to increase patients' awareness of the procedure on how to make a complaint.

[14] The process for managing concerns (complaints) in NHS Wales is known as Putting Things Right. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

Delivery of safe and effective care

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

We found that excellent progress had been made in developing Local Safety Standards for Invasive Procedures based on the national standards. Overall, we saw that checks to promote patient safety were performed well in theatre. We did, however, identify improvement was needed in some key areas.

We also identified improvement was needed to demonstrate that patients had been assessed of their risk of developing a venous thromboembolism. This resulted in HIW requiring the health board to provide an immediate improvement plan in accordance with our immediate assurance process.

Whilst, we saw some good practice in relation to the completion of pressure sore risk assessments, we identified areas for improvement in relation to other aspects of assessment and monitoring. Ward and theatre areas were clean and generally tidy and we saw good use of infection prevention and control procedures.

We saw that controlled drugs were managed safely in theatres.

Safe care

Managing risk and promoting health and safety

All theatre staff that completed a questionnaire agreed that the theatre department at the hospital had a good patient safety culture.

The National Safety Standards for Invasive Procedures (NatSSIPs)[15]

Senior managers were aware of the need to review practice in response to the publication of the National Safety Standards for Invasive Procedures (NatSSIPs).

Effective leadership was demonstrated and we found excellent progress had been made in developing Local Safety Standards for Invasive Procedures (LocSSIPs) based on the NatSSIPs. These were waiting to be formally agreed by the health board, in accordance with its governance process, before they could be implemented by clinical teams in hospitals within the health board.

The Five Steps to Safer Surgery[16] [17]

Theatre staff were asked questions within the HIW questionnaire about aspects of safety checks, and provided positive feedback about most of the checks. Theatre staff were asked in the questionnaire how much time is factored into their daily work plan to complete the safety steps. A third of theatre staff that answered the question told us that the time that they are given to complete the safety steps is not long enough.

We looked at how the Five Steps to Safer Surgery were performed within the trauma operating theatre. The five steps are Safety Briefing[18], Sign in[19], Time

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[15] National Safety Standards for Invasive Procedures (NatSSIPs) refers to the implementation of surgical safety systems and processes. Implementing the standards is expected by all NHS services by September 2017. http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/NatSSIPs%20WALES%20%28FINAL%29%20September%2020161.pdf

[16] The Five Steps to Safer Surgery - National Patient Safety Agency, 2010. Key safety steps which help prevent patients avoid suffering serious untoward preventable events such as wrong sided surgery, wrong implant insertion or inadvertent retained foreign bodies. These steps improve theatre safety, efficiency and communication. The five steps are briefing, WHO safety checks (3 steps) and debriefing.

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=93286

[17] Standards 7, 8, 9, 12 and 13 (Safety Briefing, Sign In, Time Out, Sign Out, Debriefing respectively) of the National Safety Standards for Invasive Procedures. Welsh Government, 2016.

Out[20], Sign Out[21] (the three steps of the WHO Surgical Safety Checklist) and Debriefing[22].

Safety Briefing

Almost all theatre staff that completed a questionnaire confirmed that a surgical safety briefing always happens before the start of each theatre list.

Briefings occurred at the start of those trauma operating sessions we observed during the course of our inspection. Theatre staff we spoke to confirmed that briefings were performed most of the time. Reasons for these not being consistently performed included surgeons not being present and the changing order of the trauma operating list.

We found that time was allocated to perform the briefing and that it took place in the anaesthetic room. This helped to maintain patient confidentiality. We saw that noise and interruptions were minimised during the briefing to promote effective communication between the team members.

Whilst, briefings were performed we saw that the consultant surgeon was not present at one of the briefings. Theatre staff confirmed that a radiographer did not usually attend.

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

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

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

[21] 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.

[22] 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.

Arrangements were described for the effective leading of the briefing and for team members to ask questions and raise concerns. We identified this as noteworthy practice as this approach would help to promote patient safety. Whilst important aspects relating to each individual patient were discussed, a standardised format was not used. Theatre staff confirmed that some aspects relating to patient care were only discussed if they were deemed relevant and others aspects may be assumed, (for example, the positioning of the patient during the operation). The lack of a standardised format may mean that aspects relevant to a patient's safe and effective care may be missed.

Whilst, theatre staff used the electronic recording system to show that a briefing had been completed, this did not contain any other details. An annotated theatre list was used to provide a record of the briefing but this did not include the identities of those team members present.

Theatre staff explained that prosthesis[23] and associated equipment requirements were confirmed at the briefing. It was not clear, however, who was responsible for ordering and checking these prior to the operation. We were told that the surgeon inspected the prosthesis before opening its packaging during the operation but not before the patient is sent for.

Our findings in relation to the above indicated that whilst the briefings contributed to patient safety, improvement was need to further promote safe and effective care to patients whilst in theatre.

Word Health Organisation (WHO) Surgical Safety Checklist[24]

A standardised checklist was used and read aloud by theatre staff at each step of the WHO Surgical Safety Checklist (i.e. Sign In, Time Out and Sign Out). The checklist included relevant checks that had to be verbally confirmed to promote patient safety and well being whilst in theatre and before handover to recovery staff.

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[23] A prosthesis is an artificial body part e.g. a hip joint prosthesis is use to replace a diseased or broken hip joint

[24] These are checks ensuring the correct patient is undergoing the correct operation, on the correct part of the body with the correct implant. The WHO checks consist of Sign In, Time Out and Sign Out. http://www.who.int/patientsafety/safesurgery/ss_checklist/en/

As part of the checks performed, we found that a check of each patient's name was conducted and cross referenced with details on his/her hospital wrist band and consent form. This is an important check to promote patient safety. We also found that there was a system to ensure that parts of patients' bodies were appropriately marked (for their operation) before entering the anaesthetic room. We also found that patients were involved in key safety steps as appropriate.

We saw that the Sign In was always clearly performed. We also saw that two members of theatre staff were present and for procedures involving a general anaesthetic, an anaesthetist was always present.

Theatre staff also told us that the Time Out part of the surgical safety checklist was always completed for each patient, and that the whole theatre team were mostly present during the completion of the Time Out. We saw that the Time Out was always clearly performed and that all team members involved in the procedure were present. Noise and interruptions were minimised during this stage of checking.

Comments from theatre staff indicated that the Sign Out part of the surgical safety checklist was not always completed for each patient. When it was, sometimes the whole theatre team were not present during the completion of the Sign Out. We saw that the Sign Out was always clearly performed. Not all team members, however, were present during this step.

