Follow-up Inspection (Unannounced)

Surgical Services: Trauma and Orthopaedic, Bronglais Hospital, Hywel Dda University Health Board

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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 follow-up inspection of surgical services at Bronglais Hospital, Aberystwyth within Hywel Dda University Health Board on 11 September 2018. The following clinical areas were visited during this inspection:

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

Our team, for the inspection comprised of two HIW Inspectors and two clinical peer reviewers (a theatre manager, a senior nurse). The inspection was led by a HIW inspection manager.

The purpose of this inspection was to follow-up on the improvements identified at the last inspection conducted in July 2017.

Further details about how we conduct follow-up inspections can be found in Section 5.

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

2. Summary of our inspection

Overall, we found evidence that the service strived to provide safe and effective care. However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection. However, some areas remained in need of improvement and these are referred to in more detail within the relevant sections of this report.

This is what we found the service did well:

- Responsiveness to areas for improvement highlighted during the previous inspection
- Management overview and visibility on the ward
- Provision of physiotherapy support
- Staff interactions.

This is what we recommend the service could improve:

- Staffing levels
- Social care assessments
- Some elements of infection control and general risk assessments
- Provision of meals
- Communicating with patients
- Storage of equipment.

3. What we found

Background of the service

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

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

The key areas for improvement we identified during the previous inspection included the following:

- Blood transfusion process
- Administration of oxygen to patients on transfer from theatre to recovery area
- Reporting and decision making arrangements
- The handover of information by staff before and after patients' operations
- Ensuring timely access for patients needing trauma surgery
- Ensuring patients are not fasted longer than necessary
- The completion of key safety steps in theatre
- Ensuring a consistent approach for reporting patient safety incidents.

Immediate improvements we identified during the previous inspection

Standard 2.8

- To promote patient safety and foster a consistent approach to learning from patient safety incidents, the health board is required to inform HIW of the action taken to ensure that:
    - staff responsible for administering blood products complete all the appropriate safety checks and document these in accordance with the health board's policy on administering blood products
    - a consistent approach is taken by staff for the reporting of blood product related incidents.

Actions the service said they would take

- Ward Sister and Senior Nurse Manager immediately ensure only the All Wales Blood transfusion prescription forms are available on the ward
- Ward Clerk will check weekly that only the All Wales blood transfusion forms are available on the ward
- Ward Sister will ensure all Registered Nurses (RNs) are aware of the appropriate safety checks and documentation when administering blood products
- All RNs on Ceredig Ward will demonstrate they have read and understood the health board's Transfusion Policy
- Both RNs involving in administering the blood will be booked on blood transfusion update training
- Blood transfusion training records and competencies will be checked for all RNs on Ceredig Ward to demonstrate competency

- Senior Nurse Manager for Ceredig will carry out weekly spot checks of compliance with the blood transfusion policy weekly for 6 weeks and spot check thereafter

- Letter to all clinical areas in Scheduled Care[2] reminding staff of the need to comply with the health board transfusion policy and the need to Datix[3] report any blood transfusion incidents

- Spot checks of compliance with the blood transfusion policy will be undertaken across all acute hospital areas

- All staff will be made aware of the process for reporting incidents related to blood products on the Datix system.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Immediate Improvement Plan.

Immediate improvements we identified during the previous inspection

Standards 2.1 and 2.6

- The health board is required to provide HIW with details of the action taken to promote patient safety at times when patients are transferred from the operating theatre to the recovery area. More specifically, HIW requires assurance with regard to the availability and administration of supplementary oxygen to patients whenever necessary.

[2] Scheduled care is a term used to describe any health or social care that is planned in advance.

[3] Datix is a web-based patient safety incident reporting and risk management software for healthcare and social care organizations.

Actions the service said they would take

- A letter will be disseminated to all clinical staff in Theatre, Day Surgery Unit and Anaesthetics across the health board reminding them of their responsibilities to comply with evidence base
- Spot checks of practice in all Theatres will be carried out.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Immediate Improvement Plan.

Immediate improvements we identified during the previous inspection

Governance, leadership and accountability and Standard 7.1

- The health board is required to provide HIW with details of the action to be taken to promote the provision of safe and timely patient care, to include the following:
- How staff working across the health board are made aware of the correct lines of reporting applicable to the areas in which they work/have responsibility
- The arrangements in place to empower staff to make decisions in a timely way.

