Hospital Inspection (Unannounced)

Surgical Services: Trauma and Orthopaedic care Royal Gwent Hospital/Aneurin Bevan University Health Board/Operating Theatre department/Pre- operative assessment clinic/Ward C7 East/Ward D7 East

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

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

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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**

What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Royal Gwent Hospital, within Aneurin Bevan University Health Board, on the 8, 9 and 10 January 2019. The following departments and wards were visited during this inspection:

- Pre-operative assessment clinic
- Operating theatre department
- Ward C7 East-Trauma[1] and Orthopaedics (unplanned orthopaedic care)
- Ward D7 East-Elective Orthopaedics (planned orthopaedic care).

Our team, for the inspection comprised of three HIW Inspectors (one of whom led the inspection, one supported the visit, and another took on the role of lay reviewer), and five clinical peer reviewers (a consultant surgeon, an anaesthetist, two senior nurses and a theatre manager).

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 refers to a severe injury to part of the musculoskeletal system such as bones, joints or ligaments. Treatment usually requires the input of an orthopaedic surgeon.

Summary of our inspection

Overall, we saw that systems were in place to promote patient safety. We did, however, identify that some improvements could be made to promote a consistent and fully compliant approach to performing key patient safety checks in theatre.

This is what we found the service did well:

- We found there were robust arrangements in place within the pre-operative assessment clinic which supported the delivery of safe and effective surgical care to patients
- Staff teams were patient focussed and worked well together
- There were well established, well understood guidelines in place to assess and manage delirium[2] and dementia[3]. This element of the patients' surgical care pathway was monitored and supported by a consultant orthogeriatrician[4]
- We saw that controlled drugs were managed safely in theatres

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[2] **Delirium,** is a state of mental confusion that can happen if you become medically unwell. It is also known as acute confusional state. Medical problems, surgery and medication can all cause delirium. It often starts suddenly and usually lifts when the condition causing it gets better.

[3] The word '**dementia**' describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. These changes are often small to start with, but for someone with **dementia** they have become severe enough to affect daily life.

[4] Ortho-geriatrician-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 them alongside orthopaedic surgeons, and with the support of a specialist multidisciplinary team.

- Overall, we found that operating theatre services and ward areas inspected, were well led and managed.

This is what we recommend the service could improve:

We identified a number of improvements at this inspection. Readers may therefore wish to look at Appendix C of this report. However, some of the issues concerned are shown below:

- The health board is required to inform HIW of the action taken/to be taken to maintain the privacy and dignity of patients who use the mixed gender toilet/washing areas within ward C7 East
- The health board is required to provide HIW with details of the action to be taken to ensure that there are clear patient post-operative plans in place
- Ensure that patients are not fasted for longer periods than necessary, prior to surgery
- Ensure full compliance with the Five Steps to Safer Surgery[5],[6]
- We identified the need for improvement in terms of clinical leadership. For example, surgeons and anaesthetists were not always fully engaged with the key/practical steps necessary to deliver safe care for patients undergoing invasive procedures and there was no structured post-operative review of ward patients.

Our findings in relation to venous thromboembolism (VTE)[7] risk assessment and prevention, together with the use, and content, of the health board's pre-

[5] 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.

[6] 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.

operative patient checklist, were dealt with through our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified, and the response we received from the health board, are provided in Appendix B.

[7] A venous thromboembolism (VTE) is also known as a blood clot. 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.

What we found

Background of the service

Aneurin Bevan University Health Board was established on 1 October 2009, and is responsible for the provision of NHS services to people living in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. The health board serves an estimated population of over 639,000 which equates to approximately 21 per cent of the total Welsh population.

The health board employs over 13,000 staff, two thirds of who are involved in the delivery of direct patient care.

Pre-operative assessment clinic

The pre-operative assessment clinic is a nurse led outpatient service. Here, patients' physical and mental health needs are assessed; decisions being taken about whether they are able to undergo anaesthetic/surgery. Patients are also tested for the presence of infection such as MRSA8 at this stage in the care process.

Operating Theatres

The main theatre department included nine operating theatres, three of which were associated with trauma and emergency surgery and planned orthopaedic operations. The theatre suite also contained a patient holding bay, recovery area and two day case theatres.

Planned and unplanned trauma and orthopaedic surgery took place every Monday to Saturday between the hours of 9:00am and 5:00pm; Sunday theatre lists being scheduled between 9:00am and 2:00pm.

[8] Methicillin-Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. www.nhs.uk

The operating theatre services and the location of some wards at the Royal Gwent Hospital are likely to change in the next two years, following the opening of the new Grange Hospital at Llanfrechfa Grange during 2021.

Ward C7 East

The above ward is a designated trauma orthopaedic ward which provides care, treatment and support to a maximum of 30 patients of mixed gender. The ward accommodation was found to be set out as a combination of six bed bays and individual patient rooms.

Ward D7 East

The above ward is a designated elective orthopaedic ward which provides care, treatment and support to a maximum of 20 patients of mixed gender. The ward accommodation was found to be set out in a combination of six bed bays and individual patient rooms.

The Royal Gwent Hospital submits data to the National Hip Fracture Database (NHFD)9 and the National Joint Registry (NJR)10.

[9] The NHFD is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed as part of the Falls and Fragility Fracture Audit Programme (FFFAP) by the Care Quality Improvement Department of the Royal College of Physicians, with professional representation from the British Orthopaedic Association and the British Geriatrics Society.

[10] The National Joint Registry (NJD) of England, Wales, Northern Ireland and the Isle of Man exists to define, improve and maintain the quality of care of individuals receiving joint replacement surgery across the NHS and the independent healthcare sector.

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.

We saw that staff treated patients with kindness and respect, and made efforts to promote their privacy and dignity on the wards and operating theatres.

We also found that all healthcare professionals worked well together when planning for, and providing care to, patients.

Patients told us they felt they had been provided with enough information about their care. However, we identified that the trauma ward could have displayed more health promotion and orthopaedic related material, for the benefit of patients and their families.

We also identified that improvements were needed with regard to aspects of the delivery of dignified care, communication and timely care.

During the inspection we distributed HIW questionnaires to patients and carers, to obtain their views on the services provided within the ward environment. The two that were completed, provided positive views of the services received. We also spoke with a number of patients during the inspection. There were, however, a number of patients who were unable to offer their views of services received during our visit. This was due to a combination of complex communication difficulties, preparation for theatre and post-operative recovery periods.

We also distributed HIW questionnaires to staff working within the wards we visited, operating theatres and the patient recovery area. This was, in order to obtain their views on services provided to patients. Comments received, are featured throughout this inspection report.

Staying healthy

Pre-operative assessment clinic

We considered the arrangements in place, to assess, and prepare, patients for planned orthopaedic surgery. As a result, we found that there were very good, well understood and robust systems and processes in place to support patients at the pre-operative admission stage of the surgical pathway.

For example, we found that patients were provided with suitable information to help them understand their plan of care, their medical conditions were effectively optimised and ample time was provided for patients to ask any questions. In addition, we were told that very few patients' surgery needed to be cancelled on the day of their admission, as all healthcare issues had been addressed at the pre-operative assessment stage. We were, however, not provided with the data to support this.

We held conversations with the person responsible for implementing the Anaesthesia Clinical Services Accreditation (ACSA)11 pre-operative assessment standards and found that all standards had been met.

We found there were no direct links between staff at the pre-operative assessment clinic and social services. However, we were told that, in instances where the need for social work input to the care pathway was identified, patients were provided with contact details to assist them. Additionally, we were able to confirm that patients had access to physiotherapy at the pre-admission stage and staff at the clinic communicated effectively with ward staff, in terms of patients' planned orthopaedic admissions.

Discussions with staff within the clinic also revealed that patients were referred to other healthcare professionals (dieticians, smoking cessation counsellors and alcohol counsellors), where appropriate.

The above meant that all patients received the same level of consistent care, support and advice regardless of the complexity of their planned surgery.

[11] Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review and is the Royal College of Anaesthetist's flagship scheme.

The health board should, however, undertake a review of the pre-operative assessment clinic environment. This is because we found the space provided, to be cramped and potentially challenging for some patients with limited mobility.

Ward(s)

We found there were no health promotion/orthopaedic related information leaflets available for (emergency/trauma) patients and their relatives or carers, to take away with them on ward C7 East. However, we saw the display of useful and relevant information about aspects of care in the main ward corridor.

Improvement needed

The health board is required to inform HIW of the action to be taken, to ensure that patients and their families have access to relevant health promotion and orthopaedic material within wards.