We found that there was an effective method for counting surgical instruments prior to and after each operation. This is important for the prevention of (unintentionally) retained foreign objects

Overall, our findings indicated that the WHO checklist steps were performed well by the theatre team. We did, however, identify that the Sign Out did not always confirm that a cannulae[25] had been flushed to prevent anaesthetic drugs being inadvertently administered to patients when they had returned to the ward. This is an important patient safety issue[26].

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[25]A cannula (pleural cannulae) is a thin tube inserted into a vein that can be used to administer medication.

[26] Patient Safety Notice - PSN014 / July 2015 Residual anaesthetic drugs in cannulae and intravenous lines

Debriefing

Over two thirds of theatre staff that answered the question in the questionnaire said that the surgical safety debrief rarely, or never, happens at the end of each theatre list. Theatre staff we spoke to confirmed that debriefing 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.

Incident Reporting (Theatres)

An effective system for reporting, recording, investigating and learning from (patient safety) serious incidents was described. We found an open reporting culture within theatres. This is important to identify learning from incidents and so promote patient safety. Senior staff were able to provide examples of learning from incidents and the action taken to prevent similar incidents happening again.

Improvement needed

The health board is required to provide HIW with details of the action taken to demonstrate:

- all relevant members of the team are present at the safety briefing and an appropriate record made
- confirmation that venous cannulae have been flushed (taking into account PSN 014/ July 2015)
- debriefings take place as part of the WHO Surgical Safety Checklist and Five Steps to Safety Surgery.

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http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/PSN014%20Risk%20of%20associating%20ECG%20records%20with%20wrong%20patients.pdf

Preventing pressure and tissue damage

Ward

We reviewed the care records of five patients. We saw that patients had been assessed for their risk of developing pressure sores on admission to the ward. Nursing staff demonstrated a thorough understanding of the signs of pressure sores. A recognised risk assessment tool had been completed for each patient and written care plans were in place to direct nursing staff as to the care required. We found that staff monitored patients' skin for signs of pressure and tissue damage. We identified, however, that monitoring charts had not always been completed to show that nursing staff had regularly repositioned patients and checked patients' skin for signs of pressure and tissue damage.

Specialist pressure relieving equipment (such as air mattresses and cushions) was being used and appeared to be functioning correctly. Staff confirmed that they had enough pressure relieving equipment

Safety crosses[27] were clearly displayed near the entrance of the ward for patients, their carers and staff to see. These included a safety cross providing information on the number of patients who had developed a pressure sore whilst on the ward during the preceding month. This allowed the ward team to see, via a simple system, the incidence of pressure sores with the intention of taking timely action to prevent them. This demonstrated a positive approach was being taken by the ward team in relation to pressure sore prevention and care.

Theatres

We observed how patients' skin was protected when they were positioned on the operating table. We saw that patients' limbs were supported to help reduce pain after the operation and their skin was checked by staff. Padding was available and used to protect patients' against developing pressure sores whilst

[27] The Safety Cross has been adapted from industry to make highly visible the incidence of avoidable adverse events. In doing so it ensures that the whole team is aware of avoidable events and thus instils a sense of purpose in working to avoid future events.

in theatre. Patients' skin was also checked before and after the application of diathermy[28] equipment.

Falls prevention

Ward

We found that written falls risk assessments were not available within four of the five patients' care records we reviewed. We saw that assessments had been completed regarding the safe use of bed safety rails (to help prevent patients falling from bed). Written care plan plans were not in place for the four patients without a falls risk assessment.

As mentioned previously, safety crosses were displayed. These included a safety cross for falls, which showed the number of patient falls that had happened during the preceding month. Whilst, this demonstrated a positive approach to falls management this approach was not demonstrated within the care records we reviewed.

Theatres

We observed how unconscious patients were transferred from trolleys onto the operating table. We saw that there were sufficient numbers of staff to safely move and position patients onto the operating table. Moving and handling equipment was available and used by staff appropriately. Similarly we saw safe procedures when patients were transferred from the operating table onto a bed or trolley.

Improvement needed

The health board is required to provide HIW with details of the action taken to demonstrate that nursing staff have assessed patients for their risk of falls and appropriate action is being taken to help prevent falls.

[28] Diathermy is a medical and surgical technique involving the production of heat in a part of the body by high-frequency electric currents, to stimulate the circulation, relieve pain, destroy unhealthy tissue, or cause bleeding vessels to clot.

Infection prevention and control

Ward

There were two separate wards used for patients having planned orthopaedic surgery and patients requiring surgery as a result of trauma injuries. These arrangements helped to promote effective infection prevention and control.

We saw that the ward was clean and generally free of clutter to promote effective cleaning. Cubicles were available to care for patients who needed to be nursed in isolation to help prevent cross infection. Labels were routinely used to show that shared equipment, such as commodes, had been cleaned and decontaminated. Personal protective equipment (PPE) such as disposable aprons and gloves was available and being used to promote effective infection prevention and control. Appropriate facilities were in place for the safe disposal of clinical waste, including medical sharps. Hand washing and drying facilities were available throughout the ward, together with hand sanitising gel. Effective hand hygiene is important to help prevent cross infection.

Staff were knowledgeable around effective infection prevention and control procedures. It was evident however, that staff experienced work pressures in managing infection prevention and control on the ward. During the course of our inspection, considerable time was spent by staff moving patients with suspected or confirmed infections to cubicles or other areas. This was to allow housekeeping and ward staff to thoroughly clean bed areas before patients could be admitted or returned to the ward. Comments from staff indicated that they found it difficult to perform cleaning duties as well as caring for patients on the ward. Whilst cleaning schedules had been devised, we saw gaps in records. We could not be assured, therefore, that items of equipment and areas had always been cleaned in accordance with the schedules.

Within the sample of patients' care records we reviewed, we saw that a sepsis[29] screening tool was available. This aimed to identify patients who may be developing sepsis so that prompt treatment could be given.

[29] Sepsis is a potentially life-threatening complication of an infection.

Theatres

The operating theatres, anaesthetic rooms and recovery area were clean and tidy. We confirmed that air flowed from the theatres in a way to promote effective infection prevention and control. PPE was available within theatres and the recovery area. Appropriate facilities were in place for the safe disposal of clinical waste, including medical sharps. Hand washing and drying facilities together with hand sanitising gel were available within theatres and the recovery area.

We found that staff used a recommended method when scrubbing up prior to surgical procedures. We also found that staff opened instrument sets using a strict aseptic technique[30]. Similarly, a strict aseptic approach was used when patients' skin was cleaned prior to their surgery. 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 signs were displayed to remind staff not to enter operating theatres when operations were being performed. These arrangements help to reduce the risk of patients developing preventable infections as result of surgery.

Disposable curtains were used in the recovery area. This prevented the need to wash curtains used to protect privacy and dignity and helped promote effective infection prevention and control.

