Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Surgical Services: Trauma and Orthopaedic Care

Royal Glamorgan Hospital, Cwm Taf University Health Board

Inspection date: 25 to 27 September 2018

Publication date: 28 December 2018

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Digital ISBN 978-1-78964-026-7

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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 Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant within Cwm Taf University Health Board on the 25 to 27 September 2018. The following hospital wards and departments were visited during this inspection:

- Pre-operative Assessment Clinic
- Ward 3 Trauma[1] & Orthopaedics (unplanned orthopaedic care)
- Ward 7 Elective Orthopaedics (planned orthopaedic care)
- Operating Theatres Department

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

Whilst we considered the care provided to patients having different types of operations, we focussed on the trauma and orthopaedic services provided at the Royal Glamorgan Hospital. During the course of our inspection, we also reviewed some aspects of the operating procedures within the obstetric (maternity) theatre. This was as a result of the links between obstetric theatres and main theatres, and some risks identified within obstetrics during the inspection.

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] Orthopaedic Trauma is a severe injury to part of the musculoskeletal system, such as bones, joints, or ligaments. Treatment usually requires the services of an orthopaedic surgeon and can require an orthopaedic trauma specialist.

2. Summary of our inspection

Overall, we found evidence that the service provided respectful, dignified, safe and effective care to patients. However, we identified that improvement was required to further promote the safe and effective care of patients admitted with trauma injuries in accordance with National guidance and the Health and Care Standards.

This is what we found the service did well:

- We saw that the main theatre department and the inspected wards were well led and well managed
- We saw good practice within the pre-operative assessment clinic with the use of standardised guidelines and patient pathways
- We identified good intervention and support to help patients stop smoking through the service of a smoking cessation nurse
- We saw good practice in relation to the prevention and management of pressure ulcers
- We saw good use of infection prevention and control procedures, and incidences of healthcare associated infections were low

This is what we recommend the service could improve:

- Ensure timely access to emergency surgery for trauma patients
- Ensure pre-operative patients are not fasted longer than necessary
- Ensure all patients are accurately assessed and treated to reduce the risk of developing a venous thromboembolism[2]

[2] A venous thromboembolism is a blood clot that forms within a vein.

- Ensure daily checking of resuscitation equipment
- Ensure full compliance with the Five Steps to Safer Surgery[3],[4]
- Ensure staff scrub training and competencies are completed within all departments that provide surgical procedures
- Explore interventions to improve staff morale

We had some immediate concerns which were dealt with under our immediate assurance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. These were in relation to: providing timely surgery, prevention of venous thromboembolism, daily checking of resuscitation equipment and completion of staff scrub training and competencies in all surgical departments. Details of the immediate improvements we identified are provided in Appendix B.

[3] The Five Steps for 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.

[4] 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.

3. What we found

Background of the service

Cwm Taf Health Board was established in October 2009 and achieved University status in July 2013. The health board provides primary, community, hospital and mental health services to almost 300,000 people living in Rhondda Cynon Taf and Merthyr Tydfil.

The Royal Glamorgan Hospital is situated in Ynysmaerdy, Llantrisant within Rhondda Cynon Taf, and opened in 1999. The opening of the hospital was in line with the planned closure of the East Glamorgan General Hospital in Church Village.

The Royal Glamorgan Hospital has around 570 beds, and provides a comprehensive range of in-patient, day case and outpatient facilities together with Accident and Emergency and diagnostic facilities, and it also provides maternity services. In addition, the hospital provides critical care services and also has a suite of nine operating theatres.

The hospital's Accident and Emergency department is no longer consultant led due to a restructure of Accident & Emergency functionality along the M4 Corridor in South Wales.

The Acute Mental Health Unit is also based on the Royal Glamorgan site.

The main theatre department consists of nine operating theatres and a recovery area. Within the theatre suite, there is a designated theatre for trauma and emergency surgery and another is used to perform elective (planned) orthopaedic operations. The remaining theatres provide other types of surgical procedures.

Unplanned and planned trauma and orthopaedic surgery lists run every day between Monday and Friday, with unplanned emergency trauma sessions available at the weekend. However, at the weekend (or out of hours), there were not dedicated trauma theatre lists that could be used. Therefore, patients

requiring trauma surgery would be scheduled on the CEPOD[5] (unplanned/ emergency) theatre list.

Ward 3 is a 28 bedded ward that specialises in unplanned trauma and orthopaedic surgery. Patients are usually admitted to the ward via the Accident & Emergency Department, with very few presenting as planned admissions.

Ward 7 is a 22 bedded ward specialising in elective (planned) orthopaedic surgery, where all patients are planned admissions from their usual home following pre-assessment.

The pre-operative assessment clinic is an outpatient service. It is a nurse-led clinic where patients are assessed and it is determined there, if they are physically fit enough to have surgery and an anaesthetic. Patients are also screened for infection at the clinic prior to their elective admission.

The majority of patients requiring knee or hip replacement surgery will also attend joint school[6]. This is to help facilitate enhanced recovery after surgery (ERAS)[7], which improves the quality of care provided to patients undergoing major elective surgical procedures.

The Royal Glamorgan Hospital submits data to both the National Hip Fracture Database (NHFD)[8] and the National Joint Registry (NJR)[9].

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[5] 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

[6] Joint School: Patients attend an education session called Joint School as part of a group, before their operation. A presentation is given by professionals for example, an orthopaedic nurse and physiotherapist, on the specific stages of their care. The stages are explained in detail to give a thorough understanding of what to expect with joint surgery.

[7] Enhanced Recovery after Surgery (ERAS) is an evidenced-based, multi-modal, patient-centred method of optimising surgical outcome by improving both patient experience and clinical outcomes.

[8] National Hip Fracture Database (NHFD) Annual Report 2017 The NHFD is a clinically led, web-based audit of hip fracture care that grew out of collaboration between the British Orthopaedic Association and the British Geriatrics Society and is now managed by the Royal College of Physicians.

[9] National Joint Registry (NJR) 15th Annual Report The NJR looks at National data of planned orthopaedic joint (hip, knee, ankle, elbow and shoulder) surgery outcomes.

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 their overall experience was excellent or very good, and they provided mostly positive comments about their experience. Without exception, patients also told us that they had always been treated with dignity and respect.

The pre-operative assessment clinic's screening process followed standardised national guidelines and utilised a standardised patient pathway which identified patient's individual risks for surgery. This was considered as good practice, since all patients received the same care and attention regardless of the complexity of their surgery.

There was evidence of health promotion material available in the pre-operative assessment clinic, although we recognised that this could be improved within trauma care by providing information and leaflets for patients to read and take away.

Other patient information and communication was good however, the health board must ensure that it is compliant with the Nurse Staffing Levels (Wales) Act 2016. This is to ensure that patients are informed of the nurse staffing levels on each acute adult medical and surgical ward. This should be easily visible to anyone attending the ward.

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the services provided. A total of 19 questionnaires were completed and we also spoke to some patients during the inspection.

Without exception, all of the patients that completed a questionnaire rated their overall experience as excellent or very good. Patients also provided mostly positive comments about their experience. Patient comments included the following:

"The nurses are superb; they laugh & joke to relax me".

"Very relaxing and personal service at all times. This is my first time in hospital, and the care and attention has been superb".

"Good communication throughout. Hard to find anything that can be improved. Very pleased with my care, thanks"

Patients were also asked in the questionnaires of how the hospital could improve the care or service it provides. Comments provided by patients included:

"This is a very busy unit and staff work exceedingly hard. But at times they are so overworked due to staff shortages, it is unfair on them. However, they all still give one hundred percent to their patients. It would be difficult to improve on this level of care".

"Improve breakfast, too hurried. Rushed information in regards to the next meal, it would be helpful if patients were presented with a menu. I wasn't allowed to look at the printed menu held by the catering staff".

When asking patients or relatives within the questionnaires if there was anything else that they would like to tell us about the care or service they have received, comments provided by a relative (on behalf of a patient) included:

"The ward is well managed and the staff are committed and caring. Under difficult circumstances with patients of varying & multifactorial needs, they do their utmost to provide care of the highest level. However, demand on them is high from such a heavy workload. They cope exceedingly well under difficult circumstances".

We also distributed HIW questionnaires to staff working on the wards and within theatres and recovery, 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

We considered the arrangements in place to prepare adults for their planned surgery at the pre-operative assessment clinic based at the Royal Glamorgan Hospital.

The pre-operative assessment clinic's screening process followed standardised national guidelines and also identified patient's individual risks for surgery. Guidelines were standardised across both the Royal Glamorgan Hospital and Prince Charles Hospital within the health board. We found that all patients were assessed through the same pathways regardless of their surgery type. This was considered to be good practice as it meant that all patients received the same care and attention regardless of the complexity of their surgery.

A stop smoking support service was offered as a pilot by a smoking cessation nurse through the pre-operative assessment clinic. In addition, a range of high quality patient information leaflets were available at the clinic through EIDO healthcare[10]. EIDO Healthcare produce treatment specific patient information documents for patients and these are widely used throughout many hospitals. In addition, the physiotherapy department provided leaflets with key information about recovery and exercises following specific types of surgery.. In addition, there were leaflets available for carers for patients undergoing all specialties.

Wards

We saw that a range of health promotion posters and information about some local support groups was displayed on entering the ward, for patients and carers to read. However, there were no information leaflets available for patients or relatives to read and take away on either ward. Although, we acknowledged that for elective patients, this information and leaflets had already been available for patients at the pre-operative assessment clinic.

Ward 7, the elective orthopaedic ward, clearly displayed a large comprehensive poster on the Enhanced Recovery after Surgery process (ERAS). This provided a good amount of information for patients and their relatives promoting their recovery process and optimising the surgical outcome and improving both patient experience and clinical outcomes.

[10] EIDO healthcare - Treatment specific patient information documents

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that health promotion information leaflets are available particularly within the trauma ward, for patients and relatives to read and take away.

Dignified care

Without exception, every patient that completed a HIW questionnaire said 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. Most comments within the patient questionnaires were positive and one patient commented:

> *"The nursing care is of a very high standard, from the sister to all staff and ancillary ward staff. The registrar is an excellent doctor, caring and empathetic always".*

However one patient did negatively comment on their experience:

> *"Emergency Department staff left me most of the night beside my bed in pain. With great painful effort, I forced my legs on to the bed. Some member (female) of staff was a little hostile towards me".*

Although, this same patient rated their overall hospital experience as very good within their questionnaire, and said that overall, they felt they were treated with dignity and respect during their time in hospital.

Pre-operative Assessment Clinic

We did not have the opportunity to witness clinic staff interacting with patients within the pre-operative assessment clinic. However, we saw that consulting room doors were closed when staff was reviewing patients, thus helping to maintain patients' privacy and dignity. We did speak to a patient in the department and they said that they felt prepared for surgery and were involved in the informed consent process.

Wards

We saw ward staff being kind and compassionate to patients, and treating patients with respect, courtesy and politeness at all times. We also saw staff

promoting privacy and dignity when helping patients with their personal care. This was achieved by closing dignity curtains around bed areas and closing doors to side rooms, toilets and shower rooms. Shared toilet and washing facilities were designated single gender and clearly marked as such. These arrangements also helped promote patients' privacy and dignity.

We also found that staff spoke quietly and discreetly wherever possible, to avoid their conversations with patients being overheard by others.

Theatres

Within the theatre department, we saw patients being treated with dignity and respect when they were awake and asleep (under anaesthetic). Staff maintained patients' privacy and dignity by ensuring doors to anaesthetic rooms were closed during induction of anaesthetic, and also ensuring patients were not unnecessarily exposed. Staff covered patients when they were awake and asleep, as appropriate to the surgery being undertaken. Furthermore, patients in the recovery area were appropriately covered and their privacy and dignity maintained by drawing curtains around each bed/bay when required.

When patients were waking up after their operation in recovery, we heard staff appropriately orientating patients to the time and place and explaining that they were waking up following their surgery. In addition, staff spoke discreetly to the patients wherever possible, to prevent others overhearing.

Patient information

Patient Information and Consent

All patients on Ward 7 and almost all patients on Ward 3 that completed a questionnaire told us that they had been involved as much as they wanted to be, in decisions about their care. They also said that they had been given enough time to make choices about all aspects of their care.

With the 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. Additionally, the same patients told us that the anaesthetist had seen them before the operation, to explain about how they would be put to sleep for their surgery, and to control their pain after.

Pre-operative Assessment Clinic

Patients waiting for planned joint replacement surgery attended the pre-operative assessment clinic. The clinic staff confirmed that patients were

provided with verbal information about their surgery and we saw copies of information booklets that were provided to patients. Verbal and written information included details about the hospital admission process, fasting before surgery and advice on whether or not to take prescribed medication. The leaflets also contained supporting information for patients having joint replacement surgery before and after the operation, and through the recovery process at home.

Patients waiting for planned joint replacement surgery were also invited to attend a joint school, where they were provided with information about their surgery, recovery phase and physiotherapy. The orthopaedic nurse practitioners run the joint school and they were also responsible for obtaining informed consent[11] from patients, who had gained information about their surgery as they travelled through the pre-admission process. This allowed patients enough time to ask questions and make a decision on whether to proceed with their joint replacement surgery or not. This was carried out in a dedicated consent clinic.