Dignified care

Pre-operative assessment clinic

We did not have the opportunity to see staff interacting with patients within the above clinic. However, we saw that consulting room doors were closed when staff were with patients and privacy curtains were available for use within these rooms. Such arrangements helped to maintain patients' privacy and dignity.

Ward(s)

We found that staff spoke to patients in a kind and respectful way throughout our inspection.

We saw that curtains were closed at times when patient care or support was in progress at the bedside. However, we observed one instance where curtains were not fully closed, as the patient concerned, could be seen through glass panes fitted along the main ward corridor.

We were able to confirm that conversations between patients and a variety of staff were discreet; particular consideration being given to ways of speaking with individuals who had identified difficulties associated with short term memory loss. We also heard medical and nursing staff introducing themselves to patients and their families in a warm and professional manner.

Toilet facilities were clearly marked. However, there were no signs on the doors to indicate whether they were vacant, or in use. This was, in order to prevent people from trying to enter, at inappropriate times.

In addition, the mixed gender toilet/washing area at the end of ward C7 East, were not fitted with curtains. (This was, despite the presence of curtain rails at the sinks). The above issues have the potential to undermine the dignity and privacy of patients.

Patients appeared to be well cared for and dressed appropriately in nightwear, or daywear.

Operating theatres

We found patients were treated with dignity, regardless of whether they were awake, asleep, or in recovery; staff speaking with those who were awake, in a calm, caring and respectful manner.

We also saw that patients were exposed as little as possible and suitably covered at all times, and curtains were in use between bays in recovery, to promote patients' dignity.

However, the health board should consider how it could prevent anyone seeing patients within the main theatre. This is because patients on the operating table, are visible from the theatre corridor.

Improvement needed

The health board is required to provide HIW with details of the action to be taken to ensure that ward patients in receipt of care and support, cannot be seen by people using the main corridor.

The health board is required to inform HIW about the action it intends to take, to ensure that patients are alerted whether toilets are vacant/engaged.

The health board is required to inform HIW of the action taken/to be taken to maintain the privacy and dignity of patients who use the mixed gender toilet/washing areas within ward C7 East.

The health board is required to inform HIW how it could prevent anyone in the theatre suite corridor, being able to see patients on the operating table within the main theatre.

Patient information

Patient information and consent

Patients who spoke with us, said that they had been involved as much as they wanted to be, in decisions about their care and treatment.

Pre-operative assessment clinic

We were able to confirm that the patient consent (to surgery) process, began at dedicated sessions at the above clinic; patients being given sufficient time, to listen to, and ask questions about, their treatment options. This took place approximately six weeks in advance of their planned hospital admission.

We saw that the pre-operative admission patient handbook was very detailed and an excellent source of information. We also saw there was a comprehensive selection of information leaflets covering surgical and anaesthetic procedures, for patients to take away with them for future reference. This meant that there was an emphasis on ensuring patients were as informed as possible, about their forthcoming care and treatment.

However, the health board is advised to consider how it could improve the validity of patient consent, in instances where patients are admitted to hospital on the actual day of their surgery.

Ward(s)

Safety cross[12] information was not up to date within ward C7 East, however, information was on display in relation to carer support, senior nurse contact details and Putting Things Right[13]. Conversations with some patients also revealed that they had been provided with useful information prior to their admission, and we saw information on display in both clinical areas which

[12] Safety cross information (which is usually displayed for patients and visitors to see), aims to improve patient safety, promote good practice and provide real time data which should be linked to actions/improvements.

[13] 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 claims about services provided by the National Health Service.

included frequently asked questions about care, the ward vision, pressure ulcer prevention and protected mealtimes14.

We did not find any evidence of the development of patient post-operative care plans (from the theatre recovery area to the wards), to assist staff in the delivery of a consistent standard of care. For example, there were no clear plans/records to ensure that patients' haemoglobin15 levels were checked post-operatively.

We saw that nurse staffing levels were on display in ward C7 East, however, we were told that such information had been removed from display in ward D7East. The reason for this, was unclear. This meant that the health board was non-compliant with this aspect of the Nurse Staffing Levels (Wales) Act 201616.

Improvement needed

The health board is required to provide HIW with details of how it will ensure the validity of consent to surgery, in relation to patients who are admitted to hospital on the day of their planned operation.

The health board is required to provide HIW with details of the action to be taken to ensure that there are clear patient post-operative plans in place.

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

[14] Protected mealtimes are designed to allow patients to eat their meals in a calm and relaxing environment without unnecessary interruption. They are also meant to allow nursing staff to monitor and help patients to meet their nutritional needs and improve and enhance patients' experience of hospital food

[15] Haemoglobin is a protein in red blood cells that carries oxygen to your body's organs and tissues and transports carbon dioxide from your organs and tissues back to your lungs. If a haemoglobin **test** reveals that your **haemoglobin level** is lower than normal, it means you have a low red blood cell count (anaemia).

[16] 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 time to care for patients in a sensitive manner. Nurse Staffing Levels (Wales) Act 2016.

ensure that ward staffing levels are on display to the public, in accordance with this aspect of the Nurse Staffing (Wales) Act 2016.

Communicating effectively

We found that both ward teams placed a focus on effective communication with those patients who had identified communication difficulties.

We also found that a clinic had been established to encourage carers to discuss any issues they may have and seek advice to assist them in their caring role. In addition, there was an emphasis on family involvement in patients' care (where appropriate) and the use of agreed documentation to consistently record patients' care and treatment. This was to assist all members of the ward team to clearly understand the needs of patients in their care.

We saw signs indicating that a hearing loop was available to assist patients/others with hearing difficulties. However, there were no clocks seen within the clinical areas visited. This may create difficulties for some patients in terms of orientation, to the time of day or night.

We also saw signs to inform patients and visitors, that a confidential translation service was available to assist them, in understanding the services provided if required.

We found that nurses wore red tabards at times when they were administering medication. This assisted in alerting others not to disturb them, to prevent any error.

Conversations with staff revealed that every effort was made to ensure that ward and medical staff discussed patients' needs, care plans, risk assessments and discharge planning arrangements on a regular basis.

Pre-operative Communication (ward to theatre handover)

We were able to confirm that there was a structured handover of patient information between ward and theatre staff who focused on going through each element of the pre-operative checklist. However, we were not able to confirm the consistent, pro-active involvement of patients in this process.

We were unable to find any evidence of completed risk assessments concerning the prevention of venous thromboembolism (VTE) for patients

attending theatre, or evidence of audit activity (as required by the health board's VTE policy).This, together with a small number of discrepancies in terms of prescribing items and medication to prevent a VTE, led to the issue of a HIW immediate assurance letter immediately following the inspection. The health board has since provided HIW with an immediate assurance action plan. The details of this, can be seen within Appendix B

On completion of the handover checks, patients were monitored by staff within the designated holding bay of the theatre department. This part of the patient care pathway was completed in a timely and efficient way. The only exceptions to this, related to occasions when there was a delay in transporting patients from the ward to the theatre department. This was due to the ongoing challenges of providing complex care to patients at ward level.

Post-operative Communication (theatre to recovery handover)

We found that there was no structured handover checklist in use, at the point where patients were transferred from theatre to the recovery area. This would assist in ensuring that information shared, is consistent and sufficiently detailed in accordance with the health and care standards and Standard 5-NatSSIPs)17.

Improvement needed

The health board is required to provide HIW with details about how it will ensure that a structured patient handover takes place from the operating theatre to recovery.

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

Timely care

Pre-operative assessment clinic

We found that the staff team, were ahead of schedule, in terms of inviting patients to attend the clinic, and the completion of pre-operative assessments.

Accident and Emergency

We considered the care provided to those patients admitted to the accident and emergency (A&E) department with a suspected fractured neck of femur. As a result, we found that patients received safe, timely and effective care which included prompt investigation and early diagnosis. Whilst patient transfer to wards was affected by a lack of bed availability, we were able to confirm that patients' pain was well managed and nurse consultants ensured that departmental and junior medical staff received appropriate support, in the delivery of patient care.

Planned orthopaedic care ward

We found there were often pressures on theatre time, every Monday. This was, essentially due to limited availability of theatre time on a Sunday and the fact that the number of trauma patients who attended the hospital often exceeded bed/theatre capacity. On day two of our inspection, all planned surgery had to be cancelled to enable emergency orthopaedic surgery to take place. This was due to the non-availability of ward beds.

However, we found that the development of a trauma patient assessment unit, located within ward C7 East, continued to reduce the likelihood of patients receiving care on trolleys in the emergency department. We also identified that emergency department and orthopaedic senior nurses worked very well together, to ensure that patient care was optimised, as far as possible, at all times.