Nutrition and hydration

Fasting

There are guidelines in place for the amount of time that patients should go without drink before an operation, dependent upon the procedure. The majority of theatre staff that completed a questionnaire agreed that there is an effective system in place for planned surgery which ensures patients are not deprived of fluid for longer than necessary before an operation.

Patients were asked in the questionnaire how long before their operation did they go without a drink. The guidelines for the amount of time that patients should go without drink before an operation will depend on the procedure;

[30] Aseptic technique is a procedure used by healthcare staff to prevent the spread of infection.

however, it is usually about two hours for fluids. Of those patients that answered the question, half told us that they went between 4 and 8 hours without a drink before their operation, with the other half of patients telling us that they went more than 8 hours without a drink before their operation. One patient provided the following comment in the questionnaire about fasting before their operation:

> *"Endless days of fasting and still no operation - very fed up, now getting angry"*

Patients were also asked whether they had been able to eat and drink when they needed to after their operation or procedure; most patients that answered this question confirmed that they had been able to.

As described previously, we reviewed the care records of five patients. We also reviewed a further four records of patients who had been admitted with a fractured hip and specifically considered nutrition and hydration care. We found that written nutritional risk assessments had not been completed for four of the nine patients we considered[31]. In addition, we found that patients who were being fasted for surgery were not being reassessed appropriately. Some patients were receiving intravenous fluids to help keep them hydrated but this was not being done routinely.

Improvement needed

The health board is require to provide HIW with details of the action taken to demonstrate that:

- patients are not fasted for longer than is necessary prior to surgery
- nursing staff have completed nutritional risk assessments for patients and reassessed patients as appropriate.

[31] NHFD data (2017) for the Princess of Wales Hospital shows 75.9% of patients receive a nutritional risk assessment.

Medicines management

For the purposes of this inspection, we focussed on the arrangements for medicines management in theatres.

We saw that medicines were stored securely in cupboards or fridges in an organised manner. Records showed fridge temperatures had been recorded daily to check that medicines requiring refrigeration were being stored at temperatures recommended by the medicines manufacturer. This is important to promote patient safety[32].

Most non intravenous medicines were stored separately from intravenous medicines to help prevent against medication administration errors in theatres. We saw, however, that lignocaine (a type of local anaesthetic) was being stored in the same cupboards as intravenous medication in both theatres and the recovery areas.

Controlled drugs (CDs), which have strict and well defined management arrangements, were stored securely. We saw that comprehensive records had been maintained that showed appropriate checks had been made when administering and disposing of CDs. We also saw that CDs used within theatres were subject to frequent stock checks.

Whilst part of the Sign Out process, we saw that it was not always confirmed by staff that IV devices had been removed or flushed free of residual anaesthetic drugs before leaving theatres (see section - Managing risk and promoting health and safety).

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure the appropriate and safe storage of intravenous and local anaesthetic drugs in theatres to promote patient safety.

[32] Patient Safety Notice - PSN 015 / July 2015 The storage of medicines: Refrigerators http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/PSN015%20The%20storage%20of%20medicines%20-%20refrigerators.pdf

Safeguarding children and adults at risk

The health board had written procedures in place to promote and protect the welfare of adults who become vulnerable or at risk.

During the course of our inspection, we identified there was some uncertainty around whether a referral had been made to the safeguarding team. We escalated our concerns to senior hospital staff who responded promptly and confirmed that a referral had been made. We were assured that the correct procedure had been followed but the action taken had not been fully communicated to ward staff. Senior staff confirmed they were making arrangements to share the learning from this incident to ensure improvements were made in this regard. This is noteworthy practice to promote patient safety and wellbeing.

Comments from ward and theatre staff who completed and returned a questionnaire confirmed that they were encouraged to report any patient safety issues and safeguarding concerns they may have. This indicates a positive reporting culture that promotes patient safety.

While theatre staff that completed a questionnaire told us that they felt able to speak up about anything that they saw that was wrong when working in the theatres, more than a half of theatre staff said that they rarely receive feedback of the actions taken from any reported incidents.

Blood management

Ward

We reviewed the care record of a patient who had received a blood transfusion. We found evidence to demonstrate that appropriate safety checks had been completed by nursing staff on the ward.

Theatres

Theatre staff described the blood management system in use within theatres. We found that there were arrangements to promote the timely and safe transfusion of blood products to patients when in theatre. An electronic tracking system was described for safety and audit purposes. 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. This arrangement promoted patient safety.

Medical devices, equipment and diagnostic systems

Ward

The majority of ward staff that completed a questionnaire felt that they often have access to the equipment they need to deliver safe and effective care to patients.

We saw that moving and handling equipment and patient monitoring equipment and were readily available. Ward staff confirmed that there was sufficient equipment to meets the needs of patients on the ward. Ward staff felt that the storage arrangements on the ward could be improved. At the time of our inspection, some equipment was stored in a screened area within one of the multi bedded bays. This meant that sometimes patients were disturbed by staff collecting equipment.

Theatres

The majority of staff that completed a questionnaire felt that they always have access to the equipment they need to deliver safe and effective care to patients. However, some theatre staff provided the following comments about the equipment they felt was needed at the hospital, and about the state of the theatres in general:

> *"… Basic equipment not readily available"*
>
> *"More money for equipment. New decoration and update in theatre decoration and environment needed"*

We found that key equipment to deliver care to patients was available and working within theatres and the recovery area. The only exception was a lack of a suitable thermometer at the beginning of one of the trauma operating sessions. This was addressed for subsequent patients attending theatre.

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

Arrangements were described for training staff on the use and storage of surgical instruments used during surgical operations.

We saw that staff experienced challenges in being able to store equipment. A lack of suitable storage space meant that boxes were stored in corridors and equipment was not conveniently located near to the theatres. We saw that boxes were being stored near a fire exit which could cause a hazard in the

event of a fire. This was addressed immediately when we brought this to the attention of senior theatre staff.

Equipment and medication for use in the event of a patient emergency (collapse) were readily available for use in theatres and the recovery area. Staff we spoke to were aware of the location of this equipment.

Improvement needed

The health board is required to provide HIW with details of the action taken to improve the storage of equipment both on the ward and in theatres.

Effective care

Safe and clinically effective care

Venous thromboembolism (VTE) prevention[33]

We considered the arrangements in place for assessing patients for their risk of developing a venous thromboembolism (VTE). We did this by reviewing a sample of five patients' care records and by speaking to ward staff. We also considered the health board's current policy for thromboprophylaxis. In addition we considered the handover of patients from wards to the trauma theatre.

From our findings, we could not be assured that a consistent approach was being used to assess patients for their risk of developing a VTE. The lack of a documented risk assessment also meant that we could not be assured that appropriate treatment was being prescribed as necessary and in accordance with the health board's policy.