Actions the service said they would take

- Scheduled Care structure to be disseminated to all Triumvirate teams and clinical teams in Scheduled Care
- All staff within Scheduled Care will be reminded of their line management and escalation arrangements
- Review of the Emergency Pressures and Escalation Procedure to be reviewed on each hospital site and communicated as appropriate. Specifically ensure standard operating procedures are in place for all escalation areas across all hospital sites.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Immediate Improvement Plan.

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 we spoke with during the course of the inspection generally expressed satisfaction with the care and treatment received. Patients told us that staff were kind and caring. We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner. We saw staff attending to patients in a calm and reassuring manner.

Communicating effectively

Improvements we identified during the previous inspection

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

Actions the service said they would take

- Two surgical inpatient pathway meetings have been held on 19th May and 28th July with Ceredig Ward and Theatre staff. A schedule of monthly meetings will be put in place
- An observational audit of handover from Ward to Theatre will be evidenced monthly for 3 months to ensure this is embedded in practice
- The handover between Theatre and Recovery will be standardised by agreeing a set of criteria for handover
- Staff have been reminded via a letter to introduce themselves to patients
- An audit as part of a quality improvement initiative will be conducted on Ceredig Ward to establish if staff introduce themselves

- The outcomes of the audit outcomes will be shared at ward meetings and the Scheduled Care Quality, Safety, Experience meeting
- We will launch the "Hello my name is..." campaign[4] on Ceredig Ward following the initial audit
- We will re-audit patient's experience of staff introductions to ensure this is embedded in practice.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that the majority of the above areas for improvement had been actioned as reflected in the Improvement Plan.

Although we found evidence that two Surgical Inpatient Pathway Meetings had been held on 19th May and 28th July with Ceredig Ward and Theatre staff, a schedule of monthly meetings has not been put in place.

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner.

Patients told us that staff generally took time to explain things to them. However, one patient mentioned that this did not happen consistently and that they had not been given accurate information about the need for them to refrain from eating or drinking prior to surgery. They also mentioned that they had been moved from another ward and moved to different locations within the ward without any explanation.

Improvement needed

The health board should ensure that monthly Surgical Inpatient Pathway Meetings take place, as indicated in the Improvement Plan drawn up following the previous inspection.

The health board must ensure that staff communicate effectively with patients and that patients are given comprehensive information and clear explanation in

[4] [4] "Hello my name is…" is a campaign which encourages staff to introduce themselves.

relation to all aspects of the care provided.

Timely care

Improvements we identified during the previous inspection

- The health board should make arrangements to ensure that relevant information around patients' home circumstances, which could affect their discharge home following surgery, is obtained and shared with relevant staff in a timely manner. This is with the aim of preventing delays in patient discharge as far as practicable
- The health board must make arrangements to ensure the timely admission of patients from the emergency department onto the trauma ward
- The health board must make arrangements for reducing the time it takes for elderly trauma patients to undergo surgery
- The health board must make arrangements to ensure a clear system for prioritising patients and listing patients for unplanned surgery.

Actions the service said they would take

- Conduct a review of information collected at pre-assessment and actions taken to ensure patient's social care needs are identified and communicated
- The Red to Green initiative[5] has been implemented on Ceredig Ward at Bronglais Hospital in July 2017. The Red to Green initiative will be further rolled out in all our Trauma and Orthopaedics Wards

[5] Red to Green is an initiative which defines 'red days' as those days that fail to contribute to a patient's discharge from hospital and by working better together, staff can reduce red days in favor of value-adding 'green days'. 'Green days' are where a

- Data from Red to Green is being collected. We will analyse the data to identify reasons for delays and identify solutions to barriers
- Monitor length of stay and reasons for delays to ensure that no delays are attributable to poor assessment and planning
- Implement a pre alert for fracture neck of femur (FNOF) to ensure that the hospital is aware of a patient coming in and is able to promptly respond to the patient assessment and identify and prepare a bed in the most appropriate ward
- The principle of ring fencing a trauma bed will be embedded within the escalation and site management principles in the same way as stroke bed etc. To aim to retain a protected bed at levels 1-3 of escalation
- Finalise and implement the trauma database to reduce the time it takes for elderly patients to undergo surgery and to prioritise patients for surgery.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that the majority of the above areas for improvement had been actioned as reflected in the Improvement Plan.