Emergency orthopaedic care ward-C7East

During our inspection the hospital's updated NHFD key performance indicators were made available to us as follows:

- Prompt orthogeriatric review was 94.1% as compared with the NHFD overall-90.4%
- Prompt surgery at the hospital had improved from 47.7% to 48.9%, NHFD overall being 70.1%

- NICE compliant surgery at the hospital was 65.9%, compared with the NFHD overall-57.9%
- Patients not delirious post-operatively was 78.3% (previously 88%), compared with the NHFD overall percentage of 70.4%
- Patients' prompt mobilisation had improved from 75.7% to 77.4% (compared to NHFD overall of 80.8%)
- Patients' return to their original residence was now 75.9% (previously 72%); NHFD overall being 70%.

The above meant that the health board had, in a number of areas, made improvements to the services provided to patients admitted with a hip fracture.

Our conversations with staff indicated that there were delays in patients being admitted to the trauma orthopaedic ward at times. Reasons for this included workload pressures and bed availability. In addition, there were no designated (ring fenced) beds being used to admit patients with a fractured hip. The use of such beds may promote more timely care for patients in relation to being admitted from the emergency department.

We were told that discussions were currently taking place to streamline the care pathway associated with frail elderly patients who are admitted to hospital with a hip fracture. The proposed changes would ensure that such patients receive care and treatment in a more timely way. Surgery on the day of, or day after admission had already improved following initial discussion between relevant clinical staff, although there were still many occasions when hospital bed availability remained a barrier to timely care.

Operating theatres

Overall, we found that there were effective systems in place to ensure that emergency surgery was prioritised for patients admitted to hospital with a hip fracture. This was due to the well-defined fast track care pathway. We also found that, in instances where a surgical list was cancelled, every effort was made to re-schedule cases promptly.

However, we were present in the trauma operating theatres on the three days of our inspection and found, on each occasion, that the operating lists were delayed. This was due to the lack of effective communication between clinical teams and the ward, regarding the order of the surgical list. We did, however, subsequently find that patients had been correctly prioritised for surgery, followed by consistent advice and post-operative care.

The majority of theatre staff, who completed a HIW questionnaire, indicated that, in their view, theatre scheduling was fairly well organised. They also said that enough time was factored into their daily work plan to adequately prepare for each theatre list.

Almost three quarters of theatre staff who returned a HIW questionnaire told us that they experienced daily restrictions to patient flow in their theatres. Some of the reasons given included:

> *"Collection of patients from wards. Queue to send patients to recovery"*
>
> *"No beds, no porters, change of list order"*
>
> *"Pregnancy test not completed. Operation site not marked. No beds"*

Additionally, just over a third of theatre staff told us that they felt operations were cancelled or delayed less than once a month in their theatre because of staffing issues, and half of the theatre staff felt that operations were cancelled or delayed weekly, in their theatre because of ward bed availability issues.

Improvement needed

The health board is required to provide details of the action taken/to be taken, to ensure that communication between clinical teams and wards is effective. This is, to avoid delays to the start of operating lists.

Individual care

Planning care to promote independence

We saw that care plans contained some reference to the promotion of patients' independence. There was also evidence of consistent and effective multidisciplinary contribution to the delivery of care and treatment; appropriate conversations being held with patients and/or their relatives and carers at various points in the care pathway.

An orthogeriatrician and generic rehabilitation assistants were employed to provide specialist medical input and support, respectively, to frail elderly patients needing orthopaedic surgery.

All patients except one, (within ward D7 East) had access to a nurse call buzzer to help them request assistance independently during the day or night. This matter was brought to the attention of the person in charge of the ward at the point of discovery, resulting in a call buzzer being provided on the same day.

We found that patients were supported by physiotherapy staff to help them mobilise after their operation. We also saw that there was sufficient, appropriate equipment to support patients in this regard.

On looking at a sample of eight patients' records, we found that one person had been subject to Deprivation of Liberty Safeguarding arrangements (DoLS)18, which should have still been in place. However, the ward team had not requested an extension to those arrangements, in accordance with the patient's ongoing needs. We therefore brought this matter to the attention of staff, so that appropriate and prompt action could be taken.

Operating theatres

We attended the daily trauma meeting on each of the three days of our inspection. As a result, we found that the environment where the meetings took place was inappropriate, there was a lack of a formal, multidisciplinary approach and only one consultant present. We also found that the meeting took the form of a brief handover, with limited discussion, no educational content and no ward representation. In addition, we saw that patients' details were on display in a public area which may undermine patient confidentiality and contravene current General Data Protection Regulation (GDPR)19. We were, however, able to confirm that all patients were subject to discussion; a colour coded board being used to identify outstanding surgical cases that needed to be prioritised for theatre lists.

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[18] The Mental Capacity Act Deprivation of Liberty Safeguards (D0LS) 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. The safeguards relate to people who lack the mental capacity to decide where they need to reside to receive treatment and/or care. The safeguards came into force in Wales and England on the 1 April 2009.

[19] The General Data Protection Regulation 2016/679 is a regulation in EU law on data protection and privacy for all individuals within the European Union and the European Economic Area.

An overall standardised approach to anaesthetic care was described by a senior clinician, which conformed to information gathered through the Welsh Frailty and Fracture Network20.

Improvement needed

The health board is required to inform HIW whether an extension to the patient's DoLS, authorisation has been agreed within ward C7 East. The health board is also required to provide comments about how it will prevent such instances occurring in the future.

The health board is required to provide HIW with details of how it will ensure that trauma meetings are multidisciplinary and impact positively on patients' quality of life, in accordance with the health and care standards.

The health board is required to inform HIW of the action taken to ensure that patients' personal details are protected within the operating theatre suite. This is, in accordance with GDPR.

People's rights

We saw that relatives and visitors were present outside of dedicated visiting times; some assisting their family members with eating and drinking. We also saw the display of information about John's Campaign21 within the wards, for the benefit of patients and their relatives. The above indicated that there was an emphasis on recognising and addressing patients' needs, as well as those associated with relatives and carers.

[20] The Welsh Frailty Fracture Network aims to facilitate excellent standardised care for all Wales frailty fractures.

[21] John's Campaign was founded in November 2014. Behind its simple statement of purpose, lies the belief that carers should be welcomed, and that collaboration between patients and all those connected with them is crucial to their health and their well-being. John's Campaign applies to all hospital settings: acute, community and mental health and its principles could extend to all other caring institutions where people are living away from those closest to them. http://johnscampaign.org.uk/#/

In instances where private conversations needed to be held with patients and their families, the bedside area was often used, as a large number of patients had limited mobility and complex health care needs. Otherwise, staff told us that office space would be used for privacy purposes.

Conversations with staff confirmed that patients were provided with access to advocacy22 services, in accordance with their assessed needs.

Listening and learning from feedback

Pre-operative assessment clinic

Discussions with staff at the clinic resulted in the provision of evidence regarding the most recently completed patients' survey, which had resulted in very positive feedback.

Ward(s)

We saw the positive feedback received from completed patient and visitor questionnaires on the notice board in ward C7 East. Information was also on display for patients and visitors to see with regard to the health board's response to patient feedback entitled What you Said and What we Did.

We saw numerous thank you cards on display in ward D7 East, from patients and their families.

We found reference to the health board's complaints policy and procedure on noticeboards, which was compliant with Putting Things Right arrangements. In addition, we saw that the health board's annual quality statement for 2017-18 sets out its intentions, and progress made, with regard to improving the experience of care for patients, their families and carers.

[22] **Advocacy** is a process of supporting and enabling people to express their views and concerns. Advocates also help people to access information. They also defend and promote individuals' rights and responsibilities.

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 were able to confirm that systems were in place to promote patient safety within the services inspected.

For example, we found that the health board had taken action to implement the National Safety Standards for Invasive Procedures (NatSSIPs). However, we identified that further work was needed in this regard, and efforts were needed to improve staff awareness and implementation of the practical aspects of the health board's NatSSIPs programme.

We found that there was an absence of patient risk assessments (regarding their likelihood of developing blood clots) and concerns about the content, and use of, patients' pre-operative checklists. This resulted in the issue of a HIW immediate assurance letter.

Both wards visited and the operating theatres, were visibly clean and generally tidy. We also saw good use of infection prevention and control procedures.

We were able to confirm that medicines were managed safely within the operating theatre environment.

Safe care

Our concerns regarding the absence of VTE risk assessments and aspects of the content, and use of, the health board's pre-operative patient checklist, were dealt with via our immediate assurance process. This meant that we wrote to the service immediately following the inspection, requiring that urgent remedial actions were taken. Details of the immediate improvements we identified, and the subsequent response from the health board, are provided in Appendix B.