Written VTE risk assessments were not available within the sample of care records we reviewed. This was not in accordance with the health board's policy which clearly indicates that all patients will have their risk of developing a VTE assessed and documented on admission using the thromboprophylaxis risk

[33] Blood clots are known as venous thromboembolisms or deep vein thrombosis (DVTs). VTE prevention is an important part of surgical care (especially for hip and knee surgery).

assessment tool. Ward staff we spoke to seemed unclear as to what this was and where this could be found.

Most of the care records we reviewed demonstrated that patients had a re-assessment of their VTE risk at 24 hours. This was by means of a document that could be endorsed by nursing staff to indicate whether there had been any change to the initial assessment. Given the above findings, however, we could not be assured that a suitable risk assessment tool had been referred to when completing the reassessment.

We saw that patients had been prescribed pharmacological and/or mechanical VTE prophylaxis (i.e. low molecular weight heparin or anti-embolism stockings). We identified that three patients who had been prescribed anti-embolism stockings were not wearing them. We brought this to the attention of senior ward staff so that this could be addressed. We also identified inconsistency in the completion of the medication administration record by ward staff to show that anti-embolism stockings had been applied to patients.

We considered the handover of three patients from wards to the trauma theatre. A checklist was completed by ward and theatre staff to check that all relevant documentation (including a VTE assessment) accompanied patients at handover to theatres. Whilst a checklist was being used, we identified that completed VTE assessments did not accompany patients to theatre. This was not addressed intra-operatively.

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

Peri-operative[34] hypothermia[35]

We looked at a sample of patients' care records and saw that all patients had their temperatures checked on the ward in the pre-operative phase. The records showed that most of the patients also had their temperatures checked at the recommended frequency (every four hours) in the post-operative phase on the ward. Sufficient bed linen and blankets were available on the ward to help keep patients warm after their surgical operations.

We saw that patients arriving in theatre did not have their temperatures checked. This was attributed to a suitable thermometer not being available. Patients did arrive with blankets which helped to keep them warm and promote their dignity. During the intra-operative phase and the post-operative phase in the recovery area, we saw that patients had their temperature checked and recorded at appropriate intervals. Recovery staff described that patients were not transferred back to the ward until their temperature was satisfactory (i.e. above 36 degrees Celsius. Equipment was available and routinely used both in theatres and the recovery area to actively warm patients to prevent peri-operative hypothermia.

Intravenous (IV) access on the ward

Ward staff told us that doctors, nurse practitioners and some ward nurses were able to insert short term intravenous (IV) devices so that fluids and medication could be given through patients' veins. This meant IV access was available to patients during the day and night without unnecessary delay.

Ward staff also confirmed that arrangements were in place for patients to have long term intravenous devices inserted within one to three days of them being required. This is in accordance with professional guidelines[36].

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[34] Perioperative 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).

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

Pain relief

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 between 10 and 30 minutes after they had requested extra pain relief before they got it. The majority of patients felt that they had been given enough pain medication to stop the pain.

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. During the intra-operative phase, we were told that the usual approach was to inject a local anaesthetic into the patient's wound to provide pain relief following surgery.

Patients' care records did not always demonstrate that nursing staff had assessed and monitored patients' pain. We observed, however, that patients appeared comfortable. We also saw that nursing staff asked patients about their pain and provided analgesia (pain relieving medicine) promptly. Ward staff confirmed they were able to access help and advice from a team of specialist nurses and that they found the team supportive.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure

- patients have their temperature checked at on arrival to the anaesthetic room
- nursing staff are completing all the key elements of a pain assessment and consistently monitoring patients' pain (consideration must be given to those patients who are unable to verbalise their pain).

[36] The Association of Anaesthetists of Great Britain & Ireland. Safe vascular access 2016. Hospitals are expected to provide timely insertion of routine IV devices. There should be a dedicated service which provides long term device insertion (such as central lines) within 1 to 3 days. https://www.aagbi.org/sites/default/files/Safe%20vascular%20access%202016.pdf

Quality improvement, research and innovation

An ongoing programme of audit activity to improve services was described. We were told that there had been a recent increase in number of trauma surgery operating sessions. This aimed to increase the operating capacity of theatres so that more patients could have their operations. We were also told that an audit of pre-operative fasting had been completed and work was underway to make improvements in this regard.

The Princess of Wales anaesthetic department had no active plans to achieve Anaesthesia Clinical Services Accreditation (ACSA)[37] status.

Information governance and communications technology

Our discussions with staff working in the pre assessment clinic indicated that they had sufficient diagnostic and monitoring equipment to run the clinic. The lack of a suitable fax machine and printer, however, was a source of frustration for them. Staff told us that they often have to spent time looking for a suitable fax/printer that they could use whilst ensuring they handled information safely and securely.

Theatres had an information system in use that could be easily accessed by theatre staff. This system captured a range of key information that could be used to produce efficiency reports for the management team.

During our inspection we identified that ward staff were unable to access up to date information theatre list information. Our findings in this regard are described earlier (see section - Timely care).

[37] Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary scheme for NHS and independent organisations. It is an externally accredited quality improvement initiative from the Royal College of Anaesthetists that promotes patient safety and ensures achievable standards of perioperative care are met. https://www.rcoa.ac.uk/acsa

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure staff within the pre-assessment clinic have access to a suitable fax and printing equipment.

Record keeping

Our findings in relation to the quality and completeness of record keeping have been described throughout the report. Arrangements were in place to keep written and electronic information secure against unauthorised access.

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.

We considered the management arrangements in theatres and found a management structure was in place with clear lines of reporting and accountability.

We found friendly yet professional staff teams working on the ward and within theatres. It was evident from the comments made by ward staff that they felt staffing levels and skill mix needed to be improved and that morale was low. We informed senior staff of our findings so that arrangements could be made to address this. Theatre staff confirmed that during busy periods, arrangements are put in place to ensure patients continue to receive the care they need.

Whilst comments from theatre staff indicated they felt supported by management to carry out their roles, comments from ward staff indicated improvement was needed in this regard.

Comments from both ward and theatre staff indicated that improvement was needed around access to training to maintain their continuous professional development.

Governance, leadership and accountability

For the purposes of this inspection, we focussed on the governance, leadership and accountability arrangements in theatres.

A management structure was in place and clear lines of reporting and accountability were described. A system of regular meetings was described.

These helped ensure that relevant information was shared with senior hospital and health board staff as part of the overall governance arrangements.

We saw that audit activity had taken place. These included audits around fasting and infection prevention and control (including environmental cleanliness, hand washing and surgical site infection).

Staff and resources

Workforce

During our inspection we distributed HIW questionnaires to staff working on the ward and within theatres, inviting them to provide views on the quality of care provided to patients undergoing surgery.