However, on inspecting a sample of care files, we found that pre-assessments of social care needs were not being undertaken routinely.

The Red to Green initiative was implemented as stated in the action plan. However, this was found not to be working as effectively as anticipated. A modified initiative has since been adopted and was in operation at the time of this inspection.

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patient receives an intervention that supports their care pathway out of hospital and into the best setting for their needs.

Although there had been some improvement in the time taken for patients with a fractured neck of femur to be operated on, we found that delays were encountered in some cases. These were attributed, in the main, to delays in undertaking some pre-operative investigations and tests. This issue is further confounded by the fact that there is no dedicated trauma list, and there remains to be only two theatres in operation within the hospital. It is envisaged that the refurbishment work on the other two theatres will be completed in November 2018. However, we were informed that the intensive care unit will be temporarily moved into the newly refurbished theatres for a period of time whilst the unit is refurbished. Theatres will then be operational once this work is complete.

We found that a pre alert system was in operation for patients with fractured neck of femur. We saw medical staff responding in a timely fashion to such admissions and confirmed that 100% of patients were transferred from the emergency department onto the ward within the expected four hours time frame.

We were informed that the principle of reserving a bed to be used solely for patients who have sustained a fractured neck of femur was not always implemented consistently, due to pressures on bed availability within the hospital at certain times.

We found that the staff on the ward worked well with other members of the multi-disciplinary healthcare team to provide patients with individualised care according to their assessed needs.

Improvement needed

The health board must ensure that pre-assessments of patients' social care needs are undertaken routinely and that these assessments are formally documented within care files.

The health board must continue to audit the patient care pathway to ensure that patients receive timely care and treatment and that no delays are attributable to poor assessment and planning.

The health board must continue to monitor the practice of reserving a bed to be used solely for patients who have sustained a fractured neck of femur, to ensure that patients receive timely care and treatment.

Individual care

Planning care to promote independence

Improvements we identified during the previous inspection

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

Actions the service said they would take

- Physiotherapists to put in place a mobilisation plan for elderly trauma patients on Ceredig Ward in week and at weekends
- Nursing staff on Ceredig Ward to be reminded at handover and in ward meetings of their responsibility to mobilise patients and implement the mobilisation plan
- Retrospective review of National Hip Fracture Database (NHFD)[6] to determine if the non operative rate of hip fracture in BGH is a trend
- NHFD meeting will monitor and scrutinise reasons for non operative treatment of hip fractures.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that the majority of the above areas for improvement had been actioned as reflected in the Improvement plan.

However, we found that the fractured neck of femur care pathway was not being fully implemented. We were told that the documentation was currently under review.

We found that there was generally good care planning processes in place which took account of patients' views on how they wished to be cared for.

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[6] http://www.nhfd.co.uk/

Through our conversations with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their care needs.

Improvement needed

The health board must complete the review of documentation and formalise and fully implement the fractured neck of femur care pathway without further delay.

Listening and learning from feedback

Improvements we identified during the previous inspection

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

Actions the service said they would take

- A simple patient information sheet has been implemented to tell patients who is looking after them and how to get information or raise concerns
- Patient feedback forms and a feedback box have been implemented to provide an opportunity to provide real time feedback to help us understand what patients think of the ward and their care. The Ward Sister and Senior Nurse will review these weekly. This will be shared at Ceredig Ward meetings and the Scheduled Care Quality, Safety, Experience meetings
- The Ward Sister undertake a daily walkabout of patients to seek feedback and resolve any concerns
- Ceredig Ward will conduct the Health and Care Standards Patient Survey monthly for 6 months. The Ward Sisters and Senior Nurse will review findings and evidence appropriate action. This will be shared at Ceredig Ward meetings and the Scheduled Care Quality, Safety, Experience meetings
- Putting Things Right leaflets are available in the day room and stock will be checked weekly by the Ward Clerk
- Identify other opportunities to proactively seek patient feedback and utilise the support from the Assistant Director Patient Experience.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that the majority of the above areas for improvement had been actioned as reflected in the Improvement Plan.

However, on inspection we found that there were no Putting Things Right posters or leaflets available on the ward on the day of the inspection.