Managing risk and promoting health and safety

Ward(s)

Exploration of eight patients' care records across the two wards visited, clearly indicated that appropriate and prompt action had been taken and recorded by ward staff, at times when their physical condition had changed/deteriorated.

We found that signs assisting patients and their families, to find their way to the wards, were clear.

We saw that large pieces of equipment for moving and handling purposes, were stored in the main corridors, particularly in ward C7 East. However, there was very little provision for such equipment to be stored elsewhere. Otherwise, there were no obvious slip, trip hazards within the clinical areas visited.

Staff who spoke with us demonstrated that they had a clear understanding of how to report any adverse clinical incidents.

Operating theatres

We found that the staff rest room and staff changing areas within the theatre suite, were in need of some maintenance and re-decoration. We did, however, see that supplies of theatre clothing was plentiful, together with suitable shower facilities.

We found there was no standardised procedure established in relation to Stop Before You Block[23] checks. Specifically, no formal checklist was completed, patient consent was not checked at this point and only a verbal check took place to confirm the relevant part of the patients' body where the block was to be performed. This could, potentially, lead to error.

We saw that a whiteboard was used in a consistent way, to record the use of surgical instruments and other items used during a surgical procedure.

The National Safety Standards for Invasive Procedures (NatSSIPs)

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[23] The Royal College of Anaesthetists have introduced a national patient safety initiative called **Stop Before You Block**. The campaign is aimed **at** reducing the incidence of inadvertent wrong-sided nerve **block** during regional **anaesthesia**.

The health board completed and submitted a self-assessment form to HIW in June 2018 (prior to the inspection). This confirmed that whilst work was ongoing, action was being taken to introduce, and implement, NatSSIPs.

We spoke with the nominated senior member of staff who had been leading on the above work and were provided with copies of Local Safety Standards for Invasive Procedures (LocSSIPs) which had been developed in the light of the required implementation of NatSSIPs for use in theatre. This confirmed there was an emphasis on patients' safety.

The Five Steps to Safer Surgery

We considered how the Five Steps to Safer Surgery were adhered to within the operating theatre environment. The five steps are: Safety Briefing[24], Sign In[25], Time Out[26], Sign Out[27] (which are associated with the World Health Organisation (WHO) surgical safety checklist[28]) and Debriefing[29].

Two thirds of the operating theatre staff who completed a HIW questionnaire told us that they had sufficient time to complete the above safety steps.

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[24] The Safety Briefing refers to the time when the operating team meets to share their safety concerns and discuss patients on an individual basis, as a team for the first time.

[25] Sign In is the point where the first safety check is performed (as the patient arrives in theatre), before anaesthetic is given.

[26] Time out refers to the final safety check performed before the operation starts.

[27] Sign out is the name given to the safety checks completed immediately after the operation. Issues such as whether the right procedure has been performed, whether all instruments, swabs and needles can be accounted for.

[28] WHO Checklist The checklist refers to three steps for staff to take, to ensure 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.

[29] Procedural debriefing is a key element of practice in the delivery of safe patient care. The debriefing should include the sharing of information (between the operating team) about things that went well, any problems that occurred with equipment used. Anything important is recorded and shared with the local safety network, so that staff in theatres learn from mistakes and food practice is shared.

Safety Briefing

Conversations with staff, and our observations, confirmed that safety briefings were performed within the confines of the anaesthetic room, to ensure privacy, prior the start of all theatre lists; sufficient time being factored into scheduled theatre time (theatre operating lists). We also saw that key individuals were present (senior surgeon, senior anaesthetist anaesthetic assistants and scrub/circulating assistants). In instances where other relevant staff were unable to attend the briefing, or there was a change of surgeon, it was not always evident that they received a separate re-briefing.

In all cases, one member of the team led the briefing; the lead person changing on a regular basis throughout the week, to enable all members of the team to fulfil this key role in terms of patient safety. Staff also told us that they felt confident in asking questions, if they had any concerns.

We were able to confirm that aspects of risk relating to some patients were discussed, with an emphasis on patient centred care. However, not all patients were subject to discussion. This raised the possibility of important information being missed.

We found that a record of each briefing and theatre list was made on the theatre computer system, but this did not include a list of operating team members.

We saw that the theatre information whiteboard was accessible to the operating team and contained all relevant patient information. This practise was commended by the inspection team.

During the course of the trauma operating list on day one of our inspection, the order of the list needed to be changed. We could not find any evidence that such changes were discussed with the operating team. This could lead to errors.

Our findings in relation to the above, indicated that the briefings were consistently performed which contributed positively to patient safety. However, improvement was needed to further promote the delivery of safe and effective care. Specifically, the briefing needs to be able to take into account the issues outlined above, as well as team discussion about those patients who have not yet been admitted to the hospital at the time of the briefing (that is, day surgery patients who are admitted at various times during the day).

World Health Organisation (WHO) Surgical Safety Checklist

Overall, we found that there was a culture within the operating theatre department of completing paperwork associated with the safety steps to surgery, without full recognition of their purpose, or attention to the practical aspects of this part of the surgical patients' pathway.

This was because the Sign In and Sign Out processes, were inadequate. Specifically, the Sign In process was not clearly/accurately performed and the potential for error existed at this stage, because the anaesthetist was not usually involved (the anaesthetist administering anaesthetic in some cases being different from the one who met the patient pre-operatively). In addition, one patient was still in receipt of intravenous anaesthesia whilst the Sign Out was being performed (in other words undertaking Sign Out too soon).

Similarly, senior staff (the surgeon and anaesthetist), were not always present at the Time Out, or engaged in the process; one surgeon scrubbing up in a different part of the theatre while the Time Out was being performed.

The above findings highlighted the need for further staff training in respect of NatSSIPs and the WHO surgical safety checklist approach.

Debriefing

Debriefing should be performed at the end of all operating sessions and is a key element of practice in the delivery of safe patient care. The debriefing should be seen as important part in the safe performance of an invasive procedure, as any of the other steps outlined within NatSSIPs. This process should include reference to things that went well, any problems that occurred with any equipment and the identification of any areas for improvement.

However, we found that debriefing was not performed routinely and when it did take place, the outcome was not recorded anywhere. Just over half of the theatre staff that answered the question said that the surgical safety debrief rarely, or never, happened at the end of each theatre list.

This meant that any actions that may need to be taken, or any good practice that would be useful to share with others, may not have taken place.

Site Marking

We found that the health board's pre-operative checklist did not prompt ward staff to check whether patients' limbs had been correctly identified and marked, prior to surgery and transfer to theatre. The absence of a prompt to check whether patients' correct limbs had been marked at ward level prior to theatre

transfer, led to a patient incident on day one of our inspection. We brought this to the attention of senior managers during our visit and were subsequently told that the incident had been recorded, as a near miss30, as the patient had not come to any harm.

The above matter, however, resulted in the issue of a HIW immediate assurance letter. The health board's response to our letter, can be seen within Appendix B.

Prevention of retained foreign objects

We found a safe and effective system in place, to prevent surgical items from being retained (i.e. inside patients) unintentionally. This system involved strict processes for recording and accounting for items used during the surgical procedure.

Prosthesis verification

We found that there was a safe system in place to ensure that patients received the right prosthesis31 during surgery. Additionally, any other relevant equipment required for the surgical procedure, was confirmed during the safety briefing by the surgeon. We also found that there was a wider departmental system in place for storing and checking these, prior to each operation. However, we were told that the process for ordering stock did not always result in the timely receipt of items needed.

Incident Reporting (Operating theatres)

We identified that there was a suitable system in place for reporting, recording and investigating patient safety incidents in theatre.

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[30] A **near miss** in medicine, is an event that might have resulted in harm but the problem did not reach the patient because of timely intervention by **healthcare** providers, the patient, or their family.

[31] A prosthesis is defined as an internal or external medical device for artificial replacement of an absent or impaired structure. (for example a hip joint prosthesis is use to replace a diseased or broken hip joint)

We were told that incidents were reported via the health board's electronic reporting system and were offered a description of how one particular instance

had been investigated and addressed. In addition, theatre staff who completed a HIW questionnaire told us that they felt able to speak up about anything they identified as being wrong when working in the theatres. However, just over half said that they rarely or never received feedback about the actions taken from any reported incidents. This may mean that opportunities for involving staff and learning lessons may be missed.

Without exception though, theatre staff who completed a HIW questionnaire agreed that there was a well-established and understood patient safety culture in the workplace.