Ward

In total, we received 11 completed staff questionnaires.

More than a half of ward staff felt that the staff working there did not have the right mix of skills to ensure the delivery of safe and effective care to patients. All ward staff also felt that there was an insufficient number of staff working there to ensure the delivery of safe and effective care to patients.

Comments received by ward staff included:

> *"I feel that we can no longer give sufficient care to all patients, as we are often told to clean cupboards, tables, chairs, beds, shelves, etc. the list goes on. We are short staffed to the point of not being able to give adequate care to patients let alone keeping the environment clean. Someone misses out, generally the patient"*

> *"I feel that nurse staffing levels can greatly affect the care delivered to patients. This affects both nurse and patient wellbeing as nurses workload means there is high stress & little breaks"*

> *"We are understaffed and have aired our concerns that we can't always give the care we want due to staff shortages. There is a big push for cleaning schedules but patient care should always come first"*

During the course of our inspection we also saw that staff were very busy attending to patients who required a significant amount of help. As previously

described, staff needed to spend time moving patients and cleaning equipment as part of infection prevention and control procedures. There were also occasions when staff were unable to respond to patients requests as they were busy attending to other patients.

We discussed our findings about staffing on the ward with senior staff. We were informed that staffing on the ward was being considered as part of a wider review of staffing within the hospital. We also provided feedback to senior health board representatives on the comments made by staff so that suitable arrangements could be made to address the apparent low morale amongst the ward team.

Staff were asked in the questionnaire about the potential risks of the levels of staff leaving and joining the hospital, and about the arrangements in place at busy periods. Almost all ward staff felt that the delivery of safe and effective care to patients was at risk due to the number of staff leaving or joining the organisation, and told us that during busy periods arrangements are rarely put in place to ensure patients continue to receive the care they need.

The majority of ward staff that completed a questionnaire said that they are only sometimes given access to training to maintain their continuing professional development while working in their current role. Nearly three quarters of the ward staff members that completed a questionnaire told us that they are not given enough support and leadership by management staff to carry out their role effectively; most ward staff also said that they are rarely supported by management staff to make their own decisions.

Theatres

In total, we received 15 completed staff questionnaires.

Staff were asked in the questionnaire about the potential risks of the levels of staff leaving and joining the hospital, and about the arrangements in place at busy periods. The majority of theatre staff felt that the delivery of safe and effective care to patients was not at risk due to the number of staff leaving or joining the organisation, and told us that during busy periods arrangements are always or often put in place to ensure patients continue to receive the care they need.

All but one theatre staff member that completed a questionnaire agreed that the priority in theatres in the hospital is on delivering safe and effective care for all patients rather than achieving a quick turn-over of patients.

The majority of theatre staff that completed a questionnaire said that they are only sometimes given access to training to maintain their continuing professional development while working in their current role. However, all theatre staff agreed that they are given enough support and leadership by management staff to carry out their role effectively.

Theatres had a designated Theatre Specialist Trainer who was responsible for facilitating the training of theatre staff and operating department practitioner students within theatres. Discussions with the trainer demonstrated an enthusiastic and committed approach to providing relevant training.

Theatre staff that completed a questionnaire told us that they attend monthly multi-disciplinary training, such as clinical audit days. The majority of theatre staff that completed a questionnaire said that they are often, but not always, supported by management staff to make their own decisions.

Improvement needed

The health board is required to provide details of the action taken:

- in response to the comments raised by ward staff during the inspection
- to support staff to attend training relevant to their continuing professional development.

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 trauma and orthopaedic surgery

Our inspections of trauma and orthopaedic surgery look at the following:

- Trauma surgery pathway (unplanned surgery for broken bones)
- Planned orthopaedic surgery
- National Safety Standards for Invasive Procedures (safety checks and processes during surgery).

Trauma and orthopaedic 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.

We look at the care a patient receives before an operation, during the operation and after the operation.

Our surgical inspection involves more than just the operating theatre and looks at the pathway the patient takes. It involves multiple areas in the hospital including:

- Surgical out patient clinic (decision to proceed with surgery made here)
- Pre-assessment clinic (checking patient is fit for surgery is made here)
- Pre and post-operative orthopaedic surgery ward (one trauma ward and one planned orthopaedic surgery ward)
- Operating theatres (in particular one trauma theatre and one planned orthopaedic surgery theatre if possible).

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
Boxes were stored near a fire exit within theatres.	The boxes could have caused a trip hazard and impede the safe and timely evacuation of staff from theatres in the event of a fire.	We informed senior staff within theatres of our findings.	Senior staff made arrangements for the boxes to be moved to another area.

Appendix B – Immediate improvement plan

Hospital: The Princess of Wales Hospital

Ward/department: Main Theatres and Ward 10

Date of inspection: 13, 14 and 15 March 2018

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
The health board is required to provide HIW with details of the action taken to demonstrate that patients are suitably assessed and reassessed for their risk of developing a venous thromboembolism and that appropriate treatment is prescribed as necessary in accordance with the health board's policy.	3.1 Safe and clinically effective care 3.5 Record keeping	The decision was taken immediately following feedback that the risk assessment document which was part of the revised Trauma pathway document would be replaced with the emergency surgical pathway risk assessment document (contained in the VTE policy) On the 14th March 2018 (during the HIW visit) the trauma pathway document was replaced with the emergency surgical risk assessment	Clinical Director Surgery (CDS) CDS	15th March (complete) 30th May – completed 14/03/18

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		document. A review of compliance with this risk assessment document within the trauma unit will take place in May 2018. Following the letter received from HIW on the 12th April 2018 outlining immediate improvement plan not accepted an audit was undertaken on compliance with VTE assessment, prescription, re-assessment documentation which showed performance was below an acceptable standard. Following this audit further education and communication was provided to the teams. A further audit will take place during the first week of May 2018. The current VTE policy has the following appendices- VTE risk assessment for emergency surgery and elective orthopaedics (these are on forms which form part of the	Unit Nurse Director and Unit Medical Director to liaise	Completed 12/04/18 30th April (to inform review of policy) Completed – Corporate teams