We looked at a sample of patient records and saw that patient consent forms had been completed appropriately. These were legible and the use of medical jargon and abbreviations had been avoided. We saw that the appropriate consent form (Form 4)[12] had been used for those patients who were unable to give valid consent (such as those patients with dementia). However, whilst consent forms had been completed, patients' medical records did not always contain details of verbal discussions around treatment plans, in advance of the operation.

Wards

Directions to the ward were clearly displayed, and a map near the hospital main entrance helped patients and visitors to find their way around. Notice boards on both wards were used to display the names of the nurse in charge and other staff on duty, but this was not updated consistently. This meant that some

[11] Informed consent is defined as the permission a patient gives a doctor to perform a test or procedure (for example, an operation), after the doctor has fully explained the purpose.

[12] Consent forms: Form 1 (for competent adults over 16 years), consent form 2 (for patient's under 16 years, not Gillick competent) and consent form 4 (for patients who lack capacity).

patients and/or visitors may not be clear about who was providing the patient care.

Neither ward was compliant with the Nurse Staffing Levels (Wales) Act 2016[13], which was implemented in full across Wales in April 2018. The non-compliance was related to the fact; that patients must be informed of the nurse staffing level on each adult acute medical and surgical ward, and should also be informed of the date the nurse staffing level was agreed by the Health Board. This should be easily visible to anyone attending the ward. This was not implemented on either ward.

We raised this with senior hospital staff who provided verbal assurance that plans to implement this were ongoing and this would be actioned as soon as possible. However, they did not provide us with a date for full implementation.

Theatres

We found that patients were verbally oriented to the theatre department on arrival and that pre-operative checks were cross checked with the patient. Patients were also provided with the opportunity to ask questions before being taken into the operating theatre. This opportunity was also the same within the recovery department, following their operation.

[13] Nurse Staffing Levels (Wales) Act 2016 The Nurse Staffing Levels (Wales) Act 2016 became law in March 2016 and was fully implemented in April 2018. The Act requires health service bodies to have regard for the provision of appropriate nurse staffing levels, and to ensure that they are providing sufficient nurses to allow the nurses time to care for patients sensitively.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that:

- Staff document details of verbal discussions around treatment plans to ensure consistent communication through the team
- Notice boards on all wards must display the names of the nurse in charge and other staff on duty at all times
- Patients are informed of the nurse staffing level on each adult acute medical and surgical ward, and should also be informed of the date the nurse staffing level was agreed by the Health Board, as required within the Nurse Staffing (Wales) Act 2016.

Communicating effectively

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 or Welsh.

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

Overall, patients seemed to be positive about their interactions with staff during their time in hospital. Most 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.

Pre-operative Assessment Clinic

We identified that there was effective communication to both patients and other relevant health care professionals (that was pertinent to the patient journey through the hospital and primary care) before and after the surgery.

Informed consent was gained as appropriate, and relevant information was provided to patients about their surgery and recovery and also regarding their admission to hospital, their stay and discharge information. In addition, predicted discharge dates were also provided to patients. This meant they had an awareness of when they were likely to go home, and to establish if any

discharge or social care needs were likely to be required, to support the discharge process.

Wards

We were told by staff that doctors and nurses met separately at set times every day when shift changes took place. This was in order to communicate and discuss patients' needs, plans, relevant risks and any safety issues, and to maintain continuity of care. We also saw that staff had access to prepared patient handover sheets, which were updated daily, so that all staff were aware of key patient treatment, care plans and any significant issues.

Each ward had a patient safety at a glance (PSAG) board. The PSAG board on Ward 7 clearly identified patient safety issues, whilst the PSAG board on Ward 3 was often incomplete and lacked identifiable safety issues. However, this was significantly improved on day two of our inspection, where the board was fully completed and relevant patient safety information was highlighted clearly on Ward 3.

Pre-operative Communication (ward to theatre handover)

We observed a structured verbal patient handover between ward and theatres. There was a structured and standardised pre-operative checklist with all relevant patient information completed on the ward, and this was signed by both the ward nurse and the theatre assistant and operating department practitioners. This was consistent with that outlined in the National Safety Standards for Invasive Procedures (NatSSIPs)[14].

This checklist form was used for the patient handover process. However, there have been previous occasions when the pre-operative checklist has been incomplete on the ward. This has the potential to delay the start of a theatre list when waiting for the form to be fully completed, before transfer to theatre. This was highlighted in some of the staff questionnaires, when we asked staff what were the main reasons for the restriction to patient flow. The comments included:

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

"Patients not ready for theatre from wards. For example, no checklist, relevant paperwork and observations not prepared e.g. pregnancy tests, medication charts, AE stockings".

"Usually paperwork related (documentation not completed)".

"Patients not ready for theatre on the ward. For example, checklist etc".

In addition, whilst the pre-operative checklist contains a section to check for the presence of anti-embolism stockings, some of the patients attending theatre for their operation did not have a completed venous thromboembolism (VTE) risk assessment within their notes. The risk assessment will determine if a patient requires any prophylaxis[15] for the prevention of a VTE, and would usually warrant a patient to be prescribed and to wear anti-embolism stockings with or without the addition of anti-coagulation medication (to reduce the risk of developing blood clots).

The absence of VTE risk assessments was identified in some trauma and elective orthopaedic patients. There were other issues around VTE risk assessments identified on the ward. This was reported to senior clinical staff and was addressed through our immediate assurance process, which is discussed later in the report, and can also be found in appendix B.

Once the ward to theatre handover process is complete, the theatre assistant then escorts the patient in to the anaesthetic room and remains there until the patient is asleep following the anaesthetic, and transferred in to the operating theatre. We also observed a good effort to involve patients in the initial handover process where the patient confirms their own name, address and date of birth.

The presence of the theatre assistant in the anaesthetic room is notable good practice. This is because patients' anxiety levels can be high pre-operatively, and the presence of a familiar face can be a comfort. In addition, this also provides for continuity of care for the patient and enhances the patient perception of the continuity of their care.

[15] Prophylaxis - is treatment given or action taken to prevent illness or disease.

Post-operative Communication (theatre to recovery handover)

We observed a handover from the operating team to the recovery team for all patients, and this handover included both surgical and anaesthetic information. There was a good process in place for this, whereby it was carried out in theatre following the surgery to the recovery nurse, prior to transfer in to recovery. However, there was no structured checklist for the process, and we also identified that not all post operative handovers included information as outlined within the National Safety Standards for Invasive Procedures (NatSSIPs).

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that:

- The pre-operative checklist is always completed appropriately on any ward, including non-surgical wards for example, a medical ward
- The post-operative handover includes all information recommended by the National Safety Standards for Invasive Procedures (NatSSIPs).

Timely care

Pre-operative Assessment Clinic

Patients appear to receive timely care within the pre-operative assessment department and staff reported that there were sufficient pre-operative assessment clinic appointments to ensure optimisation of patients prior to surgery.

For convenience, telephone assessments were available for patients without any complex medical conditions and for low risk surgery. In addition, high risk

clinics[16] were also available for patients with more serious medical conditions requiring higher risk surgery. Telephone assessment enables the appropriate prioritisation of patients, and will allow for more clinic appointment availability. This in turn assists patients to be reviewed in a timely manner by the relevant teams, particularly for more complex patient needs and higher risk surgery.

The pre-operative assessment clinic did not provide a one-stop service[17] for all pre-operative appointments. Therefore, patients were unable to attend pre-assessment clinic and surgical outpatient appointments on the same day. This meant that repeat hospital visits were required. However, all other aspects of pre-operative assessments and interventions were available during the scheduled pre-assessment clinic day.

Discussions with pre-operative assessment clinic staff highlighted some challenges with current waiting lists and scheduling of operations. However, the health board have acknowledged this within their theatre productivity and planning work stream, and have appointed a theatre scheduling manager. The post holder will have overarching responsibility for scheduling lists and address issues resulting in cancellations, thus looking at improving communication, identifying any issues and problem solving with remedies where applicable. This aims to promote the flow of patients through surgical scheduled care (from pre-assessment to discharge) therefore, addressing timely care.

The pre-assessment clinic also had good links with primary care, and also followed the National Institute for Health and Care Excellent (NICE) guidance for urinary tract infections (UTI)[18]. Therefore, the good links minimised any issues related to the request for General Practitioners in treating such medical or other issues, for example, prescribing antibiotics if indicated for a UTI. This

[16] High risk pre-assessment clinics provide additional assessments for patients with more complex needs in relation to their current health status. Such patients will also be reviewed by a consultant anaesthetist. Higher levels of care can be arranged following the operation as required.

[17] Services which offer surgical outpatient appointments and pre-assessment clinic appointments are focussed on patient convenience and are known as “one stop services”. This is available in some, but not all hospitals.

[18] NICE Guidelines for Urinary Tract Infections in Adults

minimises the risk of delay in patients receiving the required treatment, and the potential risk of delay in surgery.

Planned Surgical Care

We considered the arrangements for the timely care and treatment for those patients admitted to hospital for overall planned surgery. Approximately 1 in 10 patients experienced cancellation of their planned operations, on the day of surgery. Of the total number of planned operations the cancellation rate was at 10.1%.

The most common, but potentially avoidable reasons for cancellation included: insufficient staff on duty (due to sickness or vacant posts), patients not being adequately prepared for theatre (therefore, resulting in last minute notification of not being fit for surgery), and over-booking in to theatre lists (meaning not enough time to undertake all the planned operations in a scheduled day).

A further cancellation issue that is yet to be resolved within surgery and theatres is the frequency that planned surgical lists are cancelled to accommodate trauma surgery. However, members of the directorate told us that they have several ideas that are currently being explored, around how to protect dedicated trauma surgery lists throughout the week and at the weekend.

The electronic theatre information system provided efficient data on a number of measures, and work was underway within the surgical directorate to achieve theatre utilisation (the percentage of planned time used) of 85% (this was currently at 76%). The health board had already identified that improvements were required to reduce the number of cancellations for planned and day case operations, and also in reducing the number of theatre sessions that started late and finished early. This included the appointment of a theatre scheduling manager, as highlighted earlier.

The ongoing work that the surgical directorate was already undertaking in monitoring performance and making plans for improvement was excellent. A performance analysis of this showed that they were aware of the past, current and future work required for planned surgical care.

Emergency Surgical Care

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

Information submitted by the health board in the HIW Self Assessment Form on Surgical Services in June 2018, indicated that trauma meetings are conducted by the consultant on call team. These were described as ward rounds that included a review of patients admitted with trauma injuries. The self assessment form reported that trauma operating lists took place on Monday, Tuesday, Thursday and Friday and started at 1:30pm. A list also took place on Wednesday and started at 8:30am.

We attended one such ward round on day one of our inspection, and saw that orthopaedic doctors were present who reviewed patients and agreed the trauma operating list. Anaesthetic and theatre staff were not present. Whilst we were told that a trauma co-ordinator would usually be present (to organise and communicate the trauma operating list), on the days of our inspection the co-ordinator was on leave and no substitute was nominated to attend.

On day two of our inspection, a ward round did not appear to take place and we could not be assured that patients had been suitably assessed and prioritised for theatre. During the course of our inspection it became apparent that multi-disciplinary trauma meetings did not take place. This was confirmed by senior staff.

Anaesthetists that would be responsible for anesthetising patients on the trauma operating lists were not present at the meetings to advise on anaesthetic suitability. In addition, an orthogeriatrician[19], who could provide useful input into the care of frail elderly patients, was not employed in this capacity at the hospital. This meant that whilst patients' orthopaedic care needs were considered at the ward round, their overall medical care needs were not appropriately considered.

In addition to the lack of anaesthetic and orthogeriatrician presence at the meetings, theatre staff were also not present and would therefore, not be able to provide a view on the availability of theatre kit/equipment required to perform the operations. We also found that frail elderly patients with hip fractures were

[19] Orthogeriatrician - Orthogeriatrics is defined as the care of elderly orthopaedic inpatients, most often following a fractured hip. Orthogeriatric services were developed nationally as a subspecialty to address the poor outcomes of hip fracture patients by caring for patients alongside orthopaedic surgeons, and with the support of a specialist multidisciplinary team.

not always prioritised on lists and our discussions with staff on both ward and in theatres confirmed this.

We were told that trauma operating lists were formally distributed to wards at 11:00am (for afternoon operating sessions). Anaesthetists used this list to identify patients who needed to be assessed prior to theatre. Any subsequent changes to the order of the list relied on the diligence of theatre staff to contact the wards rather than a formalised system. This risks delays in theatre if changes were not communicated in a timely manner.

When we asked theatre staff what in their opinion are the main reasons for the restrictions to patient flow. Some comments included:

> *"Change to theatre list, so patients not ready"*
>
> *"Patients not ready for theatre, this could be because of the change to theatre lists".*
>
> *"Patients not ready as anaesthetist or surgeon seeing patients on ward".*
>
> *"Patient not prepared for theatre due to lack of beds and change in order of theatre lists".*

We also saw that availability of theatre kit/equipment was confirmed at the theatre team safety briefing prior to the start of the operating list. Again, it appeared that ensuring the timely availability of theatre kit/equipment relied on the diligence of theatre staff rather than as part of a multi-disciplinary team trauma meeting.