Improvement needed

The health board is required to provide HIW with details of the action taken/to be taken to ensure that the following matters are addressed with regard to NatSSIPs and the WHO surgical safety checklist:

- There was no formal checklist in use, in relation to Stop Before you Block. In addition, patient consent was not checked at this point; a verbal check only taking place
- In instances where the original operating surgeon was replaced by another surgeon as the list progressed, there was no evidence of re-briefing (Standard 7)
- There is a need to ensure that each patient is subject to discussion. This is, in order that the possibility of missing important information is minimised (point 7 Standard 7)
- The record of each safety briefing must include a list of operating team members (point 6, Standard 7)
- We could not find any evidence to demonstrate that changes to the operating list, were discussed with the operating team (as on day 1 of our inspection)
- The health board needs to make provision to discuss those patients who are not present at the hospital at the time of safety briefings (point 7, Standard 7)
- Staff were completing checklists and other theatre records without fully completing the practical aspects associated with the required

safety checks

- Debriefing was not routinely performed (point 1, Standard 13).

The health board is required to provide HIW with details of how it will ensure that staff who report incidents, receive feedback.

Preventing pressure and tissue damage

Ward(s)

We reviewed a sample of eight patients' records and were able to confirm that they had been assessed for the risk of developing pressure ulcers, on admission to the ward. In addition, it was evident that patients' risks had been re-assessed, where skin charts and care plans clearly reflected the care they required.

Operating theatres

Overall, we were able to confirm that there were well established procedures and processes in place within the operating theatre environment to prevent patients from developing pressure and skin/tissue damage. This included the safe manner in which moving and handling procedures were carried out by staff at all times. We were also able to confirm that patients' skin was checked immediately before and after application of the diathermy 32plate.

However, we found that a patient's pressure areas were not checked before surgery began (on day two of our inspection). In addition, we found that it was common practice, to apply sticky tape to patients' eyes as a means of protection during surgery, as opposed to a more gentle option such as the application of eye gel and an eye pad. The above meant that patients' skin could be compromised during surgery. Such matters were brought to the attention of staff during our inspection.

[32] Diathermy is the generation of heat and the passage of an electric current through the tissues. The energy is used to cut tissues, seal blood vessels and destroy unwanted cells by the deliberate application of intense heat.

Improvement needed

The health board is required to describe the action taken/to be taken, to ensure that all necessary steps are taken, to prevent patients from developing skin/pressure damage whilst in the operating theatres.

Falls prevention

Ward(s)

During this inspection, we focussed on falls prevention for patients. As a result, we were overall, able to confirm that efforts had been made to assess and identify patients at risk of falls, appropriate action being taken in the form of equipment to be used, and the form of support and encouragement patients needed, in terms of mobilising.

Patient Status at a Glance (PSAG)33 Boards were used to record key information about patients' care needs and helped ward staff and other members of the multidisciplinary team (e.g. physiotherapist and occupational therapist). This was, to assist with the easy identification of those patients at risk of falls.

However, we found a small number of inconsistencies in terms of the use and recording of risk assessments and patient care plans, in relation to this aspect of care; some not being completed at all (ward D7 East only).

Operating theatres

[33] Patient Status at a Glance (PSAG) boards are used in hospital wards for displaying important patient information.

We were able to confirm that staff transferred patients (following the administration of anaesthetic), safely from the theatre trolley to the operating table, and from the operating table back to a trolley following surgery.

Improvement needed

The health board is required to describe the action taken/to be taken to ensure that all patients are fully assessed for their risk of falling.

Infection prevention and control

Pre-operative assessment clinic

Staff within the pre-operative assessment clinic described the effective arrangements in place to achieve rapid MRSA swab results, to enable patients to be operated on within planned operating lists.

Ward(s)

We saw that both wards were clean and found that arrangements were in place to promote effective Infection Prevention and Control (IPC)[34].

We looked at a number of commodes within the wards and found all to be visibly clean. We also saw that staff had applied labels to the equipment, to indicate that they had been cleaned and were ready for use.

There were sufficient supplies of personal protective equipment (PPE) available (such as disposable gloves and aprons) on both wards for staff to use. Hand washing and drying facilities were also available in key areas on both wards.

However, the housekeeper's storage cupboard door was open within ward D7 East during our inspection. In addition, the door was not fitted with a lock. This

[34] **Infection prevention and control** (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health workers.

meant that there was the potential for unauthorised access to harmful substances.

We also found that hand sanitising gel dispensers were empty at the entrance of both wards. This had the potential to place patients and visitors at risk of cross. infection since visitors to the ward, could not sanitise their hands. In addition, we saw a number of boxes stored on the floor of the dirty utility (sluice) room within ward C7 East, which could become contaminated.

Operating theatres and recovery

We found that there were safe and robust policies and processes in place with regard to IPC. We saw that all equipment was cleaned between each patient and at the end of the theatre list, and staff actively challenged others, to ensure that they had a valid reason to be present in the operating theatres suite.

We found that operating theatre and Hospital Sterilisation and Decontamination Unit (HSDU)[35] staff worked very well together, to ensure that stringent infection prevention and control measures were applied to the cleaning and sterilisation of surgical instruments. There was also demonstrable involvement between the two departments at such time when new equipment was purchased. This was, to ensure that the new equipment could be processed by the HSDU department. Additionally, we were told that HSDU staff had recently developed a business case to secure extra funding to make improvements to the service provided.

We saw that staff were vigilant when opening instrument sets, checking for any damage that may pose an infection control risk. We also saw that staff followed a 'scrubbing up' procedure that included strict hand washing and the wearing of surgical gown, mask and gloves. This promotes effective infection prevention and control during surgical procedures.

During surgical procedures, we saw control measures were taken to reduce the number of staff entering the operating theatre. This again helped prevent the spread of infection.

[35] The Hospital Sterilisation and Decontamination Unit (HSDU) provides an accredited medical device decontamination service.

We confirmed that prophylactic antibiotics36 were prescribed for patients using agreed guidelines to prevent the inappropriate and over use of antibiotics.

However, we did see a small number of theatre staff in public areas, outside of the theatre environment wearing theatre scrub wear. In addition, a small number of staff were wearing watches and were not bare below the elbow at all times. This was not in-keeping with the health board's infection prevention and control policy.

The health board should also give some consideration as to how it could create an alternative entrance to theatre, to avoid disturbing positive pressure ventilation37 and also the use of disposable curtains in the recovery area.

We were able to confirm that Laminar Flow38 theatres were reliably available for relevant orthopaedic work.

Improvement needed

The health board is required to provide HIW with details of the action to be taken, to prevent unauthorised access to harmful substances stored in the housekeeper's cupboard on ward D7 East.

The health board is required to ensure that there are suitable procedures in place to replenish hand sanitising gel dispensers within wards.

The health board is required to inform HIW as to how it will ensure that staff adhere to all aspects of its IPC policy (in particular, the requirement for staff to be bare below the elbow in the workplace and the wearing of theatre scrubs in

[36] Antibiotics are sometimes given as a precaution to prevent, rather than treat, an infection. This is known as antibiotic prophylaxis.

[37] Positive-pressure ventilation means that airway pressure is applied at the patient's airway through an endotracheal or tracheostomy tube. The positive nature of the pressure causes the gas to flow into the lungs until the ventilator breath is terminated.

[38] Laminar flow theatres work to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments, surgeons and the patient's own skin

public areas).

Nutrition and hydration

Fasting before Surgery

Fasting before an operation is essential to maintaining patients' safety. This is, in order to minimise the risk of a patient vomiting or regurgitating fluid or food which could result in aspiration39 during the operation and lead to unnecessary complications.

The recommended guidelines for fasting before an operation depends 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). General guidance for a planned general anaesthetic in adults suggests that patients should drink clear fluids only, up to two hours before the operation and food should be eaten, no later than six hours before40. We therefore considered whether there was an effective process in place to ensure patients were safely fasted prior to their surgery.

However, we found that patient fasting times were unclear. This was due to inadequate recording of this aspect of care within patients' pre-operative checklists and care records and poor communication between the surgical teams and the wards compounded this situation. In addition, we found a small number of instances where patients' had been fasted for approximately 11-14 hours prior to surgery.

We found that the use of nil by mouth signs with in ward D7 East, were inconsistent, although housekeeping staff told us that they often checked patients' fasting status with the nurse in charge.

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[39] Aspiration means - to inhale something, especially a liquid, into the lungs.

[40] Peri-operative fasting in Adults

The above matters were discussed with staff and senior managers who agreed to explore this issue in more detail and take remedial action, as appropriate. This was, in order to ensure that patients are safely prepared for surgery.

Nutrition

There were arrangements in place to assess patients' nutritional needs. However, we did not find evidence of a completed nutritional risk assessment in one of the care files inspected.