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		medical records).All other services e.g. elective surgery/medicine currently refer to a laminated sheet (contained within the policy) and medical staff tick the medication sheet to confirm they have referred to the specific risk assessment. The laminate sheet does not form part of the medical records. The results of the audits will inform the development of the revised Health Board policy due June 2018. The policy is due for revision in June 2018 and thus the above point will be considered in the review of the policy to ensure there is a clear risk assessment document contained within the medical records of all patients. The current nursing documentation contains a question to confirm that VTE re-assessment has taken place at 24 hours. The current risk assessment documents (in the	with ABMU Corporate teams Unit Nurse Director and Unit Medical Director to liaise with ABMU	informed week commencing 19/03/18. Completed – Corporate teams informed week commencing 19/03/18.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		policy) do not contain a section to document reassessment. The policy is due for revision in June 2018 and thus the above point will be considered in the review of the policy to ensure there is clear documentary evidence of re- review of VTE risk assessment contained within the medical records of all patients.	Corporate teams	
		Ward 9/10 nursing staff have been reminded of the policy to sign for the application of anti-embolic stockings if prescribed.	Unit Nurse Director	16th March (complete)
		All nursing staff will be reminded by email and in Ward Sisters/Matrons meetings the need to comply with this policy	Unit Nurse Director	24.04.18 raised in Matrons meeting; 25.04.18 email sent to Ward Sisters and Matrons re-iterating compliance with policy.
		A review of compliance will take place in May 2018. Following the letter received from HIW on the 12th	Unit Nurse Director	Completed 12/04/18

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		April 2018 outlining immediate improvement plan not accepted an audit was undertaken on compliance with VTE assessment, prescription, re-assessment documentation which showed performance was below an acceptable standard. Following this audit further education and communication was provided to the teams. A further audit will take place during the first week of May 2018. The policy is due for revision in June 2018 and consideration will be given to the addition of a nursing assessment/care plan/ evaluation (to be contained in the medical records) of the application and care for a patient who has been prescribed anti-embolic stockings. The results of the audits will inform the development of the revised Health Board policy due June 2018.	Unit Nurse Director and Unit Medical Director to liaise with ABMU corporate team	Completed – Corporate teams informed week commencing 19/03/18.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Ward and theatre staff will put in place a clear standard operating procedure to clearly identify the documentation (including VTE assessment) that will accompany patient to theatre and how this will be addressed intraoperatively. This has been included in the SOP for the booking and delivery of trauma surgical procedures through operating theatres (Princess of Wales Hospital).	General Manager Clinical Support Services	Completed 25/04/18
The health board is required to provide HIW with details of the action taken to promote effective and timely care to those patients requiring surgery as a result of trauma injuries. Consideration must be given to the arrangements for the daily trauma meeting to ensure there is input from relevant multidisciplinary team members. In addition, consideration must be given to how changes to trauma operating lists are managed and communicated to relevant staff teams.	3.4 Information governance and communications technology 5.1 Timely access	The Units Clinical Support Services and Surgical Services Groups will work collaboratively to review and finalise a clear Standard Operating Procedure for the scheduling and booking of trauma lists, which will provide a structure for better communication and less cancellations. The service currently operates all day trauma lists on Monday, Tuesday and Friday. It has been	GM Clinical Support Services (GMCSS)/ GM Surgical Services (GMSS) Clinical Lead - Trauma (CLT)	Completed 25/04/18 Completed on 9th April 2018, formalised with

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		agreed that the Trauma 'Consultant of the Day' will identify a golden patient by 4pm on the previous day for these lists. Identifying this golden patient will enable the trauma sessions to start on time. The remaining list order will be decided at the morning 'post intake' ward round. This list will only include patients who are identified as ready and optimised for surgery that day thus allowing appropriate robust anaesthetic review and preparation of equipment by the theatre staff		written SOP 25.04.18
		The service operates a split CEPOD and trauma day on Wednesday and Thursday (with trauma list in the afternoon). A golden patient will be identified by 4pm the day before, with the remainder of list organised as per Point 2 above to allow safe preparation for a 13.30 start.	CLT	Completed on 9th April 2018, formalised with written SOP 25.04.18

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The post take ward round (which the HIW Peer Review members referred to as the 'Trauma Meeting') has been reviewed following HIW feedback. It has been agreed that this meeting will commence at 8am (i.e. earlier than previously). All trauma patients will be reviewed and those identified as fit for surgery will be discussed with the Trauma team and the final list order agreed definitively by 08.15. The Trauma Nurse Practitioner (or in their absence, the SpR) will personally and directly inform theatres and communicate the necessary details including patient order / special equipment / special patient considerations etc.	CLT/ Clinical Director Surgery (CDS)	Completed on 9th April 2018, formalised with written SOP 25.04.18
		The Theatre Coordinator will ensure this list is input to TOMS (theatre	Theatre Matron/GMCSS	9th April 2018 (complete)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		management system) immediately.		
		It has been agreed since the HIW Review with the Trauma Lead Consultant that the Team Brief will start at 8:40am in theatre with all the key individuals including senior operating surgeon, consultant anaesthetists and relevant theatre team present using a silent cockpit approach. If any changes to the list order are identified in Team Brief it will be agreed with all present (i.e. so all issues are understood and everyone is focussed on what has to be done for patients safety and efficiency). The Team Leader in the Team Brief will ensure TOMS is immediately amended	CLT/CDS/Clinical Director Anaesthetics and Theatres (CDAT)	Completed on 9th April 2018, formalised with written SOP 25.04.18
		Ward 9 and 10 (i.e. orthopaedic wards) will be given access to the TOMS scheduler to view the theatre	GMCSS	28th March 2018 (complete)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		list (as entered by theatre staff after the post take ward round and Team Brief) so that each patient can be prepared appropriately and achieve a safe and efficient flow to theatre for their procedures. The Unit recognises the lack of an orthogeriatric service. The Unit Directors will discuss as a priority with Executive colleagues the need to identify resource to advertise and appoint 2 x orthogeriatricians to reduce post-operative length of stay and innovatively to help provide physician support pre operatively to trauma patients to optimise them for treatment / rehabilitation. (This timescale will be informed by the receipt of the final and detailed HIW report which identifies the lack of an orthogeriatric service in POW).	Service Director and Unit Medical Director POW	30th April 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The Unit has (since Feb 3rd 2018) had additional trauma sessions allocated. The Unit believes that with more efficient use of all trauma sessions and correct optimisation and prioritisation there should be enough trauma theatre provision in the working day to deal with urgent trauma such as fractured neck of femur. Out of hours operating and cancellations will be reviewed after one month of the actions listed in this plan.	GMCSS/GMSS	7th May 2018
		The existing weekly theatres utilisation report, which is reviewed by Clinical Directors and General Managers of the two Service Groups has been modified to include trauma cancellations. The reasons for these cancellations are discussed to pick up on any themes that need addressing.	GMCSS/GMSS	30th March 2018 (complete)