Our findings meant we could not be assured that there was a formal and robust system for scheduling (including communicating changes) and prioritising frail elderly patients requiring surgery as a result of fractured hips or other trauma injuries. Since this was an immediate significant concern, this was addressed with the health board through our Immediate Assurance process which can be seen in appendix B.

Individual care

Planning care to promote independence

Multidisciplinary Trauma Care

As previously described, there was no orthogeriatrician employed at the Royal Glamorgan Hospital at the time of our inspection. This meant that frail elderly

patients needing orthopaedic surgery did not routinely have specialist medical input to their care, in accordance with best practice[20]. 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, does not replace the specialist input to patient care that can be provided by an orthogeriatrician, and also caused some delays to receiving their operation.

As previously highlighted, a trauma nurse practitioner was employed and coordinated the care of patients admitted with trauma injuries. However, this service was Monday to Friday and did not cover the weekends or bank holidays. One of the roles of the trauma nurse practitioner included arranging the input of other members of the multidisciplinary team (such as the medical teams), where applicable.

There was a trauma and orthopaedic admission document in place for new patients, which would be commenced within the emergency department and would accompany the patient throughout their hospital admission. However, there was no standardised care pathway for patients admitted to hospital with a fractured neck of femur (fractured hip).

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 hip. In addition, a pathway would help ensure that all aspects of a clinical guideline[21] are followed in a standardised way, but on an individualised basis. For example, the clinical guideline for hip fracture

[20] 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.

[21] A clinical guideline recommends how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management.

management as recommend by the National Institute for Health and Care Excellence (NICE)[22].

We found that arrangements were in place for referring patients for physiotherapy, and we were told physiotherapists were available seven days per week (although this was an on-call service at weekends). This helped ensure that patients were assessed and mobilised early after their operations[23]. Occupational therapists also provided input to help ensure patients were suitably prepared and ready for discharge.

Improvement needed

The health board is required to provide HIW with details of the action it will take to demonstrate how it will improve the provision of orthogeriatric care to frail elderly patients needing trauma surgery.

People's rights

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

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

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

[22] NICE Clinical Guideline for Hip Fracture Management.

[23] NHFD data (2017) for the Royal Glamorgan Hospital shows 43.6% of patients are mobilised out of bed the day after surgery and 99.2% of patients receive a physiotherapist assessment by the day after surgery.

Listening and learning from feedback

We asked patients through the HIW questionnaires what they thought about the care they had received during their stay in hospital. Whilst some patients said that they had been asked, the majority said that they had not been asked for their views about the care they had received during their stay in hospital.

Patients were also asked whether they would know how to make a complaint 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.

We saw that the health board had a complaints procedure in place. However, information for patients on how to raise a concern was not clearly displayed for patients. There were no posters available explaining the NHS Wales Putting Things Right process[24]. In addition, we only identified three Putting Things Right leaflets in racks outside Ward 3, for patients to read and take away and none on Ward 7.

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 and social media sites.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that:

- Information is displayed and that leaflets are readily available within patient or visitor waiting areas and the ward environments regarding the NHS Wales Putting Things Right process
- Arrangements are in place to promote awareness amongst patients

[24] 'Putting Things Right' is the integrated process for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible body in Wales.

and their carers of how they may provide feedback about their experiences.

Delivery of safe and effective care

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

Overall, we saw that checks to promote patient safety in theatres were performed well. However, we identified that improvement was required in some key areas of the Five Steps for Safer Surgery.

We also identified improvement was needed to ensure that patients had been assessed and treated for their risk of developing a venous thromboembolism.

We saw good evidence in relation to the prevention and management of pressure ulcers across the inspected wards and within theatres.

Wards and theatres were also clean and generally tidy and we saw good evidence of infection prevention and control.

Overall, we found that patients were safely fasted for surgery to minimise the risk of aspiration. However, the current process in place was not effective because patients were being fasted of oral fluid (and food), longer than was necessary, and not as recommended within national guidelines.

Safe care

As highlighted earlier, we had some immediate concerns which were dealt with under our immediate assurance process. These were in relation to: providing timely surgery, prevention of venous thromboembolism, daily checking of resuscitation equipment and completion of staff scrub training and competencies in all surgical departments.

During the course of our inspection, and through conversation with staff, we developed concerns in relation to the obstetric theatre within the Maternity Unit. It was identified that midwives who performed scrub duties within the Maternity

Unit, did not spend time in Main Theatres to develop and learn scrub skills and have the relevant competencies signed off by theatre staff. In addition, it was unclear whether the Maternity Unit staff were following the same protocols and procedures as those in use within Main Theatres.

Our findings meant that we could not be assured that midwives performing scrub duties had attended update training or had their competencies reassessed in accordance with the health board's protocol in this regard. We could also not be assured that staff had access to up to date policies and procedures. Therefore, this concern was also dealt with under our immediate assurance process.

Managing risk and promoting health and safety

Pre-operative Assessment Clinic

We found that the pre-operative assessment clinic was clean and tidy. We did not identify any obvious risks of environmental hazards that would impact on the safety of staff or patients.

Wards

We found that the wards were clean and generally well maintained. However, it was evident that there was a lack of sufficient storage space on both wards. The main corridors on both wards were being used to store equipment such as hoists, trolleys and monitoring equipment, and some hoists were also stored in the large patient shower rooms. However, staff informed us that during times when patients did use the shower, the equipment was moved out. The lack of storage presented potential trip hazards to patients, visitors and staff.

Theatres

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).

Senior managers were aware of the need to review practice in response to the publication of the National Safety Standards for Invasive Procedures (NatSSIPs). In addition, effective leadership was evident and we found good progress had been made in developing Local Safety Standards for Invasive Procedures (LocSSIPs) based on the NatSSIPs.

The Five Steps to Safer Surgery

We asked theatre staff within the HIW questionnaire about aspects of safety checks, and provided positive feedback about most of the checks. The staff were asked how much time is factored into their daily work plan to complete the safety steps. Half of the 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[25], Sign in[26], Time Out[27], Sign Out[28] (which are the three steps of the World Health Organization (WHO) Surgical Safety Checklist[29]) and Debriefing[30].

Safety Briefing

During the inspection, we saw that the safety briefings always occurred (and with all the relevant team members present) at the start of the trauma and elective orthopaedic operating sessions. Theatre staff we spoke to also

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

[26] Sign In is the first safety check which is performed when the patient immediately arrives in theatre and before the anaesthetic is given.

[27] Time Out is the final safety check which is performed before the operation starts.

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

[29] WHO Checklist The Checklist are three steps for checks ensuring that the correct patient is undergoing the correct operation, on the correct part of the body with the correct implant. The WHO checklist consist of Sign In, Time Out and Sign Out.

[30] Debriefing is the fifth and final step. 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.

confirmed that briefings were always undertaken. However, within the staff questionnaires, some staff stated that briefings occurred often but not always.

We found that time was allocated to perform the briefing and that it took place in the equipment room adjacent to the theatre. 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.

Although important aspects relating to each individual patient were discussed, a standardised briefing model was not used. The lack of a standardised model increases the risk that aspects relevant to a patient's safe and effective care may be missed. Theatre staff used an electronic recording system to show that a briefing had been completed; this did not contain any other details. A copy of the theatre list was used to provide a record of the briefing and any comments were hand written on to the list for each patient. However, the record did not include the identities of those team members present, but it was displayed within the theatre during surgery.

Theatre staff explained that prosthesis[31] and associated equipment requirements were confirmed at the briefing. The theatre sister or charge nurse was responsible for ordering and checking these prior to the operation. We were told that the surgeon does not routinely inspect the prosthesis before the patient is sent for.

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

Word Health Organization (WHO) Surgical Safety Checklist

A standardised checklist was used and was verbalised to the teams by the relevant theatre staff at each of the three steps 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.

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

As part of the checks performed, we found that a check of each patient's name was conducted verbally and also cross checked with details on their hospital wrist band (patient identity) and consent form. We also found that there was a process in place to ensure that the relevant part of a patients' body for the site of operation, was appropriately marked before entering the anaesthetic room (this was usually completed on the ward). We also found that patients were involved in key safety steps as appropriate.

We saw that the Sign In process was always performed and that two members of theatre staff were present, and for procedures involving a general anaesthetic, an anaesthetist was always present. Any problems identified at ward handover were also resolved before commencing the Sign In. However, not all of the required checks within the WHO surgical safety checklist, were always read out from the computer screen (or hard copy), in the anaesthetic room. There was a risk with this, in that some points may be missed, and some were missed on a number of observed occasions.

Theatre staff also told us that the Time Out process of the surgical safety checklist was always completed for each patient, and that the whole theatre team were present during the completion of the Time Out. Noise and interruptions were minimised during this stage of checking.

We observed a number of Time Out processes and again, we identified an issue with this, where it was not always clearly performed. This was because staff relied on the process by memory covering most points, and they did not read out the relevant checks from the form that was displayed electronically on the computer screen (or hard copy), in theatre. Again, there was a risk with this, in that some points may be missed, and were missed on a number of observed occasions.

We saw that the Sign Out process of the WHO checklist was not always completed for each patient; this was confirmed verbally by some staff and within the staff questionnaires. When it was completed, sometimes the whole theatre team were not present. We also saw that the Sign Out was not always clearly performed for the same reasons as above. In addition, we identified that

the Sign Out process did not always confirm that a venous cannula[32] had been flushed (or removed), to prevent anaesthetic drugs being inadvertently administered to patients when they had returned to the ward. This is an important patient safety issue as identified within the national patient safety alert for removal or flushing of lines or a cannula after procedures[33].

We saw 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 but at times were substandard. There was no designated individual who takes ownership of the WHO checklist. Different individuals carried out the three different steps, and nobody read the available checklist from the computer system. The checks were undertaken but were never complete. The Sign In, Time Out and Sign Out processes were never read from the WHO checklist. Staff used the pre-operative checklist as a substitute therefore, most questions were asked based on memory rather than that stipulated within the WHO checklist.

A caveat to the issues identified is, that the computer system in use requires a sequential approach. Therefore, the person responsible for the Sign In within the anaesthetic room performs the checks. If they do not follow and record the checks on the screen, before the patient enters the theatre, then the person responsible for the Time Out cannot access or record the relevant checks on the computer system.

Debriefing

The majority of the theatre staff that completed a questionnaire said that the surgical safety debriefs rarely, or never take place, at the end of each theatre list. Theatre staff we spoke to also confirmed that debriefing did not occur. The staff in general, also did not seem to be aware of the debriefing process within

[32] A venous cannula is a sterile device that is inserted into a vein, primarily to allow for the therapeutic administration of medication, fluid and/or blood products, and its insertion should be clinically indicated, and once it is no longer required it should be removed immediately

[33] Patient Safety Alert - Removal or flushing of lines or cannula after procedures.

the Five Steps for Safer Surgery. In addition, we did not witness a debriefing take place after any of the theatre lists we observed had finished. As a result, there was no clear process in place 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 identified and described by a number of staff. We found an encouraging and open incident or near miss reporting culture within theatres. This is important to identify learning from incidents or near misses and therefore promotes 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 it will take to ensure that:

- Following the safety briefing, that appropriate records are made of the comments raised and attendees and displayed within the theatre
- All responsible theatre individuals responsible for completing the WHO surgical safety checklist, reads from the computer system and records the check completion, to ensure every point is always fully checked correctly, with all three aspects of the checklist
- Confirmation is documented each venous cannula has been flushed (taking into account PSN 014/ July 2015)
- Briefings always take place at the end of a theatre list, as part of the WHO Surgical Safety Checklist and Five Steps to Safety Surgery.

Preventing pressure and tissue damage

Ward

We reviewed a sample of five patient records and saw that patients had been assessed for their risk of developing pressure ulcers on admission to the wards. Nursing staff also demonstrated an understanding of the risks for developing pressure ulcers and the prevention of them.

A risk assessment tool had been completed for each patient and care plans were in place for pressure ulcer prevention and management. We found that staff monitored patients' skin for signs of pressure and tissue damage. However, the monitoring records had not always been completed to demonstrate that nursing staff had regularly repositioned patients and checked patients' skin for signs of pressure and tissue damage. This usually happened at night between 01.00am and 06.00am.

Specialist pressure relieving equipment (such as air mattresses and cushions) was available if required. Staff confirmed that they had always had enough pressure relieving equipment, when required.

The health board safety crosses[34] for pressure ulcers were clearly displayed near the entrance of wards 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 current month. This demonstrated a positive approach was being taken by the ward team in relation to pressure sore prevention and care. Staff also displayed how many days had passed where a patient had not developed a pressure ulcer within the ward care.

As reported on the National Hip Fracture Database, the number of patients not to have developed a pressure ulcer who were admitted with a fracture hip at the Royal Glamorgan Hospital in 2017 was 92.6%. The was above the All Wales average of 90.4%.

Theatres

We observed that patients' skin was protected when they were positioned on the operating table. We also saw that patients' limbs were supported to help reduce pain after the operation and for staff to check patients' skin and potential pressure points for tissue damage. Padding was available and used to protect patients' against developing pressure sores whilst in theatre.