We found that patients' food and fluid charts were in place, where needed.

Patients who spoke with us said that they had a choice of meals every day, as well as drinks at mealtimes and other times of the day. We saw that all patients had drinking water placed within their reach. We also saw staff and relatives assisting patients who were unable to eat and drink independently.

On observing a mealtime on day two of our inspection, we saw that food was served promptly. We also heard staff checking that patients were in receipt of the meal they had ordered; alternatives being provided in response to individual requests. This meant that there was an emphasis on ensuring that patients' intake of food was sufficient; nutrition known to play its part in good post-operative recovery.

Improvement needed

The health board is required to inform HIW of the action taken to ensure that patients are not without food or drink for longer periods than necessary, prior to surgery.

The health board is required to provide HIW with details of how it will ensure that nil by mouth signs are appropriately and consistently used in the wards prior to surgery.

Medicines management

During this inspection, we focussed on the systems in place regarding the safe administration of prescribed medicines in the operating theatres.

We found that one patient had been transferred to the theatre from the ward, without their medication chart. This led to the need for theatre staff to obtain the chart in order to take the necessary steps to determine why the patient concerned had an intravenous infusion in progress, which contained an

antibiotic. It was, however, not possible for theatre staff to initially determine whether the patient was receiving the right medication for the correct reason, at the right dose and at the right time, as required by the health and care standards.

We also found that fridge temperatures were not being regularly monitored and recorded within a log book as required. This meant that there was potential for drugs to be stored in sub optimal temperatures.

With the exception of the above, we found that medicines were stored appropriately; complete records being kept in relation to checks of controlled drugs41. The separation of drugs by their reason for use (that is, general, emergency and local anaesthetics), was commended by the inspection team, on the basis of safety and ease of use by staff.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that all patients transferred to theatre are accompanied by their current medication chart.

The health board is required to inform HIW about how it will ensure that drug fridge temperatures are recorded on a regular basis.

Safeguarding children and adults at risk

The health board had a policy and procedure in place to promote and protect the welfare of children and adults who were vulnerable or at risk. We also found that patients had access to external advocates as and when needed.

It was evident that ward staff had some understanding of the Mental Capacity Act 2005 and the application of the Deprivation of Liberty Safeguards.

[41] A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law.

Training in relation to safeguarding concerning children and adults was mandatory. However, we found that compliance with such training was as follows:

- Operating theatres-96.63%
- Ward C7 East-74.19% (adults and children)
- Ward D7 East-63.4% (adults) and 59.09% (children)

We also advised senior managers (associated with operating theatres) to consider providing relevant staff with level three safeguarding training.

Improvement needed

The health board is required to inform HIW of the action taken/to be taken to ensure that all staff complete mandatory safeguarding training.

Blood management

Ward(s)

We reviewed a sample of patients' care records and found that documentation in relation to blood transfusions, was done well. The All Wales Blood Product Transfusion document was used. We also found evidence to demonstrate that appropriate safety checks had been completed by nursing staff.

Operating theatres

Theatre staff who spoke with us, described the blood management processes in place. For example, there were arrangements to promote the timely and safe transfusion of sufficient blood supplies and blood products to patients in theatre when needed. We also saw the display of a detailed blood management/major haemorrhage protocol. This was visible to staff in all key areas to ensure that patients who suffered significant bleeding during surgery, received blood

products promptly as required, and as a priority. In addition, all operating department practitioners were trained in the use of cell salvage[42] equipment.

Medical devices, equipment and diagnostic systems

Ward(s)

The majority of ward staff who completed a questionnaire felt that they regularly had access to the equipment they needed to deliver safe and effective care to patients. However, we found that a number of machines (used for checking patients' blood pressure) within Ward C7 East, had been in need of repair for some time, leaving only two that were fit for use. This was, despite ward staff having reported the faulty equipment in a timely way. This matter needs to be addressed.

We found that there were suitable arrangements in place, on both wards, in terms of checking, and replacing emergency equipment.

Operating theatres

We were able to confirm that the operating theatres and recovery areas visited were well equipped; a separate annexe being available for those occasions when patients required resuscitation. Storage was, however, problematic (in particular, the rack system in place to store surgical instrument trays, where this could result in injury to staff). This was due to the limited space available. We also identified the need for improvement, regarding a number of issues as outlined in the box below.

We were provided with a copy of the information held, which provided clear evidence that all operating theatre equipment and lighting was checked on a regular basis, in support of the delivery of safe care to patients.

The majority of theatre staff who completed a HIW questionnaire felt that they always, or often, had access to the equipment they needed to deliver safe and

[42] Intraoperative blood salvage, also known as autologous blood transfusion or cell salvage, is a medical procedure involving recovering blood lost during surgery and re-infusing it into the patient. Equipment has been developed to assist in salvaging the patient's own blood in the perioperative setting.

effective care to patients. However, they also indicated that more theatre swabs, gel pads, high flow nasal oxygen and patient trolleys, would assist them further, in their day to day work.

The health board should consider providing staff with greater access to computers for recording and training purposes, together with television/radio services, in support of patients who spend longer periods of time in the recovery area.

Improvement needed

The health board is required to inform HIW of the action taken to ensure that faulty equipment within the wards is repaired in a prompt manner, in support of patient care.

The health board is required to provide HIW with a description of the action it intends to take with regard to the following:

- The storage of surgical instrument trays
- We found that there was no standardisation of anaesthetic emergency algorithms[43]
- The intubating laryngeal masks, were out of date (located on the difficult airway trolley)
- There were no capnographs[44] in use in the recovery area of the theatre suite. This could impact on patients' safety whilst recovering from general anaesthetic
- Sufficient numbers of PK Alaris[45] pumps and blood gas monitors[46] were not readily available for staff to use when caring for patients.

[43] Algorithms are written guides for clinicians in the management of patient emergencies.

[44] Capnography is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Its main development has been as a monitoring tool for use during anaesthesia and intensive care.

[45] The Alaris PK Syringe Pump provides the user with an infusion tool for the administration of drugs for anaesthesia.

Effective care

Safe and clinically effective care

Ward(s)

Discussions with ward staff revealed that although there was not a fully established enhanced recovery after surgery47 protocol in place, there was an emphasis on enabling patients to fully achieve their individual post-operative goals in a safe and timely way.

Operating theatres

Just over half of the theatre staff who completed a HIW questionnaire indicated that the delivery of safe and effective care to patients was not at risk due to staff leaving or joining the organisation. In addition, almost all stated that, during busy periods, arrangements were often, or always, put in place to ensure patients continued to receive the care they needed.

HIW questionnaire respondents stated that patients often arrived in theatre well prepared and with everything in place for their operation. The majority also agreed that the overriding priority in theatres was on the delivery of safe and effective care, rather than achieving a quick turn-over of patients.

We were able to confirm that there were effective arrangements in place for the scheduling of planned and emergency operations. For example, a weekly

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[46] A blood gas test measures the amount of oxygen and carbon dioxide in the blood.

[47] Enhanced Recovery After Surgery (ERAS) protocols are multimodal perioperative care pathways designed to achieve early recovery after surgical procedures by maintaining pre-operative organ function and reducing the profound stress response following surgery.

meeting was attended by relevant staff to ensure that agreed theatre lists were available to all concerned in a timely way; the details of which were clear and unambiguous. We also found that theatre lists took into account, the urgency of the surgery to be performed and patients' medical conditions/allergies.

We were told that there were newly established processes in place to ensure that emergency trauma lists were staffed by senior surgeons and anaesthetists with no other commitments to routine work at the same time. This was, in order to enable such professionals to focus exclusively on the delivery of safe and effective care to patients.

We were able to confirm that patients (adults and children) received safe care, in the recovery area, from skilled and knowledgeable professionals.

Venous thromboembolism prophylaxis (VTE)

We could not find any evidence of completed VTE risk assessments at ward level, or within the operating theatres. In addition, we could not find any evidence of audit activity in relation to this important aspect of patient care, or clarity in terms of prescribed treatment (within two patient's medication charts). The above findings were not consistent with the requirements of the health board's current VTE policy and procedure.

We therefore issued the health board with a HIW immediate assurance letter, to request that urgent and sufficient action to be taken to address the above matters. The response subsequently received from the health board, provided HIW with sufficient assurance that appropriate action had been/would be taken.

We saw that VTE prevention equipment was available and used, in the operating theatre environment.

Peri-operative hypothermia

Overall, we found there were effective systems in place and sufficient use of equipment to minimise peri-operative hypothermia in patients. This was, as a result of the completion of systematic risk assessments and active patient management. In addition, patients admitted to the day surgery area, were encouraged to walk to theatre wherever possible, to maintain their body temperature and reduce the risk of the above.