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): Jamie Marchant

Job role: Service Director Princess of Wales Hospital

Date: 26.03.2018

Appendix C – Improvement plan

Hospital: The Princess of Wales Hospital

Ward/department: Main Theatres and Ward 10

Date of inspection: 13, 14 and 15 March 2018

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 is required to provide HIW with details of the action taken to demonstrate that: a verbal handover of patients from the ward to theatres takes place all relevant documentation accompanies patients to theatres	3.2 Communicating effectively	• Liaised with theatres and ward staff to ensure handover of Pre-operative checklist takes place within the ward. Ward manager and senior staff to ensure all staff on ward 10 observe handover to ensure/promote best practice. • The pre-operative marking verification checks identified on the checklist as Point 2 request that prior to leaving	Matron/Ward Manager Matron/Ward Manager	Completed June 2018 Completed June 2018

The post-operative handover includes all information set recommended by the NatSSIPs.		ward, surgical site mark is inspected & confirmed against notes. All notes accompany patient to theatre. • Ward staff need to handover the patient to theatre, checking the site for surgery and signing documentation. This can be audited against the ward/theatre signature documentation to measure compliance. Incidents can be audited through Datix. • Feedback to be provided to staff at regular ward meetings around compliance. • The post operative handover from recovery to ward staff is now embedded in our processes and is part of our LocSSIP. This is verified on TOMS.	Ward Manager/Ward Staff Ward Manager Ward 10 Service Manager, Clinical Support Services	Completed June 2018 June 2018 Completed May 2018
The health board is required to provide HIW with details of the action taken to appoint an orthogeriatrician.	6.1 Planning Care to promote independence	The feedback on the lack of an Orthgeriatric service within POW was raised by the Unit at the Annual Performance Review with the Executive Team on May 9th. There have been a number of meetings to discuss the model which could be implemented in POW and further meetings planned with colleagues	Unit Service Director/Unit Medical Director	31st July 2018

		from external hospitals. This will inform the submission of a formal model and case to the Executive Team in July 2018.		
The health board is required to provide HIW with details of the action taken to increase patients' awareness of the procedure on how to make a complaint.	6.3 Listening and Learning from feedback	Friends and Family leaflets are available on wards as well as information on how to make a complaint. The ABMU website provides information to those who wish to make a complaint and how to do so.	Unit Nurse Director	Completed May 2018

Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to demonstrate: all relevant members of the team are present at the safety briefing and an appropriate record made confirmation that venous cannulae have been flushed (taking into account PSN 014/ July 2015) debriefings take place as part of the WHO Surgical Safety Checklist and Five Steps to Safety Surgery.	2.1 Managing risk and promoting health and safety	The team brief is documented on TOMS. A letter has been sent to all surgical and anaesthetic staff outlining the safety requirements for operating theatres and outlining very clearly the expectation that they are all actively participating and present at the team brief. This is now superseded by PSN 040 which sets out requirement to confirm and document flushing or removal of lines from the recovery unit, prior to transfer out by September 2018. It is included in the LocSSIP for sign out from theatre and also handover communication from recovery to the ward and the patient care plan is the printed document which will evidence this. The letter signed by the Unit Medical Director, Nurse Director and Service Director outlines the absolute requirement for debriefs to take place especially after a case where the plan has deviated or some element of the case could have been improved upon.	Clinical Director, Anaesthetics & Theatres/Service Group Manager, Clinical Support Services Clinical Director, Anaesthetics & Theatres/Matron Unit Service Director/Unit Medical Director/Unit Nurse Director	Completed June 2018 Completed May 2018 Completed June 2018

		This will be followed up in a joint audit meeting in July 2018 where theatre related incidents and learning will be discussed in detail.	Clinical Director, Anaesthetics & Theatres/Clinical Director Surgery	18/07/18
The health board is required to provide HIW with details of the action taken to demonstrate that nursing staff have assessed patients for their risk of falls and appropriate action is being taken to help prevent falls.	2.3 Falls prevention	New Falls policy to be ratified and rolled out across the Health Board. Current policy due for renewal.	Unit Nurse Director (as ABMU Falls Lead)	31/08/18
		New Falls Multifactorial risk assessment to be piloted on ward 10.	Senior Matron/Matron/ Ward Manager	31/08/18
		Documentation POINT reviews to be actioned monthly and checked by senior matron. Action Plan from the review to be completed and discussed with ward staff.	Senior Matron/Ward Manager	Completed May 2018
		Audit number of falls monthly through Datix and governance team according to severity. As part of this process, all patient falls	Unit Nurse Director/Senior	Completed (monthly,

		resulting in harm require a full Root Cause Analysis investigation. This is presented to falls scrutiny panel for discussion with the outcome of the RCA clarifying if the fall was avoidable or not. Lessons learnt to be fed back to the ward staff at team meetings. Ward Manager to up-load minutes and RCA to Datix incident report for closure. Equipment - Introduction of High low beds/crash mats to nurse patients at risk of falls	Matron Ward Manager Unit Nurse Director (Health Board lead for falls)	ongoing) Completed monthly (ongoing) Completed March 2018
The health board is require to provide HIW with details of the action taken to demonstrate that: patients are not fasted for longer than is necessary prior to surgery nursing staff have completed nutritional risk assessments for patients and reassessed patients as appropriate.	2.5 Nutrition and hydration	• Work is currently being undertaken regarding the standard of communication following the daily trauma meeting. Particularly in relation to any changes to the order of the theatre list preventing patients being fasted for longer than necessary. • As part of a documentation audit, the ward is reviewed monthly against its compliance with completion of the	T&O Nurse Practitioner/ Trauma Consultant Ward Manager/Ward	Commenced June 2018 Completed June 2018

		nutritional risk assessment and re assessment. All patients have access to sit on weighing scales and where appropriate referral to dietetic services.	Staff	
		• The information collated as part of the monthly review can provide assurances that nutrition and hydration remains pivotal to ongoing rehabilitation. Where the audit identifies areas that require improvement, the ward manager will be required to develop an action plan, which will be shared with all health professionals.	Matron/Ward Manager	31/07/18
		• We have also undertaken teaching sessions with ward staff about the importance of post op hydration and nutrition as part of ERAS pathway. We have developed a post op care plan for NOF patients with this criteria added in.	Trauma & Orthopaedic Nurse Practitioner	Since 2017 (ongoing)
		• We have also developed a new integrated care plan for #nof patients that explicitly states the importance of minimising nil by mouth (NBM) period and we are also planning to begin	Trauma & Orthopaedic Nurse Practitioner	30/09/18

		prescribing preload (carbohydrate loading) for this patient group as part of the ERAS approach. Fasting protocol is as follows: • Patients for AM theatre list - No solids from 2 am and water only until 7 Am (Morning theatre list commences at 9 AM) • Patients for PM theatre list – Light early breakfast before 7 AM and water allowed until 11 am (Afternoon theatre list commences at 1PM) • 6 hours fasting period for food and 2 hours for water.	Trauma & Orthopaedic Consultant/Trauma & Orthopaedic Nurse Practitioner Trauma & Orthopaedic Consultant/Trauma & Orthopaedic Nurse Practitioner Trauma & Orthopaedic Consultant/Trauma & Orthopaedic Nurse Practitioner	Completed April 2018 Completed April 2018 Completed April 2018
The health board is required to provide HIW with details of the action taken to ensure the appropriate and safe storage of intravenous and local anaesthetic drugs in theatres to promote patient safety.	2.6 Medicines management	This was picked up during the visit debrief and a new storage cabinet has been ordered for recovery and is in place.	Service Group Manager, Clinical Support Services/Matron	Completed May 2018