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[34] Pressure Ulcer Safety Cross - The Pressure Ulcer Safety Cross has a number of key aims: Raise awareness regarding how many pressure ulcers are acquired, improve patient safety, promote good practice, provide real time incidence data and to link the data to an improvement aim.

We identified good practice in relation to potential pressure ulcer development and monitoring in theatre. The change in practice happened as a result of some patients being identified on the ward with red pressure areas following surgery. These patients had not been identified with, or documented as having red pressure areas before surgery. Therefore, this led to difficulty in identifying when and where the potential pressure ulcer had developed.

This new process clearly ensures that the patients skin integrity is monitored at every stage of the patients peri-operative journey (before, during and immediately after surgery) and then handed over to the recovery staff and ward staff.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that nursing staff regularly reposition patients and check the patients' skin for signs of pressure and tissue damage on the wards.

Falls prevention

Ward

As reported on the National Hip Fracture Database, the number of falls assessments for patients who were admitted with a fracture hip at the Royal Glamorgan Hospital in 2017 was 53.5%. This was below the All Wales average of 68.8%.

We reviewed a sample of five patient records on each ward and saw that all patients had been assessed for their risk of falls. We saw that assessments had been completed on admission with all five patients however, only two of the five patients were reassessed and the record updated during their stay. Where a patient was at risk of falls, individualised care plans were in place as appropriate and in compliance with the health board's policy.

As with pressure ulcer monitoring, safety crosses for the incidence of falls were displayed on both wards. These showed the number of patient falls that had occurred during the current month.

Theatres

We observed how unconscious patients (following anaesthetic) were transferred from trolleys onto the operating table. We saw that there were

sufficient numbers of staff to safely move and position patients as required onto the operating table. Moving and handling equipment was readily available and used by staff correctly as appropriate. Likewise, we saw safe procedures when patients were transferred from the operating table onto a bed or trolley following their surgery.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that nursing staff have re-assessed and updated risk assessments and care plans for patients at risk of falls, including any appropriate action taken to help prevent falls.

Infection prevention and control

Wards

There were separate wards used for patients having planned orthopaedic surgery and patients admitted as a result of trauma injuries. This was good practice and these arrangements helped to promote effective infection prevention and control. This is because planned admissions have been screened in advance for their infection status. This was particularly important for patients having planned joint replacement surgery.

We saw that the wards were clean and generally free of clutter to promote effective cleaning. However, as highlighted earlier numerous large equipment items such as, hoists were stored in the main corridors and bathrooms. Side rooms were also available to care for patients who required isolation to minimise the risk of cross infection.

Signed and dated green labels were routinely used to show that shared equipment, such as commodes, had been cleaned and decontaminated. However, when checking the resuscitation equipment, we identified that the defibrillator and trolley had not been cleaned for approximately four weeks on one of the wards. This was confirmed by the date written on the green label and the large amount of dust present. This was raised with the ward sister and the equipment and trolley were thoroughly cleaned and re-labelled during the inspection.

Personal protective equipment (PPE) such as; disposable aprons and gloves, was available, and was being used appropriately to maintain effective infection prevention and control. Appropriate facilities were in place for the safe disposal

of clinical waste, including medical sharps such as needles. Hand washing and drying facilities were available throughout the ward, together with hand sanitising gel. Effective hand hygiene is essential to help prevent cross infection.

As with most hospitals, the wards displayed safety crosses as highlighted earlier for Clostridium Difficile (C. Diff)[35] and Methicillin-resistant Staphylococcus Aureus (MRSA)[36]. The safety crosses showed that the wards had excellent results with their last known acquired cases of C. Diff and MRSA. On Ward 3 (Trauma ward) this was over 600 days and on Ward 7 (elective orthopaedic ward) where patients are screened for certain infections pre-operatively, this was over 1,000 days. This data suggests that staff are vigilant in compliance with infection prevention and control.

Within the sample of patients' care records we reviewed, we saw that a sepsis[37] screening tool[38] was available within the All Wales National Early Warning Score (NEWS)[39] (patient vital observation charts). On discussion with staff they were aware of the screening and reporting mechanism for sepsis. The actions required for a patient with sepsis were displayed in the treatment rooms. This aims to identify patients who may be developing sepsis, to ensure that prompt medical review and treatment could be commenced.

Theatres

The operating theatres, anaesthetic rooms and recovery area were clean and tidy. Storage of large equipment was an issue in theatres and there were

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[35] Clostridium Difficile (C. Diff) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.

[36] Methicillin-resistant Staphylococcus Aureus (MRSA) refers to a group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus Aureus. MRSA is responsible for several difficult-to-treat infections in humans.

[37] Sepsis is a serious complication of an infection. Without quick treatment, sepsis can be life threatening.

[38] Sepsis Screening Tool

[39] National Early Warning Score (NEWS) charts.

numerous items stored within designated areas clearly outlined within the theatre corridors. We confirmed that air flowed from the theatres in a way to promote effective infection prevention and control. PPE (including theatre hats and masks) 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.

The hospital had appropriate facilities which ensured all the surgical instruments were sterile before use. After use, instruments were appropriately processed by the sterile services department (instrument cleaning and decontamination department) for sterilisation, repackaging and storage. We were assured that that everything was completed appropriately to ensure the sterility of surgical equipment for operations, and all instruments could be traced to individual patients if required.

We found that staff used a recommended method when scrubbing up (cleaning their hands and nails appropriately) prior to participating in surgical procedures. We also found that staff opened instrument sets using a strict aseptic technique[40]. Similarly, a strict aseptic approach was used when patients' skin was cleaned prior to their surgery. However, we found that the bare below the elbow policy[41] in theatre was not always enforced. Although not scrubbed to perform the operation, some anaesthetic staff wore watches throughout surgery and some surgeons promptly put their watches back on, as soon as they were de-scrubbed within the operating theatre.

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

[40] Aseptic technique is a set of specific practices and procedures performed under carefully controlled conditions with the goal of minimising contamination by pathogens to prevent cross infection.

[41] All healthcare workers should ensure they can decontaminate their hands at all times by: being bare below the elbow when delivering direct patient care (i.e. wearing short-sleeved garments or being able to roll/push up sleeves), removing wrist and hand jewellery (i.e. not wearing a wrist-watch or stoned rings), keeping fingernails short, clean and free of nail polish, and covering cuts/abrasions with waterproof dressings.

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.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that all staff comply with the Bare Below the Elbow policy.

Nutrition and hydration

Fasting before Surgery

Fasting before an operation is essential to maintain patient safety. This is to minimise the risk of a patient vomiting or regurgitating fluids or food, and then aspirating[42] during the operation, when they are asleep under anaesthetic. The period of fasting should meet a certain minimum period but not unnecessarily prolonged.

The recommended guidelines for fasting before an operation will depend on patient characteristics, the urgency of the procedure (planned or emergency), the kind of procedure, the type of anaesthetic required such as, general (asleep) or local (awake). The guidance for a planned general anaesthetic in adults is that patients should drink clear fluids only, up until two hours before the operation and eating food is up to six hours before[43]. However, there is different guidance for fluid fasting in children since May 2018[44]. We therefore considered whether there was an effective process in place to ensure patients were safely fasted prior to their surgery.

[42] Aspirate - to inhale something, especially a liquid, into the lungs.

[43] Peri-operative fasting in Adults

[44] Fluid fasting in children

Patients told us they had been provided with information as to how long they needed to go without food and drink so they could safely undergo surgery. However, within the patient questionnaires, of the 15 patients who answered the question how long before your operation did you go without a drink, only two patients told us that they last has a drink less than four hours before surgery. Three patients told us that the time was between four and eight hours and ten patients told us that they last had a drink more than eight hours before their operation. One patient commented within the questionnaire that:

> *"Time without a drink seemed rather long. 25 hours without fluid so was put on a drip"*

Staff also told us that patients were often fasted for longer than was necessary and we also saw this as documented within the patient records. Sometimes this was because a patient's time slot on the operating list had not been confirmed.

We were also told that prolonged fasting happened more often in relation to patients with trauma injuries because of the limited trauma operating times. The limited half day afternoon trauma sessions (and one morning session) contributed to some reasons behind prolonged fasting of patients. Other operations before the trauma list could easily over run over time therefore, delaying the start time of the trauma list. This also had the potential to cancel some patients due to time constraints.

Most patients were fasted in the event that there would be time for them to have an operation. We saw this happen to a frail elderly patient awaiting unplanned orthopaedic surgery, where the decision not to operate was then made late in the day and was fasted unnecessarily, going without food and oral fluids most of the day. However, patients did remain hydrated in almost all instances, with intravenous fluid infusions (fluid infused in to the vein through a cannula).

Overall, we found that patients were safely fasted for surgery to minimise the risk of aspiration. However, the current process in place was not effective because patients were being fasted of oral fluid (and food), longer than was necessary, and as recommended within guidelines.

Nutrition

There was a process in place requiring staff to complete nutritional risk assessments for patients within 24 hours of admission. Nutrition assessment performance data for patients admitted with a fractured neck of femur (hip) was only 40.7% in 2017. This was below the All Wales average of 68.7%. However, our findings during inspection within the small sample of patient notes that we

reviewed, demonstrated that all patients had been assessed as appropriate. Although, none of the patients had been reassessed following admission.

Food and fluid charts were in place where required, to ensure that oral intake was monitored to maintain adequate hydration and nutrition. We found evidence of good practice where mealtimes were protected, to ensure that patients were not disturbed by staff or unnecessary visitors. In addition, health assistants would follow the food trolley to support a patient (if required) with eating and drinking.

Most patients told us that they had a choice of meals each day and were happy with the food, other than that highlighted earlier in the report. In addition, patients did not have to wait long to be served with their meal and all staff were seen to be very helpful.

All patients had water jugs and drinks were placed within easy reach where appropriate, and patients were helped to sit in an upright position to eat and drink.

Improvement needed

The health board is require to provide HIW with details of the action it will take to ensure 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.

Medicines management

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

We saw that medicines were not always stored securely in cupboards and fridges in an organised manner. Many cupboards that we inspected did not have locks. 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 maintain medicine viability and to therefore, promote patient safety[45].

Medicines given by injection were stored separately from others to minimise the risk of medicine administration errors. Epidural or spinal medication was also stored separately from intravenous medications. This demonstrated compliance with the recommended guidelines for the management of epidural analgesia (pain) in the hospital setting[46].

Controlled drugs (CDs), which have strict and well defined management arrangements, were also stored securely. We saw that comprehensive records had been maintained demonstrating that appropriate checks had been completed when administering and disposing of CDs. We also saw that CDs used within theatres were subject to regular stock checks. The health board also had a comprehensive policy in place for the management of CDs.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that medication is stored securely.

Safeguarding children and adults at risk

The health board had a policy and procedures in place to promote and protect the welfare of children and adults who were vulnerable or at risk. Training for safeguarding children and adults was mandatory and there were good processes in place to ensure staff completed training and training updates.

Patients said they felt safe and would be comfortable in speaking to a member of staff if needed. Conversations with staff in ward areas showed that they had an awareness of safeguarding procedures, including how they would report any alleged suspicions or known incidents of abuse.

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[45] Patient Safety Notice - for the storage of medicines in refrigerators.

[46] Guidelines for the management of epidural analgesia in the hospital setting

Comments from ward and theatre staff that completed a questionnaire said that they were encouraged to report any patient safety issues, incidents and safeguarding concerns. 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, many said that they rarely receive feedback of the actions taken from any reported incidents. However, it was apparent that the more senior the post holder, the more feedback they received.

During our investigation, there were two patients who required one to one nursing support on Ward 3. This meant that a health care assistant was required to remain with each patient 24 hours a day, to maintain their safety and well-being, and prevent them from leaving, due to lack of mental capacity.

Any patient requiring this level of observation, and is therefore deprived of their liberty, requires a mental capacity assessment[47] under the Mental Capacity Act 2005[48]. If it is identified that a patient lacks capacity, then staff need to complete a Deprivation of Liberty Safeguarding (DoLS)[49] application and referral to the independent mental capacity advocate (IMCA)[50], and an appropriate care plan to accompany this. This must then be available within the patient notes.

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[47] Mental Capacity Assessment - The Mental Capacity Act states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. An assessment is required to determine this.

[48] Mental Capacity Act 2005 - The Mental Capacity Act 2005 is an Act of the Parliament of the United Kingdom applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

[49] DoLS - The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect vulnerable adults, who may become, or are being deprived of their liberty in a care home or hospital setting. These safeguards are for people who lack capacity to decide where they need to reside to receive treatment and/or care and need to be deprived of their liberty, in their best interests, otherwise than under the Mental Health Act 1983 (MCA Code of Practice). The safeguards came into force in Wales and England on the 1st April 2009.

[50] The local authority, or the NHS decision maker must make a referral if a patient is un-befriended (has no 'appropriate' family and friends who can be consulted), and has been

We identified that there was no evidence that an assessment was carried out within either patient records, other than nursing staff had documented that had been completed by a doctor. Discussions with staff also highlighted that they always provide a form to the doctor for patients requiring assessment however, they said that doctors do not always complete this, or document that it has been undertaken.