However, staff who spoke with us, were unaware that patients' temperature should, ideally, be more than 36 degrees Celsius prior to anaesthesia. The health board should therefore review staff education and understanding in this regard.

Pain Management-wards

On examination of eight patients' records and observation of the individuals concerned, we were able to confirm that pain relief medication had been administered as prescribed; each person appearing to be comfortable when approached. However, we found some inconsistency in the recording of patients' pain across the three forms of documentation used to record this aspect of patient. care (care pathway, NEWS48 chart and PCA49 chart). The above findings meant that issues with regard to this element of patients' care could be missed and pain relief medication could potentially be over/under prescribed.

We found that there was a pro-active approach to assessing, monitoring and managing patients' pain (as a result of a hip fracture).

Pain management-recovery

We found there was an effective system in place to address patients' pain and post-operative nausea.

Delirium Management

We found there were well established and understood processes in place to assess and manage patients with delirium and/or dementia. Such processes were overseen and monitored by the orthogeriatrician and ward sisters through daily patient reviews; every attempt being made to liaise with, and involve patients and their families. In addition, a patient and carer leaflet was available to help their understanding of delirium.

We saw that patients were subject to a detailed, recorded patient assessment on admission to the ward. We also found that there was a robust approach to

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

[49] Patient Controlled Analgesia (PCA) is a method of pain relief that allows a patient to self-administer small doses of analgesia as required, from a locked programmable pump. PCA is appropriate for patients' who have acute pain which is likely to warrant repeated doses of non-oral opioid.

patients' presentation post-operatively through the continued use of the 4AT50 screening tool. Additionally, discussions with the orthogeriatrician revealed the focus placed on addressing reversible causes of delirium; tailoring communication with patients in accordance with their identified needs. The health board was commended for the above approach to the delivery of safe and effective care.

We found that ward staff used a form of communication called Bundle Clocks51 which were located above patients' beds to alert them to key points in the delivery of care. We were also able to confirm that there was a well-established multidisciplinary approach to the delivery of care in the hip fracture programme.

Improvement needed

The health board is required to provide HIW with details of the action to be taken to ensure that staff are aware of all elements of the assessment and management of peri-operative hypothermia.

The health board is required to inform HIW about how it will ensure that the recording of patients' pain scores are reviewed and are consistent within wards.

Quality improvement, research and innovation

The trauma and orthopaedic service regularly provided data to the National Hip Fracture Database (NHFD) and the National Joint Registry (NJR).

[50] The 4AT is a clinical screening tool designed to be used by any health professional for the rapid assessment of delirium and cognitive impairment.

[51] A bundle is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes. Bundle clocks are simply set to remind staff to when care needs to be delivered.

Staff confirmed that data from the NHFD was regularly audited and presented at surgical morbidity and mortality meetings52 to discuss findings and identify areas for improvement.

The health board completed and submitted a self-assessment form to HIW prior to the inspection. This confirmed that the health board takes action in response to findings from the NHFD and the NJR clinical report with a view to making improvements as appropriate.

Ward audit activity focussed on a variety of care practises which included the effectiveness of hand hygiene and instances of patient falls.

Information governance and communications technology

Ward(s)

During our visit to ward D7 East, we saw the following:

- The patient status at a glance board doors were open for the whole time during our visit. This meant that patients' personal details could easily be seen by people other than ward staff
- A computer screen located at the nurses' station was found to be unlocked (on day one) which meant that patient identifiable information could easily be seen
- Patients' theatre notes needed to be held securely as patients' personal details were on display on top of a metal trolley where they were being stored at the time of our visit.

Each of the above three issues, had the potential to compromise patient confidentiality.

Operating theatres

We found there were suitable systems in place to ensure the effective collection, sharing and reporting of theatre data and information which were

[52] Morbidity and mortality meetings are seen as a key activity for reviewing the performance of the surgical team and ensuring quality.

easily accessed and used by staff. We also found that regular audits were completed by consultant staff to identify areas where efficiency could be improved.

However, we saw the display of patients' names on a briefing board in the anaesthetic room. This had the potential to undermine confidentiality, as patients would be able to see these details clearly, prior to being anaesthetised.

Improvement needed

The health board is required to inform HIW about how it will ensure that patient information is held securely and in strict confidence at all times, within the wards.

The health board is required to inform HIW about how it will ensure that patients' confidential details are protected within the anaesthetic room.

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.

Overall, we found evidence of strong and consistent management and leadership arrangements within the operating theatres and wards inspected. This resulted in a positive staff culture and a clear willingness to further develop the services offered to patients.

We did, however; identify the need for improvement to elements of clinical leadership and staff training.

Governance, leadership and accountability

Overall, we found evidence of strong leadership and good governance (audit and recording) arrangements within the wards inspected and operating theatre environment, with an emphasis on supporting, and advocating on behalf of, patients.

We were provided with notes from monthly theatre directorate meetings where discussions took place regarding patient safety and quality, overall performance, IPC matters and issues relating to the theatre workforce: actions being allocated to named, relevant staff.

We were also provided with a copy of a bespoke report entitled NHS Benchmarking Network Operating Theatres Project 2018, as the health board (like all other health boards in Wales), had participated in the benchmarking exercise; the overall outcome of which was positive. The only issues that fell below the national mean, related to the need for improvement in the completion of staff training and appraisal.

We found that aspects of clinical leadership regarding the day to day work of the operating theatres needed to be improved. Such issues are shown in the improvement needed box below.

As previously stated, we distributed HIW questionnaires to staff working in the operating theatres. This was, in order to determine their views about their working conditions and to understand their views on the quality of care provided to patients undergoing surgery at the hospital.

In total, we received 21 completed questionnaires. The majority of those indicated that staff were always, or often, supported by managers to make their own decisions and carry out their roles effectively. Staff also indicated that the theatre team worked very well together.

Questionnaire respondents highlighted some concerns about the limited time allocated to personal training, staff shortages and missing equipment. Such responses did not provide any further information about those matters. Other comments included:

> *"Lack of portering staff to collect patients, lack of recovery staff to receive patients from theatre"*

> *"Staffing issues - co-ordinating lunches etc - could be better"*

Discussions with staff working in the theatre environment during the three days of our inspection revealed that staff enjoyed their work.

Theatre managers described the systems in place monitoring the quality and safety of the theatre service. They confirmed that the department had an up to date risk register. This identified potential and actual risks to the delivery of the service and identified actions to mitigate against these. Theatre managers also confirmed that regular audit activity took place to identify areas for service improvement.

During our inspection we also distributed HIW questionnaires to staff working on both wards. Two were completed, both of which offered positive views of the workplace and patient care.

Ward staff also told us that they felt well supported by managers and their peer group. In addition, we were able to confirm the presence of effective leadership and good teamwork in both wards inspected.

Improvement needed

The health board is required to provide HIW with details of how it intends to address the following:

- Surgeons and anaesthetists were not always fully engaged with the

key/practical steps necessary to deliver safe care for patients undergoing invasive procedures

- There was a lack of consistency in the way which the trauma list was managed (for example, there was a lack of ownership)
- Clinical (orthopaedic) job plans did not support continuity of care, or the delivery of consultant led care, for the whole emergency pathway
- There was no structured post-operative review of ward patients
- There was no evidence of orthopaedic consultant led ward rounds with multidisciplinary input.

Staff and resources

Workforce

General issues

We were provided with details of a staff incentive scheme, which was being used across the health board. This was entitled the Early Bird Winter Initiative- effective from 1 January 2019 to 31 March 2019. Early indications were, that the initiative was proving to be successful in filling gaps at times of unforeseen staff sickness and absence.

We found that the health board was not fully compliant with its targets for completing staff annual appraisals. We spoke with senior managers about this issue; all indicating that there were plans in place to address this situation. This was, in recognition of the value in identifying training needs and providing staff with the opportunity for two way discussion about their work and personal development.

Ward(s)

Our observations indicated that ward teams had the right knowledge and skills to meet the care needs of patients on the wards.

Operating theatres

Our observations and findings also indicated that theatre teams had the right skills and level of knowledge to perform their roles.

We found there were a number of staff vacancies at the time of our inspection (two scrub nurses, two recovery staff and one Operating Department Practitioner ODP53 Band 6). However, no agency staff were being used at present; the department using a pool of bank staff instead, five of whom were regularly used, for continuity purposes. Discussions with senior managers also provided assurance that staffing levels rarely impacted negatively on theatre flow.

Training-operating theatres

We were provided with a blank copy of an induction pack for a theatre scrub practitioner and found the content to be satisfactory and appropriate.