Improvement needed

The health board must ensure that Putting Things Right posters and leaflets are made available on Ceredig Ward, and that the stock of leaflets is checked on a regular basis, as indicated in the Improvement Plan drawn up following the previous inspection.

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 the staff team were committed to providing patients with safe and effective care.

Suitable equipment was available and being used to monitor patients' condition and to help prevent patients developing pressure sores and to prevent patient falls.

The ward was clean and arrangements were in place to reduce cross infection. However, some issues remain in relation to safe storage of equipment on the ward.

There were formal medication management processes in place.

Managing risk and promoting health and safety

Improvements we identified during the previous inspection

- The health board should make arrangements to review the storage of equipment on the ward and take action as appropriate to reduce the risk of injury to patients and staff
- The health board must make arrangements to promote a consistent approach for the reporting of patient safety related incidents and shared learning.

Actions the service said they would take

- The Senior Nurse Manager and Assistant Site Operations Manager, Estates have done a full walkabout to review storage and equipment on Ceredig to identify improvement opportunities
- Findings from the walkabout will be recorded, an action plan developed and progress reported through Ceredig Ward meetings and the Scheduled Care, Quality, Safety, Experience meetings

- Non essential equipment in corridor to be removed and Senior Nurse Manager Scheduled Care and Senior Sister Ceredig to monitor daily and address inappropriate storage concerns as they arise
- Storage of surplus beds will be addressed once the identified library store has been refurbished
- Risk assessments to be completed to evidence the environmental review and safeguards put in place to mitigate risk to patients particularly at risk of falls
- Standards for Datix incident reporting to be disseminated via a letter to Theatre and ward staff form the Head of Nursing Scheduled Care
- All Theatre and ward staff reminded to use NHS Wales email address when reporting incidents on Datix (to receive feedback)
- Themes from incidents and lessons learned to be a regular feature on Theatre meeting agenda to be evidenced through team meeting minutes.

What we found on follow-up

During this inspection we confirmed through discussions with staff and examination of documents, that the majority of the above areas for improvement had been actioned as reflected in the Improvement Plan.

We found that non essential equipment was being appropriate stored when not in use. However, the ward corridor appeared cluttered, particularly during the busy morning period when there was greater use of equipment such as trolleys and hoists. This requires monitoring.

We were informed that the majority of staff had been allocated NHS Wales e-mail addresses and that this was being checked during individual performance and development review meetings. However, due to the number of staff members involved, this was still an on-going process.

Improvement needed

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

The health board must continue with the task of allocating all staff with NHS Wales e-mail addresses.

Improvements we identified during the previous inspection

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

Actions the service said they would take

- Principles for the placement of patients on Ceredig Ward to be drafted and implemented
- The Hospital Site Team will adhere to the infection prevention and control principles when allocating beds on Ceredig Ward
- All patients will be discussed at bed meetings to ensure that Infection Prevention and Control issues have been considered
- Exceptions in compliance to be Datix incident reported and monitored by the Senior Nurse Manager

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Improvement Plan. However, we feel that the mix of patients on the ward requires continuous monitoring to ensure that there is adequate segregation between trauma, orthopaedic and general surgery patients to reduce the risk of cross infection. This is particularly important for protection of elective orthopaedic patients undergoing joint surgery.

During a tour of the ward, we found a wooden framed chair stored in one of the bathrooms. This was considered a cross infection risk, since the wood was not impervious to fluids and microorganisms. This was brought to the attention of the Senior Nurse Manager who took immediate steps to have the chair removed.

We also found two, five litre containers of shampoo stored on the floor within two bathrooms. Not only is this a cross infection and a general health and safety risk, having communal shampoo is considered to be institutional practice and should be discouraged. This was brought to the attention of the Senior Nurse Manager who took immediate steps to have the shampoo containers removed.

Improvement needed

The health board must continue to monitor the mix of patients on the ward to ensure that there is adequate segregation between trauma, orthopaedic and general surgery patients to reduce the risk of cross infection.

The health board must discourage the use of five litre shampoo containers for communal patient use on the ward.

Nutrition and hydration

Improvements we identified during the previous inspection

- The health board must make arrangements to ensure that patients are not fasted for unnecessary long periods of time
- The health board should make arrangements to review the quality and availability of meals in response to patient feedback.