One patient record contained the relevant care plan for DoLS, whilst the other did not. The same patient with the care plan did not have a record of the referral to the IMCA, whilst the other who did not have a care plan did have this in the records. As highlighted above, neither patient had evidence that an assessment took place.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that:

- All patients have a mental capacity assessment where applicable, and evidence provided in the patient medical records.
- A DoLS referral for assessment has been completed appropriately and the appropriate DoLS care plan is completed and placed in the patient medical records.

Blood management

Wards

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

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assessed as lacking the capacity to make a decision about: Serious medical treatments, Long-term moves (more than 28 days in hospital or more than 8 weeks in a care home) and Deprivation of Liberty Safeguards (DoLS).

Theatre staff described the blood management process that was 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. A tracking system was described for the cold chain of blood products to ensure patient safety and for audit purposes. Any unused blood products could be returned to the blood bank through the tracking system, to minimise wastage, if the product was no longer required.

There was a hospital major haemorrhage policy and procedure in place, to ensure that patients who suffered significant bleeding during surgery, received blood products promptly as required, and as a priority.

Overall, we were assured there was a system in place which ensured that patients, who needed blood, would receive the right blood, at the right time, and only if needed. We also found that the All Wales blood transfusion record was being used within the wards and theatres, so that transfusions were documented appropriately.

Medical devices, equipment and diagnostic systems

Wards

We saw that the wards had a range of equipment such as, emergency equipment, patient monitoring equipment, joint cooling equipment (for pain and swelling) for patients following joint surgery, pressure relieving mattresses and moving and handling equipment. These all appeared visibly clean and well maintained.

We considered the arrangements for the checking of resuscitation equipment on Ward 3. Records had been maintained of equipment checks by staff however, there were a number of gaps in the records for the months of June, July, August and September 2018. This indicated that the resuscitation trolley had not always been checked daily as required by local policy. The lack of regular checks meant that there was a potential risk for the resuscitation trolley not being sufficiently stocked or safe to use in the event of a patient emergency.

Our concerns regarding resuscitation equipment checks were dealt with under our immediate assurance process. Details of the required immediate improvements are provided in Appendix B.

Theatres

Essential equipment was readily available for the safe and normal functioning of the theatres. There was a maintenance programme which ensured equipment

was regularly serviced. Training was also provided for theatre staff so they were familiar with new and existing equipment. If specialist equipment was required, then this would be ordered in when required and usually accompanied the company representative. Annual inspection and verification of specialised ventilation for healthcare premises[51] was also undertaken as required

Emergency equipment in theatres and recovery was available, and all safety checks were completed and documented. In addition, there was equipment readily available and guidelines in place for difficult airway management[52]. Resuscitation equipment for children was also available. However, we identified that emergency guideline folders in the operating theatres were either incomplete, out of date or absent. Capnography[53] monitoring was not readily available and used in the recovery unit for patients emerging from anaesthetic and breathing spontaneously with a supraglottic airway device[54] in place.

We also found that there was no portable suction available (for transferring patients at risk of requiring suction), during transfer back to the wards.

During the inspection, a patient was transferred to the ground floor following ear, nose and throat (ENT) surgery. Whilst travelling down in the lift, the nurse, patient and relevant others became trapped in the lift for a short period of time, due to its malfunction. There was no harm to the patient concerned and they did not require suction however; this is an example of where portable suction should be available to transfer patients at risk of requiring suction (such as those following ENT surgery), back to the ward.

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[51] Annual verification of specialised air ventilation for healthcare premises

[52] Difficult Airway Guidelines - There were difficult airway trolleys with appropriate difficult airway equipment (e.g. video laryngoscopes, fibre optic scopes).

[53] Capnography - is the monitoring of the concentration or partial pressure of carbon dioxide in the respiratory (breathing) gases. Its main development has been as a monitoring tool for use during anaesthesia (when patients are asleep (under anaesthetic) for operations and in intensive care.

[54] Supraglottic airway device – is a tube like device that the anaesthetist inserts in mouth to protect the patients airway to support breathing during a general anaesthetic.

Improvement needed

The health board is require to provide HIW with details of the action it will take to ensure that:

- Capnography is readily available and used in the recovery unit whilst the patient is emerging from anaesthetic and breathing spontaneously with a supraglottic device in place
- Portable suction is readily available to transfer patients (at risk of requiring suction following surgery) back to the wards.

Effective care

Safe and clinically effective care

Venous thromboembolism prophylaxis (VTE)[55]

The inspection team considered the arrangements in place for assessing patients for their risk of developing a VTE. We did this by reviewing a sample of ten patients' care records and by speaking to ward staff on both Ward 3 and Ward 7. We also considered the Cwm Taf University Health Board guidance for VTE prophylaxis.

Written VTE risk assessments were not available within eight of the ten care records we reviewed. This was not in accordance with the health board's guidance which clearly indicates that all patients will have their risk of developing a VTE assessed, or if the guidance is not followed, the reason documented in the patient's care record. None of the care records we reviewed demonstrated that patients had a re-assessment of their VTE risk at 24 hours. This was not in accordance with the health board's guidance. From our findings, we could not be assured that patients were always being risk assessed for venous thromboembolism.

[55] Venous thromboembolisms are known as blood clots. Thrombosis prevention, (also known as thrombosis prophylaxis) is a treatment to prevent the formation of blood clots inside a blood vessel. Some people are at a higher risk for the formation of blood clots than others, particularly those having limb surgery.

We saw that patients on both wards had been prescribed medication and/or mechanical (anti-embolism stockings) for VTE prophylaxis. We identified that one patient on Ward 3, who was prescribed anti-embolism stockings, was not wearing them and therefore, increased their risk of developing a VTE. We brought this to the immediate attention of senior ward staff so that this could be addressed. We also identified inconsistencies in the completion of the medication administration record by Ward 3 staff to show that anti-embolism stockings had been applied to patients. This contravened the health board's policy for completion of medication administration records.

We considered the handover of four patients from the wards to the theatre. Whilst a pre-operative checklist was used, this did not explicitly refer to VTE risk assessments. We identified that completed VTE assessments did not always accompany patients to theatre.

In addition, patients did not always receive VTE prophylaxis during their operation (where it could be considered appropriate to do so, for example, those patients needing long operations). Our discussions with an anaesthetist indicated that prescribing post-operative VTE prophylaxis was the responsibility of the orthopaedic doctor but discussions with the consultant orthopaedic surgeon indicated this was a decision made in theatre and in conjunction with anaesthetic staff. We could not, therefore, be assured that a standardised approach to pre-operative, intra-operative and post-operative VTE prophylaxis was in place.

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

Peri-operative Hypothermia[56]

We considered the process in place to manage peri-operative hypothermia in accordance with national recommendations[57]. We found, that the national

[56] 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). 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.

standards were being met following surgery. However, improvement was required for patients before and during surgery.

Temperature checks were always performed before the operation. Patients were provided with blankets on transfer to theatre, to prevent them getting cold. No risk assessments were completed to identify which patients were at risk of getting cold during surgery. Warming devices such as warm air blankets were also not used before the operation.

During the operation, temperature checks were not always performed when they should be. Warming devices were usually used in theatre, but not in combination with an intravenous fluid warmer, when indicated.

Within the recovery unit, we found that patient temperatures were checked and that warming air blankets in place when required. This meant that if patients did get cold during surgery, they would be warmed prior to their return to the ward.

We found that patients' temperatures were recorded regularly post-operatively on the ward and saw extra blankets being used, to help keep patients warm.

Pain Management

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 received 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 fascia iliaca[58] nerve block for pain relief. During the intra-operative phase, we were also told that the usual approach was to inject a local anaesthetic into the patient's wound, to provide initial pain relief following surgery.

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[57] Peri-operative Hypothermia NICE Guidline - Hypothermia prevention and management in adults having surgery.

[58] A fascia iliaca nerve block, a type of local anesthesia (nerve block), used for the hip and thigh.

We saw staff in recovery treating patient's pain appropriately. Patients would only be transferred back to the ward once they were comfortable. In addition the hospital had an acute pain service where patients could be referred to if there were issues controlling pain pre or post surgery.

Patients' care records did not always demonstrate that nursing staff had assessed and monitored patients' pain. However, we observed 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 require to provide HIW with details of the action it will take to ensure:

- How it will improve the prevention and management of perioperative hypothermia, in adult patients undergoing surgery
- That all 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).

Quality improvement, research and innovation

We found that the Royal Glamorgan Hospital had effective arrangements for sending data to the National Hip Fracture Database (NHFD), which is a mandatory national audit for improving trauma care for the frail elderly patient. The hospital also submitted data to the National Joint Registry which is a mandatory national audit for joint replacements in planned orthopaedic care.

As highlighted earlier in the report, an enhanced recovery after surgery (ERAS) pathway had been developed for patients receiving planned hip and knee surgery. In addition, we also found that patients were admitted on the day of surgery for planned orthopaedic surgery, unless there was specific medical reason where they were required to attend before surgery.

The surgical directorate identified a number of quality improvement initiatives and we were provided with evidence of performance analysis and improvement plans, which demonstrated positive changes for both planned and unplanned care and what was also panned for the near future.

The anaesthetic department had no current plans to gain anaesthesia clinical services accreditation (ACSA)[59] for external accreditation status however; this is not a mandatory requirement. In addition, we could not identify that anaesthetic standards for national hip fracture care had been implemented.

Information governance and communications technology

Our discussions with staff working in the pre-operative assessment clinic indicated that they had sufficient diagnostic and monitoring equipment to manage the appropriate patient care.

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

During our inspection we identified that ward staff were unable to access up to date information theatre list information. Therefore, this relied on the diligence of theatre staff or the trauma co-ordinator, to inform the wards of any changes to the order of the theatre lists.

There was a system in place which aimed to ensure patient data was effectively and safety stored. This was good electronically however, on both wards, patient notes were not always stored securely. Patient case notes were stored in a designated notes trolley however; the trolleys were not lockable to prevent inappropriate or unauthorised access to the notes. In addition, when patients were awaiting theatre on Ward 7, notes were left unattended on a dressing trolley on the outer side of the nurse station. This increased the risk of breaching patient confidentiality and inappropriate and unauthorised access to patient data.

[59] Anaesthesis Clinical Services Accreditation (ACSA) - is an independent accreditation scheme from the Royal College of Anaesthetists which ensures quality improvement in a number of different areas. It is a scheme recognised by other professional bodies such as CQC (care quality Commission in England) and The Healthcare Quality Improvement Partnership (HQIP).

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure that patient identifiable data and care records are kept securely at all times.

Record keeping

Our findings in relation to record keeping within patient's case notes, pre-assessment clinic and theatre notes have been described in various sections throughout the report. As highlighted, we looked at, for example; a range of assessment tools, checklists, monitoring charts, care plans and evaluations of care both in written patient case notes and electronically.

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.

Theatres and the inspected wards were well managed with staff working effectively as a team and there were clear lines of reporting and accountability.

We found friendly and professional staff teams working on the ward and within theatres. However, It was evident from the comments made by staff that they felt staffing levels and skill mix needed to be improved and that morale was low.

We did not see evidence of how the hospital was always compliant with the Nurse Staffing (Wales) Act 2016. This was because there was an ongoing issue with wards maintaining adequate staffing levels on duty within the acute ward areas, at all times.

Issues highlighted with poor morale, staffing levels and skill mix were addressed with senior hospital staff during our inspection.

Governance, leadership and accountability

Each of the clinical areas visited during the inspection revealed that management and leadership was good. This was particularly evident on both wards and this was also established by discussions with staff and comments within questionnaires. Clear lines of reporting and accountability were also described.

There was good evidence of effective teamwork and communication within the relevant departments. However, as discussed earlier in the report, communication was sometimes at the diligence of others, to ensure that vital information was communicated appropriately. For example, theatre staff

informing the wards when there is a list change, since the wards did not have electronic access to the theatre lists.

We found senior managers associated with both wards and theatres had a good focus on patient flow, and were taking appropriate steps to improve performance in surgical care.

There was an effective governance system in place. Both the wards and theatre managers demonstrated how they accurately and honestly reported any incidents. Action plans for improvement were also developed from incidents where appropriate. From discussions with staff, it was established that they do not always receive feedback following incidents submitted. Further emphasis on sharing incident outcomes with more junior staff would be beneficial, as discussed earlier.

Surgical directorate quality and safety meetings were held regularly however, theatre staff do not get invited to the meetings. The minutes are shared with staff along with any learning identified. However, some staff said that they did not have easy access to the minutes. In addition, we did not see any evidence of reviews with feedback. A system of other regular meetings was also described within theatres. These helped ensure that relevant information was shared with theatre staff as part of the overall governance arrangements. These included incidents related specifically to theatres.

In theatres, we saw that audit activity had taken place. These included audits for example, around fasting and infection prevention and control, (including environmental cleanliness, hand washing and surgical site infection). We also identified additional good practice related to gynaecology patients that required the insertion of a pack following surgery. All female gynaecology patients are required to wear a pink wristband post operatively, to highlight to staff that there is a surgical pack in place that will require removal. The pink arm band is only removed once the pack has been removed. This was an initiative that was implemented as learning from a previous clinical incident.

We also saw evidence of clinical audit activity being conducted on the wards. Safety crosses were displayed near the entrance of both wards and included information on the incidence of pressure ulcers, falls and infections as highlighted earlier.