The health board is required to provide HIW with details of the action taken to improve the storage of equipment both on the ward and in theatres.	2.9 Medical devices, equipment and diagnostic systems	• Additional storage space for disposable equipment and some mechanical has been identified at the end of one of the bays, which has now been sectioned off. • Limited Storage within ward 10 impacts on the ward environment with many of the patients requiring aids for mobility. Additional storage has been requested which needs to be located close to the ward for easy access. • We are actively trying to secure a suitable space located closely to theatres for appropriate and safe equipment storage. Business cases have been prepared and submitted to previous senior management but appropriate space is at a premium. There is an opportunity again in late 2018 to look at a vacated space below theatres, which has the potential to help address this problem. A small project planning group will be established to explore this further and develop case for capital consideration by 31st December 2018.	Ward Manager/Senior Matron Ward Manager/Senior Matron/Estates Officer Unit Service Director/Service Group Manager, Clinical Support Services	Completed May 2018. 31/08/18 31/08/18

The health board is required to provide HIW with details of the action taken to ensure: patients have their temperature checked on arrival to the anaesthetic room. Nursing staff are completing all the key elements of a pain assessment and consistently monitoring patients' pain (consideration must be given to those patients who are unable to verbalise their pain).	3.1 Safe and clinically effective care	Patients have their temperature checked on arrival in the anaesthetic room and this is recorded on TOMS. Spot-check audits by senior theatre staff will be undertaken to confirm compliance in June 2018. Acute Pain Service (APS) have completed and disseminated audit on pain management in fractured neck of femur patients – disseminated to ED and Orthopaedics 11.05.18. Action plan for all departments has been provided, APS will present results to Matrons & Ward Managers at Professional Nurse Forum in July 2018. Ward Manager Ward 10 has added pain assessment compliance and use of appropriated pain assessment tools to monthly documentation checks Acute Pain Service completed an audit on pain assessment compliance May 2018 within all surgical and ICU areas – in the process of completing data analysis and will be disseminated to Wards/Matrons/Professional Forum	Matron Pain Assessment Team Ward Manager Ward 10 Acute Pain Service/Ward Managers/	Completed 29/06/18 18/07/18 Completed May 2018 Data analysis to be completed by

		meetings Acute Pain Service has requested that compliance to pain assessment documentation is added to the All Wales Health Care Monitoring System [metrics]. Proposed indicators sent to Matron Clinical Support Services. APS currently awaiting response; if cannot be incorporated for designated wards onto the All Wales Health Care Monitoring System [metrics] then to be discussed at Professional Forum Meeting to arrange monthly quality indicators checked by Ward Managers or Matrons. **Ongoing measures in place:** Acute Pain service deliver pain management study days to all surgical areas, which incorporates pain assessment requirements and tools available for patients unable to verbalise their pain Acute Pain service deliver pain assessment session within Mandatory training days at Princess of Wales	Matrons Matron/Pain Assessment Team Pain Assessment Team	W/C July 23rd 2018 for dissemination 31/08/18 Completed May 2018 Completed

		Hospital, which incorporates pain assessment requirements and tools available for patients unable to verbalise their pain Pain assessment tools for clients unable to verbalise their pain accessible on COIN Each patient is reviewed on a daily basis with a check for compliance to pain assessment documentation [including PCA/Epidural and spinal observations] and feedback to staff if there are gaps observed, if there are repeated gaps an IR1 would be submitted. Compliance with attendance at Acute Pain Study Day's sent to all Ward Managers to book training and updates as required	Pain Assessment Team Ward staff Pain Assessment Team Pain Assessment Team	May 2018 Completed May 2018 Completed May 2018 Completed May 2018
The health board is required to provide HIW with details of the action taken to ensure staff within the pre-assessment clinic have access to a suitable fax and printing equipment.	3.4 Information governance and communications technology	Pre-Assessment clinic currently have access to a fax facilities this is required to allow the department to receive medication lists from the General Practitioners. However, staff are increasingly able to access this information	Service Group Manager, Surgery/Matron	Completed June 2018

		via the clinical portal. Occasionally staff are required to fax information to the GP. There are currently 4 printers available in the department; this is deemed adequate for their needs.	 Service Group Manager, Surgery/Matron	 Completed June 2018
Quality of management and leadership				
The health board is required to provide details of the action taken: in response to the comments raised by ward staff during the inspection To support staff to attend training relevant to their continuing professional development. .	7.1 Workforce	Delivery Unit has developed a job description for a CPD position, this post will undertake a training needs analysis for the ward area. The post has been approved by the vacancy control board with the expectation of an appointment in place by Autumn 2018. In-house training needs to be provided by the specialist nurses and practitioners have been asked to deliver on ward-based education bites to support staff development. Ward Manager's supernumerary status will support the backfill for staff to be released. Unit Nurse Director authorised Ward	Unit Nurse Director/Senior Matron Matron/Ward Manager Matron/Ward Manager	September 2018 31/07/18 Completed April 2018 Completed

		Manager to request bank/agency cover for an increase in Health Care Support Workers, to improve patient safety and quality of care.	Unit Nurse Director	June 2018
		Unit Nurse Director has submitted nurse staffing act risk assessments to the Health Board NSA (Nurse Staffing Act) Task & Finish Group. The risk assessment is on the POW Delivery Unit's risk register, which includes the need for an increase in funded establishment for Health Care Support Workers. Risk mitigated as outlined in narrative above.	Unit Nurse Director	Completed February 2018
		Nurse Staffing Act options were presented by the Interim Director of Nursing & Patient Experience to the Board on Monday 25th June. Approval given to progress towards attainment of the staffing levels, as laid down in the Nurse Staffing Act (Wales) for acute medical and surgical wards in ABMU.	Interim Executive Director of Nursing & Patient Experience	Completed 25th June 2018.
		Unit Nurse Director and Senior Matron will meet with Ward Staff along with the newly appointed Matron for Ward 10, whose start date is 30th July 2018, in response to the	Unit Nurse Director	31st August 2018

		comments raised by Ward Staff during the inspection.		

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): **Mr Jamie Marchant**

Job role: **Service Director**

Date: **28/06/2018**