Actions the service said they would take

- Data from the recent fasting audit to be fed back to clinical teams
- A letter to clinical teams reminding them of the principles for fasting patients and to Datix incident report if trauma patients are cancelled to be disseminated
- Health Board Fasting Policy to be finalised and implemented
- A follow up fasting audit to be conducted within 6 months of implementation of the revised policy
- The Hospital Head of Nursing and Catering Manager do a weekly survey of patients of patient experience of meals. They will continue to audit 4 patients weekly across all inpatient areas. Any improvement opportunities identified will be actioned accordingly.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Improvement Plan.

However, some of the patients we spoke with told us that the food was not always served in a timely way and as a consequence it was sometimes cold.

Improvement needed

The health board must continue to audit the provision of meals on the ward.

Medicines management

Improvements we identified during the previous inspection

The health board must make arrangements:

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

Actions the service said they would take

- Separate the storage of intravenous and local anaesthetics drugs
- Implementation of the All Wales Theatre Controlled Drug Register
- Every location where CDs are stocked will have the 3-6 monthly check undertaken by Pharmacy in accordance with the Health Board Medicines Policy.

What we found on follow-up

During this inspection we confirmed, through observation, discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Improvement Plan.

Safeguarding children and adults at risk

Improvements we identified during the previous inspection

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

Actions the service said they would take

- A global email will be disseminated to remind staff that the health board adult safeguarding team are the single point of contact for advice and support regarding safeguarding concerns and / or referrals
- The flowchart for adult safeguarding referrals will be updated and uploaded to the Health Board Intranet Site
- Adult safeguarding training in the health board will reinforce that the health board adult safeguarding team are the single point of contact for advice and support.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Improvement Plan.

There were no active safeguarding issues at the time of this inspection.

Effective care

Safe and clinically effective care

Improvements we identified during the previous inspection

- The health board must make arrangements to ensure that the standards for the Five Steps to Safer Surgery[7] are met
- The health board must make arrangements to ensure that Venous Thrombosis Embolism (VTE) risk assessments are consistently completed

[7] Five Steps to Safer Surgery is a surgical safety checklist. It involves briefing, sign-in, timeout, sign-out and debriefing, and is now advocated by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures.

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

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

Actions the service said they would take

- Letter to Theatre staff reminding them of the importance of the Five Steps to Safer Surgery

- Audit of compliance to be completed monthly for 3 months

- Existing VTE risk forms to be reviewed with a view to amalgamating

- VTE risk assessment forms to be kept with drugs charts

- Monitor and respond to Health Board VTE Risk assessment compliance audit results

- Audit of recording temperatures during the intra operative stage of surgery

- An audit of pain scores and pain control has been conducted on Ceredig and Rhiannon Wards and will be repeated monthly for 6 months

- The outcome of the audit will be discussed with the multidisciplinary team and at ward meetings and action plans developed as appropriate

- A review of pain management across the Surgical patient pathway will take place with the multi-disciplinary team through the Surgical Patient Pathway meeting to ensure patient's needs for pain relief are met.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as reflected in the Improvement Plan.

Anti-embolism compression stockings were being prescribed and administered to patients. However, staff applying the stockings were not signing the administration charts to reflect this.

Improvement needed

The health board must ensure that staff sign administration charts when they administer prescribed anti-embolism compression stockings to patients.

Record keeping

Improvements we identified during the previous inspection

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

Actions the service said they would take

- Letter to reiterate the standards of record keeping to be issued to nursing and medical staff in Scheduled Care.

What we found on follow-up

During this inspection we confirmed, through examination of documents, that the above area for improvement had been actioned as indicated in the Inspection Plan.

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 services review and monitor their own performance against the Health and Care Standards.

Overall, we found good management and leadership within the department, with staff commenting positively on the support they received from the department managers.

Staff told us that they were treated fairly at work and that an open and supportive culture existed. The management structure had been amended following the previous inspection. Staff told us that they were aware of the senior management structure within the organisation and that the communication between senior management and staff had improved and was generally effective.

Robust and strong management structure has now been implemented in the operating theatres, and all staff understand when questioned that they knew the correct line of reporting,

It is evident by the information provided that the Theatre directorate and Theatre staff, there is a culture now in place that strives for improvement, this is also evident by the amount of issues that have now been addressed.