Staff and resources

Workforce

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

Wards

In total, we received 10 completed staff questionnaires from staff working within Ward 7. All but one member of staff agreed there is a sufficient number of staff working there to ensure the delivery of safe and effective care to patients. In addition, all but one member of staff agreed that staff have the right skill mix of skills to ensure the delivery of safe and effective care to patients. However, despite this a number of staff felt that morale and staff mood was low on the ward due to the ongoing risk of being moved to another department to cover staff shortages elsewhere.

Comments received within the staff questionnaires on Ward 7 included:

> *"Morale is low on the ward due to the number of staff being moved to cover shortages on other wards, frequently leaving our own ward short staffed and below the staff to patient ratio. This movement is causing unease as the ward you could be moved to may be above the competency of your skills and place you in an unsafe situation".*
>
> *“There is low morale & mood on the ward amongst staff due to the constant threat of moving to other areas that you are not competent to work in, often leaving your own ward short staffed".*
>
> *"I feel that the morale among staff members is very low due to the constant threat of being moved to areas where you don't feel competent or sure to work. Also the safety issues regarding the night shift where there is only two staff members left on shift most nights where the managers say that two staff members are sufficient to nurse 14 patients, most of which are post op".*

We received eight completed staff questionnaires from staff working within Ward 3. Half agreed and the other half disagreed, that there is a sufficient number of staff working there to ensure the delivery of safe and effective care to patients. However, all staff agreed that the staff have the right skill mix of skills to ensure the delivery of safe and effective care to patients.

Comments received within the staff questionnaires on Ward 3 included:

"We are often short of qualified nursing staff due to staff leaving or being moved to another ward. This means we depend on agency staff very often. Unfortunately, they can cancel their shifts at short notice and we are not able to cover them again, leaving the ward short of qualified staff. Most wards in the hospital seem to be short staffed at present. When we are fully staffed, we very often have to send our qualified staff to other wards, leaving us short staffed. The ward is too busy, with often very poorly patients and patients with dementia".

"1.Short staffed. 2. Only hear bad things and not good. 3. Sometimes at meal times there is not enough staff to assist with food. 4. The sister is included in the ward numbers".

During conversation with staff on both wards, they felt that the frequent episodes of being short staffed due to unfilled shifts, or staff being removed to work elsewhere, had a direct impact on patient care. Staff said that this was because there was often not enough staff (particularly by night) to assist, turn and reposition patients to prevent skin damage. In addition, staff felt there was also an increased risk of staff musculoskeletal injuries. This was due to insufficient staff available to perform manual handling tasks, which staff wanted to carry out, to minimise the risk of patients developing pressure ulcers. Additionally, when there was only two staff on duty, staff said that they could not leave the ward to take a break for twelve and a half hours, in order to maintain patient safety.

During the course of our inspection we saw on both wards that staff members were very busy attending to patients who required a significant amount of help. Staff also 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 and nurse call buzzers for prolonged periods, as they were busy attending to other patients.

Staff were asked in the questionnaires; is the delivery of safe and effective care to patients at risk due to the number of staff leaving or joining the organisation? All but two staff across both wards answered yes to this question (one said no and the other didn't know). In addition, staff were asked; during busy periods, how often are arrangements put in place to ensure patients continue to receive the care they need? All staff on Ward 3 said that this was often or always. However, five staff answered often or always to this question on Ward 7, four saying this was rare, and one person did not know.

We discussed our findings about staffing on the wards with senior staff. We were informed that staffing issues and short staffed areas were always risk assessed to ensure adequate staff cover was suitable across the hospital. In addition, we observed that at times, the senior staff within the hospital did not always request additional staffing in a timely manner and often relied upon moving staff from ward to ward to cover shortfalls.

We also identified some reporting or communication discrepancies for staff shortages. For example, when we arrived on a ward and there were shortages in both qualified and unqualified staff. This had been escalated to relevant seniors during the night shift however, during the 08.30a.m. Bed (patient flow) meeting; staff stated that they were unaware of this issue. 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 some ward teams.

The majority of staff on both wards that completed a questionnaire said that they were very often given access to training to maintain their continuing professional development while working in their current role. In addition, all staff said that they are given enough support and leadership by management staff to carry out their role effectively. Staff also said that they are also supported by management staff to make their own decisions.

Theatres

In total, we received 38 completed staff questionnaires.

Staff were asked in the questionnaire about the potential risks to safe and effective care as a result of the number of staff leaving and joining the hospital. Of those that answered this question, 21 staff felt that there was a risk to safe and effective care as a result of staff leaving or joining, whilst 15 staff felt there was no risk.

The majority of staff 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. However, six staff disagreed.

The majority of staff that completed a questionnaire said that they are sometimes or very often, given access to training to maintain their continuing professional development while working in their current role. However, nine staff said that for them, this was rare or never happened. One comment from the staff questionnaires said:

"A lack of staff prevents and inhibits learning opportunities for equipment and study days".

Most theatre staff agreed that they were given enough support and leadership by management staff to carry out their role effectively. However, seven staff said that they were not given enough support. The majority of staff also felt that they were supported by management staff to make their own decisions. However some felt they were not supported. Some comments from the staff questionnaires include:

"The deterioration in moral leads to high staff turnover and pressure to increase productivity, without any evidence that their contribution is valued".

"On calls are too long. Also being called back in after going home is exhausting following a long busy shift. These shifts can be up to 24 hours".

"The department is highly efficient but the production line approach negatively affects staff morale and sickness levels. The health board seems intent on increasing the number of cases even though we have less staff to facilitate".

Improvement needed

The health board is required to provide HIW with details of the action it will take:

- To ensure there is compliance with the Nurse Staffing (Wales) Act 2016, to maintain adequate staffing on duty within the acute ward areas at all times. In addition, that there is a robust process in place for managing vacancies in all areas and unplanned absences
- In response to the comments raised by ward staff during the inspection.

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
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Hospital: Royal Glamorgan Hospital

Ward/department: Main Theatre, Pre-Operative Assessment Clinic, Ward 3 and Ward 7

Date of inspection: 25 - 27 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
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	Standard 3.1, 5.1	The Health Board (HB) acknowledges the findings and as part of a wider service reconfiguration programme, and is reviewing the management and delivery of trauma across all its DGH sites. This is an ambitious programme, and the planning for which, commences in December 2018 with implementation anticipated for April to June 2019.	Clinical Director and Interim Head of Nursing	Commences December 2018 – Implementation quarter one 2019/20

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
changes to trauma operating lists are managed and communicated to relevant staff teams.		This will lead to significant change in the management of trauma. The programme also recognises our commitment to improve the scheduling of trauma. We recognise that trauma management needs a robust multidisciplinary approach and this includes daily trauma meetings. As this requires a major change to job plans, we will be supporting this change as part of the service change programme and incrementally implementing where job plans allow. A standard operating procedure and a flow chart is currently being developed. Further support will be given via the Theatre Patient Safety Huddles. The huddles comprise of the Theatre Coordinator, Anaesthetist, the nurse in charge of the Recovery Unit and Theatre Scheduling Manager. This will take place twice daily at 10:30		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		and 15:30. The Health Board (HB) also acknowledges that during the inspection, the site Trauma Co-ordinator was on annual leave therefore, there was a deficit in terms of demonstrating the co-ordination of trauma at the RGH. Immediate action has been taken to provide cross cover from the Orthopaedic ANPs. We acknowledge the need for timely care and the context of the high level of subspecialisation in Orthopaedics. The HB has a consultant on-call to manage trauma and to ensure the best outcomes for patients we schedule trauma in order of clinical priority, to the most appropriate surgeon e.g. a hip surgeon and this can mean using their next available elective list. The HB would like to assure HIW that we recognise that the		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		prioritisation of trauma is a clinical decision that is made by the consultants in a multi-disciplinary context. In the short-term and in parallel with the major reconfiguration work that is being undertaken with Professor Tim Briggs, we will look at ways to ensure this takes place in a more structured way and this is immediately implemented where current job plans allow. This will include a daily 8.00am multi-disciplinary trauma team meeting, with an action log to be completed by the Trauma Co-ordinator. The Clinical Director (CD), Directorate Manager (DM, Consultants and Assistant Director for Surgery, will continue to work closely together and identify further measures that will facilitate this multi-disciplinary approach.		
The health board is required to provide HIW with	Standard	Cwm Taf UHB has guidelines in	Interim Head of	27 September 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
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 to reduce the risk of VTE.	2.1, 3.1, 3.5	place for VTE prophylaxis (chemical and mechanical) for Medicine and Surgical Inpatients. These have been circulated to the Directorate Managers, Heads of Nursing, CD's, Senior Nurses and Ward Managers in order that the information is cascaded to all of the medical and nursing teams. The All Wales Inpatient Medication Chart is specifically designed in order that the VTE risk assessment is considered prior to the prescription of any other medication. The VTE section requests the prescription of the anti-coagulant. The responsible Registered Nurse must ensure he/she signs that the prescription has been administered in line with Cwm Taf UHB Medicines Management Policy. Feedback from the HIW inspection to Wards 3 and 7 has been provided	Nursing, DM, CD for T&O	27 September 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		by the Interim Head of Nursing to the multidisciplinary teams that work on ward 3 and 7 and all of the Ward Managers for all Acute Wards/Clinical Areas on the RGH site at a meeting held on the 17th October 2018. A presentation was delivered across the organisation for the multidisciplinary team outlining the requirements for venous thromboembolism risk assessment and prescribing in 2016. The presentation document has been recirculated to the multidisciplinary team on wards 3 and 7 by the DM and Interim Head of Nursing. Ward 3 and Ward 7 have a system in place where the guidelines described above are embedded into every day practice. The medical		27 September 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		staff and the trauma & orthopaedic nurse practitioners (who are independent prescribers), are responsible for the assessment of patients and the prescription of the prophylaxis. The Registered Nurses sign the medication prescription in line with Cwm Taf UHB's Medicines Management policy. Cwm Taf UHB has a Thrombosis and Anti Coagulation Committee in place, attended by the Consultant Haematologist, in order to provide expert advice. Pertinent information from these meetings is shared with the nursing and medical teams. The designated clinical governance lead (a consultant physician), has set up ward based multidisciplinary quality improvement teams, to		In place- with representation by the senior nurse from surgery In place- with representation by the senior nurse from surgery

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		ensure there is a collaborative approach to patient quality and safety. VTE Prophylaxis is currently one of the area that is being addressed. The learning from the projects is cascaded to the multidisciplinary teams. The following audits are in place to monitor compliance: • Weekly audit undertaken by a designated Registered Nurse on both Wards 3 and 7 where 6 patients are reviewed to monitor VTE compliance • Senior Nurses review of 6 patients in a clinical area twice weekly, to monitor patient quality and safety elements, using a check list. VTE prophylaxis is part of these checks		1 October 2018 8 October 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• Pharmacy undertake an audit to identify noncompliance of critical time medications • The Ward Managers undertake the above audit monthly to monitor compliance. Intra-operative and post-operative VTE prophylaxis is administered on an individual assessment between the Orthopaedic Surgeon and Anaesthetist within the UHB guidelines. Specialist advice from the Haematologist is also sought.		Ongoing-in place 31 October 2018 In place
The health board is required to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is always available and safe to use in the event of a patient emergency on Ward 3 and other wards and departments across the health board.	Standard 2.6 and 2.9	It is the responsibility of the Ward Manager to ensure that the Resuscitation trolley is checked on a daily basis. The person checking the trolley has to sign to evidence the process has	Heads of Nursing	27 September 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		been followed. The Senior Nurse responsible for the surgical wards monitors the compliance daily Monday to Friday and addresses any noncompliance immediately. The Site Managers on a Saturday, Sunday and Bank Holidays check that the Resuscitation Trolley Check compliance is audited in the absence of the Senior Nurse. The Senior Nurses undertaking the twice weekly audits in clinical areas also check the Resuscitation Trolley Check compliance as part of the Patient Safety and Quality checklist. The Resuscitation Check Compliance for all wards is discussed each morning as part of the briefing at the Patient Safety		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Huddles by the Head of Nursing or the Deputy. This forms part of the formal document utilised to record information discussed during the meeting. The process described above is expected on all wards and clinical areas. This was reinforced to all Heads of Nursing and Directorate Managers in recent correspondence form the Executive Director of Nursing, Midwifery and Patient Care. Attached below. This message will be reiterated at the UHB's Heads of Nursing Forum on the 4 December 2018 outlining the monitoring arrangements expected. Spot checks will be undertaken through December 2018 by the Patient Improvement Team led by	Heads of Nursing	4 December 2018 By end of December 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		the Interim Assistant Director of Nursing.		
The health board is required to provide HIW with details of the action taken to ensure that midwives (and other staff who perform scrub nurse duties): • Are up to date with relevant training and competency assessments to allow them	Standard 3.1 and 7.1	A training Implementation action plan has been developed and is being monitored as part of the weekly Maternity Directorate Assurance Group chaired by the Assistant Director of Surgery and the Maternity Executive Assurance Group, chaired monthly by the Director of Nursing.	Head of Midwifery / Assistant Director of Surgery	In place

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
to perform scrub nurse duties • Have access to up to date policies and procedures relevant to surgical procedures performed in the Maternity Unit.		Access to Policies and Procedures are on SharePoint and this is available for staff to access. All staff will be reminded of this. Policies are being reviewed as part of the above process. A sustainable plan for obstetric scrub staff will be implemented by March 2019 which sees the transfer of the management of all theatres to the main theatre management team and main theatre scrub nurses will rotate into the obstetric theatres. This will ensure uniform SOPs in all theatre environments. At Prince Charles Hospital, the obstetric theatre is within the main theatre suite currently and therefore scrub nurses rotate into obstetric theatres and the main theatre team	Head of Midwifery Head of Midwifery with Senior Nurse Theatres Head of Midwifery with Senior Nurse Theatres	In place March 2019 1 December 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		leader monitors practice and competence. This practice will be implemented at the Royal Glamorgan Hospital from December 2018 until the integration of services in March 2019. Main theatre scrub nurses will rotate in to obstetric theatre to supervise practice and expedite training and competency assessment.		
The health board is required to provide HIW with details of the action taken to ensure that: • Complete an evaluation of the current staffing and on-call rotas arrangements to identify areas for improvement • Explore the possibility for an on-call room to be created for recovery staff	Standard 7.1	The E Rostering System is being implemented throughout the Theatre Departments within Cwm Taf UHB, and this includes Recovery. The work commenced in August 2018. The Service Improvement Systems Administrator/Trainer is currently reviewing the current shift patterns with the Senior Nurse and Directorate Manager in collaboration with the staff to ensure compliance	Interim head of Nursing; D Matthews Directorate Manager-Neil Cooper	April 2019 31st October 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		with the European Working Time Directive. This involves a review of the on-call system in Recovery to ensure the health and well-being of staff is maintained. As an interim measure the Senior Nurse is working with the recovery nursing team to ensure that the staff do not work the day before the on call shift as well as having the following day as a “day off” on their planned rota. Thus, an on call room is not required.		