Staff and resources

Workforce

Improvements we identified during the previous inspection

- The health board must make arrangements for staff to attend training relevant to their roles.

Actions the service said they would take

- Training Needs Analysis to be completed and used to inform the identification and commissioning of appropriate training for Theatre staff
- Theatre staff in Personal Appraisal and Development Reviews (PADRs) to be reminded of their responsibilities to identify own training needs and maintain continuing professional development
- Format for multidisciplinary team learning to be finalised and training sessions arranged on audit days.

What we found on follow-up

During this inspection we confirmed, through discussions with staff and examination of documents, that all of the above areas for improvement had been actioned as indicated in the Improvement Plan.

However, we found the ward to be very short staffed on the day of the inspection visit. This was due to some staff members having called in sick at short notice. The issue was escalated during the morning and additional staff were secured.

Following the inspection we were provided with information relating to staff training. The information provided showed that not all staff employed on Ceredig Ward had completed all elements of mandatory training.

The health board must continue to monitor staffing levels on the ward and must be proactive in dealing with shortages.

The health board must ensure that all staff have completed all elements of mandatory training.

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 conduct follow-up inspections

Follow-up inspections can be announced or 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. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

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 will also highlight any outstanding areas of improvement that need to be made.

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
During a tour of the ward, we found a wooden framed chair stored in one of the bathrooms.	This is considered a cross infection risk.	This was brought to the attention of the Senior Nurse Manager.	Immediate steps were taken to remove the chair.
We found two, five litre containers of shampoo stored on the floor within two bathrooms.	This is a cross infection and a general health and safety risk. In addition, the use of communal shampoo is considered to be institutional practice.	This was brought to the attention of the Senior Nurse Manager.	Immediate steps were taken to remove the shampoo containers.

Appendix B – Immediate improvement plan

Service: Bronglais Hospital, Ceredig Ward and Theatres

Date of inspection: 11 September 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
No immediate assurance issues were identified during this 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):

Job role:

Date:

Appendix C – Improvement plan

Service: Bronglais Hospital, Ceredig Ward and Theatres

Date of inspection: 11 September 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 should ensure that monthly Surgical Inpatient Pathway Meetings take place, as indicated in the Improvement Plan drawn up following the previous inspection.	3.2 Communicating effectively	A schedule of monthly meetings has been established. Meetings will be evidenced through minutes of each meeting.	David Harrison, Senior Nurse Manager	Complete
The health board must ensure that staff communicate effectively with patients and that patients are given comprehensive information and clear explanation in relation to all aspects of the care provided.		Nursing staff will attend Board Rounds to agree plan of care and communication plan to patient. Patient feedback forms will be reviewed monthly. Pre op and post op information is provided by Consultant and ANP.	David Harrison, Senior Nurse Manager	30th November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Patient diary information continues to be collected. This is scrutinised bi-monthly and action plans to improve service. Discharge discussed with patient on admission and patients and family encouraged to complete their needs on admission.		
The health board must ensure that pre-assessments of patients' social care needs are undertaken routinely and that these assessments are formally documented within care files.	5.1 Timely access	A letter has been sent to pre – assessment staff to remind them of their responsibility to carry out an assessment of patient's social care needs. Monthly spot check audit of pre – assessment records will be carried out for 6 months.	Mandy Nichols-Davies, Head of Nursing Scheduled Care Helen George, Senior Nurse Manager	Complete 30th November 2018
The health board must continue to audit the patient care pathway to ensure that patients receive timely care and treatment and that no delays are attributable to poor assessment and planning.		The Health Board will continue to participate in the NHFD audit. The NHFD monthly meetings held on 3 acute sites will continue to monitor the outcomes for patients. This will include	Lydia Davies, Service Delivery Manager T&O	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the patient care pathway and timely care and treatment and act on any factors which result in poor assessment and planning.		
The health board must continue to monitor the practice of reserving a bed to be used solely for patients who have sustained a fractured neck of femur, to ensure that patients receive timely care and treatment.		The principle of ring fencing a trauma bed is embedded within the escalation and site management principles in the same way as stroke bed etc. The Hospital Site Team aim to retain a protected bed at levels 1-3 of escalation. Seek agreement from WAST to implement a fracture neck of femur pre-alert pre-hospital.	Dawn Jones, Hospital Head of Nursing Dawn Jones, Hospital Head of Nursing	Complete 30th March 2019
The health board must complete the review of documentation and formalise and fully implement the fractured neck of femur care pathway without further delay.	6.1 Planning Care to promote independence	A shared care pathway for patients with a fractured neck of femur has been agreed. Pilots are being planned on each acute site. The Health Board will fully implement the pathway across the 3 hospitals managing T&O.	Mohammed Yaqoob Clinical Lead	30th September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that Putting Things Right leaflets are made available on Ceredig Ward and that the stock of leaflets is checked on a regular basis, as indicated in the Improvement Plan drawn up following the previous inspection.	6.3 Listening and Learning from feedback	The Ceredig Ward Clerk will check and maintain stock daily. The Senior Nurse Manager will do a weekly spot check.	David Harrison, Senior Nurse Manager	Complete
Delivery of safe and effective care				
The health board must continue to review the storage of equipment on the ward and take action as appropriate to reduce the risk of injury to patients and staff.	2.1 Managing risk and promoting health and safety	An onsite Equipment Library is now operational. The Senior Nurse Manager will conduct daily informal environmental checks and a formal monthly spot check audit.	David Harrison, Senior Nurse Manager Scheduled Care	Complete
The health board must continue with the task of allocating all staff with NHS Wales e-mail addresses.		All new staff will be allocated a NHS Wales email address on employment. A review of existing staff on Ceredig will be completed to ensure all staff have a NHS Wales email address.	David Harrison, Senior Nurse Manager David Harrison, Senior Nurse Manager	Complete 31st December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must continue to monitor the mix of patients on the ward to ensure that there is adequate segregation between trauma, orthopaedic general surgery patients, to reduce the risk of cross infection.	2.4 Infection Prevention and Control (IPC) and Decontamination	Patient mix on Ceredig is reviewed daily by the ward managers and Senior Nurse Manager to prevent risk of cross infection. A plan to segregate elective orthopaedic patients is to be identified and proposed.	Dawn Jones, Hospital Head of Nursing Dawn Jones, Hospital Head of Nursing	Complete 30th March2019
The health board must discourage the use of five litre shampoo containers on the ward.		A letter will be sent to all staff to remind them not to share toiletries between patients.	David Harrison, Senior Nurse Manager	30th November 2018
The health board must continue to audit the provision of meals on the ward.	2.5 Nutrition and Hydration	The Hospital Head of Nursing and Catering Manager will continue to undertake a monthly survey of patient experience of meals. Any improvement opportunities identified will be actioned accordingly.	Dawn Jones, Hospital Head of Nursing	30th November 2018
The health board must ensure that staff sign administration charts when they administer prescribed anti-embolism compression stockings to patients.	2.6 Medicines Management	All staff have been informally reminded to sign administration charts when they administer anti-embolic stockings. This will be followed up with a letter. A monthly spot check will take place for	David Harrison, Senior Nurse Manager	30th November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		3 months to monitor compliance.		
Quality of management and leadership				
The health board must continue to monitor staffing levels on the ward and must be proactive in dealing with shortages.	7.1 Workforce	The hospital management team continue to monitor staffing daily through risk assessments. Block booking of contract agency staff will be revisited to improve continuity of care. Work closely with recruitment to actively support the local recruitment process. Several initiatives are underway to "grow your own" including Open University nurse training for Healthcare Support Workers, promotion of part time/return to practice and level 4 training and working with Aberystwyth and Swansea University to have a local school of nursing in Aberystwyth to initially support 20 student nurses. Introduce 6 monthly reviews of staffing levels in line with Nurse Staffing Levels	Dawn Jones, Hospital Head of Nursing Dawn Jones, Hospital Head of Nursing Dawn Jones,	30th March 2019 30th June 2019 30th March

Improvement needed	Standard	Service action	Responsible officer	Timescale
		(Wales) Act	Hospital Head of Nursing	2019
The health board must ensure that all staff have completed all elements of mandatory training.		The Senior Nurse Manager monitors staff compliance monthly. Staff will continue to have access to a monthly mandatory training study day. Mandatory training compliance will continue to be monitored through the staff PADR process.	David Harrison, Senior Nurse Manager	30th March 2019

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): Dawn Jones

Job role: Hospital Head of Nursing

Date: 16/11/18