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.

Name: Deborah Lewis

Job role: Assistant Director of Surgery

Name: Deborah Mathews

Job role: Interim Head of Nursing

Name: Paula Pearce

Job role: Directorate Manager

Date: 23 November 2018

Appendix C – Improvement plan

Hospital: Royal Glamorgan Hospital

Ward/department: Surgical, Trauma and Orthopaedic Wards

Date of inspection: 25th – 27th 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 is required to provide HIW with details of the action it will take to ensure that health promotion information leaflets are available particularly within the trauma ward, for patients and relatives to read and take away.	1.1 Health promotion, protection and improvement	Eido Health promotion leaflets are available on both Wards 3 and 7. The leaflets provide information on specific surgery types, any risks and the importance of mobility and exercise during the recovery and rehabilitation period. The leaflets also provide links to other websites for further information. Leaflet racks have also been ordered for all wards to promote visibility and accessibility of leaflets, for patients and visitors.	Head of Nursing Head of Nursing	Immediate 31st December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Any information leaflet that may be unavailable can be accessed immediately on Cwm Taf UHB's internal internet system-SharePoint. All staff have been made aware of how to access this information. The Orthopaedic Advanced Nurse Practitioners will also confirm during clerking, that the patients have received the relevant information leaflets and document this information.		Immediate Immediate
The health board is required to provide HIW with details of the action it will take to ensure that: • Staff document details of verbal discussions around treatment plans to ensure consistent communication through the team • Notice boards on all wards must display the names of the nurse in charge and other staff on duty at all times • Patients must be informed of the nurse staffing level on each adult	4.2 Patient Information	All Staff have been reminded verbally and in writing that all oral discussions about a patients' management of care must be documented clearly and concisely within the communication documents of the nursing record, care pathway or medical notes. The names of all the responsible staff on duty are now displayed on the ward. Details of the Health Board's agreed staffing levels are now displayed on the template entering	Head of Nursing Head of Nursing	Complete October 2018 Complete November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
acute medical and surgical ward and should also be informed of the date the nurse staffing level was agreed by the Health Board. This should be easily visible to anyone attending the ward.		all of the acute wards, in line with Nurse Staffing Levels (Wales) Act (2016). Nursing staff will utilise Cwm Taf UHB's Incident Reporting procedure to identify staffing deficits that may impact on patient care and safety.		
The health board is required to provide HIW with details of the action it will take to ensure that: • The pre-operative checklist is always completed appropriately on any ward, including non-surgical wards. For example, a medical ward • The post-operative handover includes all information recommended by the National Safety Standards for Invasive Procedures (NatSSIPs).	3.2 Communicating effectively	Registered Nurses will be reminded that they must adhere to Cwm Taf UHB's Peri-operative Patient Check and Transfer Protocol. This is also a competency that must be achieved as part of the Graduate Nurse Training Programme. The Pre-operative checklist is used throughout the UHB and completed by nursing staff prior to transfer to theatre. This is a two signature check at ward level, the final signature is the Registered Nurse. Any patient planned for surgery from non-surgical areas, are discussed at the Patient Safety Huddle. Huddles are held 3 times daily on the Acute Site. This is to identify any required support and to action immediately. Out of hours, this information is communicated to the Site Manager. The surgical team and nursing staff will inform	Head of Nursing, Clinical Director, Senior Nurse Theatre.	Complete October 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the bed manager of any patient planned for surgery from a non-surgical area. This is to ensure that a bed is identified on the correct surgical ward, so that patients are cared for by the most appropriately skilled teams. The theatre staff escorting patients to theatre will also undertake a patient check. A final check is undertaken on arrival to the anaesthetic room by theatre staff, and a signature is recorded on the reverse of the checklist. The RGH theatres has implemented the Post-Operative Handover procedure which is currently in use in Prince Charles Hospital. This is in line with the National Safety Standards for Invasive Procedures (NatSSIPs), adapted for Wales (2016). This includes: **Patient Information -** Patient details, the procedure and any allergy **Anaesthetic Information -** Type of anaesthetic, arterial/central venous lines, antibiotics, fluids and pain relief **Surgical Information -** The presence of drains, packs, catheter, blood loss and types of suture.		December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The current document will be replaced by a Standard Operating Procedure (SOP). This will be added to the Theatre Operating Management System and used across both acute sites, in line with the NatSSIPs. The SOP will be discussed and approved in the integrated governance meeting. Prior to a patient transfer back to the ward from Recovery, a formal handover is undertaken between the recovery and ward registered nurses. Handover detail is documented within the Peri-Operative Patient Check and Transfer Protocol.		January 2019
The health board is required to provide HIW with details of the action it will take to demonstrate how it will improve the provision of Orthogeriatric care to frail elderly patients needing trauma surgery.	6.1 Planning Care to promote independence	The UHB acknowledges the deficit in orthogeriatricians therefore, a multidisciplinary team workshop was held on 11 December 2018. In attendance were representatives from the Getting It Right First Time (GIRFT) (national orthopaedic leads in England), to support Cwm Taf UHB with planning a service redesign for trauma and orthopaedic services. This will encompass every aspect of service delivery, including the care of older people with fractures. Within the current service, frail elderly patients requiring trauma surgery are admitted under and remain under the care of the orthopaedic surgical	Assistant Director of Surgery. Clinical Director	June 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		team. Any specialist medical input is provided via onward referrals for opinion / input. This includes referrals to the orthogeriatric service. A critical factor in both phases is the strengthening of the orthogeriatric service, to facilitate the management of frailty fractures entirely within that service and supported by relevant specialists including orthopaedic surgeons. There is now a daily trauma meeting where each trauma patient is discussed individually. With any co-morbidity risks that are identified, a referral is made to the appropriate medical specialty to optimise the patient prior to attending theatre. An action log is also maintained by the Trauma Nurse with patient plans for those awaiting surgery. Where surgery delays are encountered the UHB utilises the Datix Incident Reporting Procedure. This will be investigated and any actions identified will be communicated with Directorate managers, Consultants and Senior Nurses at Integrated Governance Meetings. This practice will be monitored through the action	Head of Nursing and Clinical Directors	By end of December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		log and incident reporting process. Weekly audits are undertaken at ward level to identify trends. Where issues are identified action is taken and this is shared as lessons learned during staff briefings.		
The health board is required to provide HIW with details of the action it will take to ensure that: • Information is displayed and that leaflets are readily available within patient or visitor waiting areas and the ward environments regarding the NHS Wales Putting Things Right process • Arrangements are in place to promote awareness amongst patients and their carers of how they may provide feedback about their experiences.	6.3 Listening and Learning from feedback	Information relating to NHS Wales Putting Things Right Process is now displayed at the entrance of each ward. The Patient Advice and Liaison Service (PALS) information leaflet is also available. The Ward Manager will ensure this information is always available. Each patient/relative is given a 'Have your Say' leaflet on admission. There is collection box available on each ward for completed leaflets. This information is also discussed with the patient and family through the admission process. Each ward ensures that the Ward Manager or deputy is available through visiting times. Nursing staff will proactively undertake walkabouts at visiting time to give patients and their relative's the opportunity to discuss any issues. Nursing staff have commenced the patient handover at the bedside in order that there is	Head of Nursing	By end of December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		patient involvement in their care delivery. Each month, patients are asked if they could complete a Patient Experience survey. This information is reviewed and logged onto the NHS Wales Health and Care Monitoring System Dashboard. Real time surveys are also undertaken across the UHB by the PALS team. This information is immediately fed back to the staff so that action can be taken. The outcomes are also discussed at nurse handovers. The responses recorded include: "You said" and the outcomes "we did". Cwm Taf UHB has a quarterly multidisciplinary group meeting for Listening and Learning from Patient Experience & Feedback. The agenda places patients and their families at the centre of their care. The emphasis is on obtaining any positive or negative patient feedback, and this is now viewed as part of overall patient/user experience The patient feedback is used for learning and		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		improving patient care and safety and experience.		
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action it will take to ensure that: • Following the safety briefing appropriate records are made of the comments raised and attendees and displayed within the theatre • All responsible theatre individuals that are completing the WHO surgical safety checklist, reads from the computer system and records the check completion, to ensure every point is always fully checked correctly, with all three aspects of the checklist.	2.1 Managing risk and promoting health and safety	All staff teams that are involved with patient care in theatre are recorded on the patient pathway, and printed at the end of the peri-operative journey, and is retained in the patients notes. Any actions or issues identified during this process are reported on the Patient Pathway Document or via the University Health Board Incident Reporting Procedure. Following the HIW inspection and recommendations, the WHO checklist has been laminated in each theatre and the surgical safety checklist is completed at the side of the patient whilst in the anaesthetic room and within the theatre.	Head of Nursing	Complete November 2018
The health board is required to	2.2 Preventing	All staff have been reminded of Cwm Taf UHB	Head of	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
provide HIW with details of the action it will take to ensure that nursing staff regularly reposition patients and check the patients' skin for signs of pressure and tissue damage on the wards.	pressure and tissue damage	policy on the Prevention and Treatment of Pressure Ulcers, and that a Waterlow risk assessment is mandatory and must be completed within 6 hours of admission. Depending on the level of risk, a skin bundle is implemented and reviewed according to the assessment outcome. Weekly audits are undertaken of the Skin Bundle any issues are identified and actioned immediately. Where pressure ulcers are identified on admission or develop during admission, they are recorded on a pressure ulcer passport. This remains with the patient during admission to aid communication. In addition, an incident form is completed via Datix. As part of the Datix investigation, a review of the reposition charts is undertaken to identify any noncompliance and then addressed immediately. Incidents are monitored through monthly clinical business meetings and quarterly senior nurse patient quality and risk meetings, to identify risks and actions required to mitigate these. Senior Nurses also meet monthly with the Patient Safety	Nursing	November 2018.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Manager to review incidents. There are Tissue Viability Nurses (TVNs) who are immediately accessible for advice and support on each acute site. They provide monthly formal training sessions across the UHB. All nurses must attend training to improve their knowledge for the prevention and management of pressure ulcers. The nursing handover is undertaken at the bedside, and a retrospective review of the reposition charts is undertaken. If anomalies are identified these are addressed and actioned immediately. Patients at risk of developing pressure ulcers are also provided with a patient information leaflet which contains advice and information around mobility, repositioning and treatment. This leaflet is also shared with family/carers. The ward managers are supervisory. One of their daily objectives is to review the documentation for all patients who are at risks of developing pressure ulcers. In addition, Senior Nurses now undertake twice weekly audits to check compliance with repositioning. During the audit		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		immediate feedback is provided to the responsible Nurse and Ward Manager.		
The health board is required to provide HIW with details of the action it will take to ensure that nursing staff have re-assessed and updated risk assessments and care plans for patients at risk of falls including any appropriate action taken to help prevent falls.	2.3 Falls Prevention	Nursing staff have been reminded of the Cwm Taf UHB Policy for the Reduction of Falls Risks for Inpatients. All patients must be assessed for the risk of falls using the All Wales Falls Risk assessment within 6 hours of admission. This is updated daily and ensures robust communication between the nursing team. A manual handling risk assessment must also be undertaken to ensure that the appropriate equipment is used. Any patient identified with a falls risk, a care plan must be implemented and updated daily. Patients at risk are nursed in observational bays/cohort bay. Where 1:1 supervision is required staffing is increased accordingly, and in line with the Policy for Safe Support and Supervision of Patients. Ward managers must review the practice and documentation for all patients who are at risk of falls daily. This includes: • Patients are informed on the use of nurse call bells, and this must be kept within their reach.	Head of Nursing	Completed November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Patients are orientated to the ward and encouraged to wear appropriate footwear. • Referral to the physiotherapist and occupational therapist where appropriate. • Essential equipment is identified as required, including low level beds or alarm cushions. Weekly audits are undertaken at ward level to identify any trends. If issues are identified, action is taken and this is shared as lessons learned during staff briefings. Senior Nurses undertake a twice weekly audit of Falls Risk Assessment compliance. Immediate feedback is provided to the responsible Nurse and Ward Manager. Any trends or issues identified are discussed at the Senior Nurse and Ward Managers monthly Governance Meetings to identify actions for improvement. Incidents are reported through Datix and are monitored through monthly clinical business meetings and quarterly senior nurse patient quality and risk meetings, to identify risks and actions required to mitigate these. Senior Nurses		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		also meet monthly with the Patient Safety Manager to review incidents. Senior Nurses also meet monthly with the Patient Safety Manager to review incidents.		
The health board is require to provide HIW with details of the action it will take to ensure that all staff comply with the Bare Below the Elbow policy	2.4 Infection Prevention and Control (IPC) and Decontamination	All staff are encouraged to challenge any member of the multidisciplinary team who are noncompliant with the Bare Below the Elbow policy. An objective of ward managers is for the prevention and control of healthcare associated infection, which includes monitoring compliance with the Bare Below the Elbow policy. Any issues identified are monitored through the Directorate Infection Control Meetings and the quarterly Infection Prevention Control Committee. Weekly audits are undertaken by the Ward and Infection Prevention Control Teams. If any issues are identified, action is taken immediately, and outcomes are uploaded onto the NHS Wales Health and Care Monitoring System Dashboard. If trends of noncompliance are identified, increased training will be provided for all	Interim Head of Nursing	Completed November 2018.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		members of the multidisciplinary team, to raise awareness and improve their practice. All wards and departments have hand hygiene champions who will continually raise staff awareness and provide training. The issue is addressed during multidisciplinary Ward Board Rounds and theatre Patient Safety Huddles. Bare Below the Elbow is also addressed through the 'Message of the Day', which is now part of the theatre Formal Briefing. Bare Below the Elbow is currently on the Infection Prevention Control Team Risk Register.		
The health board is require to provide HIW with details of the action it will take to ensure 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	2.5 Nutrition and Hydration	All staff have been reminded of Cwm Taf UHB protocol for the Management of Nil by Mouth (fasting). It has been reiterated to staff that prior to surgery, a patient is fasted for 6 hours for food and 2 for fluids, which is in line with NICE Guidelines. Within the daily trauma meeting, patients will be scheduled for theatre times. This will ensure that	Head of Nursing	Completed November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
as appropriate.		patients are optimised and fasted according to local and NICE Guidelines. The nursing teams have also been informed of the trauma lists on the acute sites. This will provide an indication to the teams where patients are scheduled. If there is noncompliance the Trauma Coordinator or ward staff must complete an incident form via Datix, and an investigation will be undertaken. The information is also recorded on the Action Log that the Trauma Coordinator has introduced following the HIW inspection. It is now a requirement that the Trauma Nurse documents how a patients nutritional and hydration needs have been met and maintained prior to surgery. Ward managers must review practice for any patients who are at risk of prolonged fasting, and whether the management plans in place are appropriate. The nursing staff have been reminded of adhering to the Malnutrition Universal Screening Tool (MUST) assessment which must be undertaken within 24 hours from admission. Dependent on the level of risk a care plan is implemented.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The patient nutrition and hydration status is now reviewed during the multidisciplinary ward round and relevant plans are documented in the Medical and Nursing records. Nursing staff have been reminded of the importance of implementing and completing fluid balance and food charts if ordered within the patients' management plan, to accurately monitor intake and output. The Drink A Drop campaign has been implemented across all clinical areas of Cwm Taf UHB. The Trauma Ward is currently piloting the Prompt Cup to remind patients to keep drinking. The Senior Nurses undertake a twice weekly audit to check the Nutritional Screening Assessment, Fluid Balance Chart and the All Wales Food Chart completion compliance, as part of the Patient Safety and Quality checklist. Feedback is provided as per pressure ulcer and falls audits. The nursing bedside handover also allows for a retrospective review of the MUST assessment and the care plan. Any issues can be identified and		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		actioned immediately. There is a weekly ward audit undertaken which includes the Nutritional Screening Assessment and actions are set as applicable.		
The health board is required to provide HIW with details of the action it will take to ensure that medication is stored securely	2.6 Medicines Management	Nursing staff have been reminded of Cwm Taf UHB Medicines Management policy to enhance their understanding of their responsibilities around medicines management. It is expected that all medicine cupboards and fridges are locked at all times in all wards and departments. In addition, that treatment rom doors are locked. There must only be 3 sets of keys available for the general medicines cupboards. One set is held by the nurse in charge and the other 2 sets by other designated Registered nurses only. There is also only 1 set of keys available for the drug fridge and CD cupboard, which must be held by the Nurse in Charge. There is a system in place where staff must sign for the keys between each shift to ensure that the UHB has a robust audit trail in place. Spot-check audits are undertaken by Senior Nurses	Head of Nursing	Completed November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		and the Head of Nursing. Medicines Management issues are addressed at the daily ward board rounds and theatre patient safety huddles and as part of the Formal Briefing. There is an audit trail kept of these checks. Out of Hours the Site Manager undertakes the Medicine Management Compliance checks as described in the "Patient Safety Huddles" and reports any issues immediately. Any Medicines Management issues must be reported via the Datix incident reporting procedure. The Senior Nurses undertake a twice weekly audit as per pressure ulcer, falls and nutrition and hydration audits. The Ward manager also undertakes a weekly audit. Pharmacist staff attend wards and departments daily. Informal checks are undertaken and any anomalies are reported immediately to the nurse in charge or ward manager. Within theatres locks are being fitted to all theatre anaesthetic cupboards and fridges that store drugs throughout the theatre suites across	Head of Nursing and Senior Nurse.	December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the UHB. Audit checks on this practice will be undertaken by the Head of Nursing and the Senior Nurse.		
The health board is required to provide HIW with details of the action it will take to ensure: • That all patient have a mental capacity assessment where applicable, and evidence provided in the patient medical records • A DoLS referral for assessment has been completed appropriately and the appropriate DoLS care plan is completed and placed in the patient medical records	2.7 Safeguarding children and adults at risk	The multidisciplinary team have been informed that any patients that may require a Deprivation of Liberty Safeguards (DoLS) application, must initially have a have a Mental Capacity Assessment (MCA). This can be undertaken by any member of the multidisciplinary team. It is now standard practice that all patients that have or may require a DoLS, are discussed on the daily Board Round. The medical notes are reviewed at the time by the nurse in charge, to ensure that a MCA has been undertaken. The patient care plan is then updated accordingly. A Red folder system is also in place as an alert to identify those patients with a DoLS in place. Deprivation of Liberty Safeguards is a regular agenda item on the UHB's quarterly Adult at Risk meeting and the clinical business meeting. Monitoring of compliance with MCA assessments and documentation and staff training has also been implemented.	Head of Nursing	Completed November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Monitoring of team training compliance is also a key objective of the ward managers. Mental capacity level 2 e-Learning is addressed with staff during personal development reviews.		
The health board is require to provide HIW with details of the action it will take to ensure that: • Capnography is readily available and used in the recovery unit whilst the patient is emerging from anaesthetic and breathing spontaneously with a supraglottic device in place • Portable suction is readily available to transfer patients (at risk of requiring suction following surgery) back to the wards.	2.9 Medical devices, equipment and diagnostic systems	Capnography monitors are available on each of the acute hospital sites. Since the HIW inspection, all recovery team staff on both sites have completed an awareness session for capnography use. Competency updates and raising awareness on the location of the capnography monitors within recovery and theatres has also been undertaken. A signed register of training completion is now held by the head of nursing on both acute sites. During the theatre departmental meeting held on 11 December 2018, the Senior Nurse reinforced to the nursing and ODP teams in the recovery unit; that the use of capnography monitoring is required as detailed within the guidelines of the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The guidelines state: *"minimum monitoring which includes capnography should be maintained until the*	Head of Nursing	Completed November 2018 December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		patient has recovered fully from anaesthesia." Theatre staff have been informed that any theatre patient transfer that uses a lift must be transferred on a trolley that has the fixed suction unit.		
The health board is require to provide HIW with details of the action it will take to demonstrate: • How it will improve the prevention and management of perioperative hypothermia, in adult patients undergoing surgery • That all 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	Hypothermia Risk is assessed through continued monitoring using the National Early Warning Score (NEWS) chart, where there is a clear escalation process of the clinical response required. The senior nurse discussed these actions at the departmental meeting held on 11 December 2018. The senior nurse has reinforced to the multidisciplinary team that the base line temperature of all patients must be undertaken on arrival into the anaesthetic room, and there must be ongoing monitoring whilst in theatre. In addition, any patient with a baseline temperature of below 36℃ must not proceed with surgery as per NICE guidelines (2016). This must be escalated to the anaesthetist and surgeon, and reported via Cwm Taf UHB Datix incident procedure. Appropriate action will also be taken to warm the patient with warm fluids	Head of Nursing	Completed December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		and warming blankets as appropriate. Laminated posters are now in place throughout theatres, reminding staff of the importance of temperature monitoring. The senior nurse will implement a weekly NEWS audit, which includes temperature monitoring. Any issues identified will be actioned immediately. Identified trends will be discussed bimonthly at departmental for shared learning and positive changes in practice. All patients have pain scores documented and recorded on the patient pathway in Theatre. These are recorded on the NEWS chart prior to the patient leaving recovery. An audit tool is currently being developed to monitor this compliance in theatres. Weekly ward audits will also be undertaken to identify trends. Where issues are identified action is taken and this is discussed for shared learning in staff briefings. During bedside handover, a review of pain assessments and analgesia administration, and patient participation in their care and treatment is discussed. Any issues identified are actioned	Senior Nurse Head of Nursing/Senior Nurse	December 2018 January 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		immediately. The Senior Nurses undertake a twice weekly audit and this includes communicating with patients and checking pain assessment compliance and analgesia administration, as part of the Patient Safety and Quality checklist. Any issues will be addressed immediately with the nurse in charge.		
The health board is required to provide HIW with details of the action it will take to ensure that patient identifiable data and care records will be kept securely at all times.	3.4 Information Governance and Communications Technology	All staff teams within Cwm Taf UHB have been reminded that they must adhere to the NHS Wales Information Governance policy. The nursing teams have also been informed that they must undertake the core Information Governance Training. This is monitored by the ward manager. The ward or department manager has a responsibility to ensure that all identifiable patient data is kept secure at all times. All staff are encouraged to challenge any noncompliance. All medical notes are stored in a designated trolley that can only be accessed by the multidisciplinary team caring for that patient. Any notes that are actively being reviewed are placed	Head of Nursing.	Completed November 2018.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		back in trolley immediately. New trolleys have been ordered with locks to maintain security of the medical notes. All staff have been informed any breach in confidentiality must be reported via the UHB's Datix Incident Procedure, where an investigation will be undertaken and lessons learned are shared.		January 2019
Quality of management and leadership				
The health board is required to provide HIW with details of the action it will take to ensure that: • There is compliance with the Nurse Staffing (Wales) Act 2016, to maintain adequate staffing on duty within the acute ward areas at all times • There is a robust process in place for managing vacancies and unplanned absences • Consideration is made in	7.1 Workforce	Details of staffing levels are displayed on the template at the entrance all of the wards. Staffing levels are monitored daily (Monday to Friday) by the senior nurses and by the site manager (out of hours), and an audit trail of staffing levels is maintained. Staffing levels are captured daily in the patient safety huddles across both acute sites. When staff may be deployed to support areas experiencing short term absence, this information is captured on a database to maintain an audit trail.	Head of Nursing	Completed November 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
response to the comments raised by ward staff during the inspection.		The organisation endeavours to keep staff within their usual ward or department. However, decisions are made to ensure that the low staffing risk across the whole site is minimised, therefore staff may be deployed temporarily. This information is communicated sensitively to the staff member with a rationale provided. The ward managers are integral to ensuring that this communication is positive and that any nursing deployments are to support their colleagues and maintain patient safety, whilst delivering a high standard of care. Nursing staff will utilise Cwm Taf UHB's Incident Reporting procedure to identify staffing deficits that may impact on patient care and safety. Consideration of the outcomes of the National Staff Survey (2018) is given to improve local working conditions for staff through reflective practice and ultimately to improve patient care. There is a process in place to identify any new vacancies, which are recorded on TRAC within 5 days of resignation. In addition, there is an audit sickness and absence and compliance with the All Wales Sickness and Absence policy. Where		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		issues are identified these are addressed. Collectively, this data is reviewed monthly at the clinical business meetings, and any noncompliance is addressed immediately.		

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): Deb Matthews

Job role: Interim Head of Nursing

Date: 12th December 2018 **Revised and Updated v2**