One member of staff who completed a HIW questionnaire indicated that they were not given enough support by management staff to carry out their role effectively. However, the majority of respondents indicated that they were sometimes, or very often, given access to training to maintain their continuous professional development whilst working in their current role.

All theatre staff who spoke with us said that they attended monthly multi-disciplinary training, such as clinical audit days, the content of which was considered to be relevant and in support of good practice. We also saw copies of the training provided.

Discussion with senior managers highlighted plans to develop dual skilled ODPs in the future (anaesthaesia and scrub duties).

We advised senior managers of the need to provide staff with additional training in respect of emergency scenarios, Emergency Paediatric Life Support (EPLS54) and Advanced Life Support (ALS55) training for recovery staff.

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[53] Operating department practitioners (ODPs) are a vital part of the multidisciplinary operating theatre team, providing a high standard of patient-focused care during anaesthesia, surgery and recovery, responding to patients' physical and psychological needs.

[54] EPLS is a two day course teaching the fundamental skills for assessment and clinical management of paediatrics who are victims of deteriorating acute illness and cardiac arrest.

Training-wards

Ward staff and senior managers acknowledged that current compliance with mandatory/other staff training needed to be improved. They also described plans to address this issue.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that staff are provided with adequate mandatory/relevant training within wards and the operating theatre environment.

[55] ALS - Advanced Life Support. The Resuscitation Council (UK) Advanced Life Support (ALS) course was launched 1993. It is a standardised national course teaching evidence-based resuscitation guidelines and skills to healthcare professionals in the United Kingdom.

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, measurable, 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.

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
Ward C7 East A large container of hair shampoo was present in a toilet/shower room.	The shampoo could have been ingested by patients/visitors with cognitive impairment.	All issues identified/cited within this Appendix, were escalated to ward staff on discovery, in order that immediate action be taken.	By the end of the inspection each of the issues raised within both clinical areas had been fully addressed.
Ward D7East Two mattresses (awaiting collection by porters), were stored on the floor to the side of fire doors at the end of the ward One patient did not have a nurse call	Both mattresses were partially blocking the fire exit, which could have prevented staff from assisting patients to safety, in the event of a fire		

buzzer Soiled shower curtain in use Two oxygen cylinders were not secured in any way-were free standing.	The absence of the nurse call buzzer prevented the patient from alerting staff to times when they needed assistance. This matter also had the potential to undermine their dignity This matter could have resulted in cross infection and also undermined the dignity of patients using the facility The cylinders could have caused injury to patients, visitors or staff		

Appendix B – Immediate improvement plan

Hospital: Royal Gwent Hospital

Ward/department: Operating Theatres/Ward C7East/Ward D7 East

Date of inspection: 8, 9 and 10 January 2019

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 be taken, to ensure that patients are assessed and re-assessed regarding their risk of developing a venous thromboembolism (VTE). The health board is also required to describe how it will assure itself that appropriate treatment is prescribed and administered to patients, to reduce their risk of developing a VTE. This is because we could not find any evidence of completed VTE risk assessments, audit of this important aspect of patient care, or clarity in terms of prescribed	2.1, 3.1 and 3.5	The risk assessment for VTE for emergency orthopaedic patients will be completed within 24 hours of admission. A written reminder of this requirement has been sent to clinicians with immediate effect. This communication will be reinforced through all appropriate meetings. Risk assessments will be made readily available to the wards and Emergency Department.		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
treatment (within two patient's medication charts), in accordance with the health board's current VTE policy and procedure.		Senior Nurses within Surgery, T&O and Emergency Department will reinforce the need for risk assessments to all nursing staff including Advanced Nurse Practitioners within T&O. An audit will be undertaken within 4 weeks after VTE risk assessment reinforcement with Pharmacy support via ward based teams to measure compliance. Ongoing compliance will be monitored through the audit process. All clinical directors within the scheduled care division have received a written reminder about VTE prophylaxis with the request for this important message to be cascaded to clinicians. Assurance that patients are treated		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		appropriately with thromboprophylaxis for the appropriate duration will be audited by pharmacy within the on-going monthly process		
During the morning of Day 1 of our inspection (8 January 2019), we found that the consent form (4) relating to a patient who was brought to theatre, contained an error. The error was discovered by an Operating Department Practitioner (ODP), who, on checking the patient's details and identity, discovered that reference to both their right and left lower limb was recorded on the consent form, on separate pages. The member of staff therefore sought clarification from the patient and relevant staff, to determine which limb was to be subject to surgery. This issue occurred as a result of human error and a degree of illegible writing within the consent form. The potential surgical error, was,	2.1, 3.1 and 3.5	Immediate action taken to remind all ward staff with responsibility to undertake pre-operative checks within Scheduled Care Division regarding correlation of consent form and marked surgical site. This message will be reinforced via daily staff meetings with ward sisters, communication to senior Nurses and communication cascaded to individual ward staff members. Learning has been shared with ward staff outside of Scheduled care Division, including Obstetrics and		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
however, averted as indicated above, due to the stringent checking process adopted by the ODP. However, we proceeded to consider the wider pre-operative checking process that took place within ward areas and also found that the checklist in use did not provide ward staff with any prompt to check whether patients' limbs had been marked correctly prior to their departure for theatre. The health board is therefore required to provide details of the action taken/to be taken with regard to the above. This is to ensure the delivery of safe and effective care to all patients and to minimise the risk of error in the future.		Gynaecology regarding this pre-operative check list standard. Clarity & legibility on consent forms with concurrent site marking of the patient has been reinforced to clinicians with responsibility for consenting patients for surgery. A task and finish group has been identified to standardise and revise the pre-operative checklist to ensure the inclusion of the prompt for correlation of consent form and marked surgical site.		

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

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Royal Gwent Hospital

Ward/department: Theatre department/Ward C7 East/Ward D7 East

Date of inspection: 8, 9 and 10 January 2019

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 inform HIW of the action to be taken, to ensure that patients and their families have access to relevant health promotion and orthopaedic material within wards.	1.1 Health promotion, protection and improvement	D7E has racking with patient information leaflets stocked Racking for C7E to be ordered and filled with information leaflets from Patient Information unit (PIU) site and Making Every Contact Count (MECC) site Ward clerk to replenish and maintain the racking system.	Senior Nurse - Laura Thomson	30th April 2019 On-going
The health board is required to provide HIW	4.1 Dignified Care	All staff to be reminded to ensure curtains are	Laura Thomson	Complete–

Improvement needed	Standard	Service action	Responsible officer	Timescale
with details of the action to be taken to ensure that ward patients in receipt of care and support, cannot be seen by people using the main ward corridor. The health board is required to inform HIW about the action it will take, to ensure that patients are alerted to whether toilets are vacant/engaged. The health board is required to inform HIW of the action taken/to be taken to maintain the privacy and dignity of patients who use the mixed gender toilet/washing areas within ward C7 East. The health board is required to inform HIW how it could prevent anyone in the theatre suite corridor, being able to see patients on the operating table within the main theatre.		closed correctly to prevent visibility from corridor Senior Nurse to "spot check" during ward visits. Engaged signs have been ordered to attach to toilet doors Actioned immediately following HIW visit – curtains now in place. RGH Theatres are a closed area. Swipe or doorbell access only. Theatre areas consist of an anaesthetic room with double doors to corridor and further double doors into the theatre area. Both sets of doors should be shut at all times. Theatre staff to be reminded of their responsibility to maintain dignity and privacy of patients within the suite and to	Senior Nurse - Laura Thomson Senior Nurse - Laura Thomson Senior Nurse - Laura Thomson Senior Nurse– Judith Willis	January 2019 On-going 30th April 2019 Complete May 31st 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		keep doors closed – this will be addressed at the next audit day when the full report will also be discussed. All glass in doors will be checked and covered with obscure covering.	Senior Nurse– Judith Willis	March 31st 2019
The health board is required to provide HIW with details of how it will ensure the validity of consent to surgery, in relation to patients who are admitted to hospital on the day of their planned operation.	4.2 Patient Information	For elective patients, the pre-assessment clinic provides verbal and written information about the proposed surgery. This is then followed up in a Consultant Surgeon Consent Clinic where understanding of the procedure is ascertained and opportunity to ask questions prior to signing the consent is provided. The pre-operative checklist has been amended to include the check of signed consent against listed procedure. This checklist will be used for both elective and emergency patients.	Mr Aled Evans, Clinical Director Senior Nurse – Judith Willis	Ongoing Complete– January 2019
The health board is required to provide HIW with details of the action to be taken to		The intention is to explore specific proforma	Mr Aled Evans-	Sept 30th 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
ensure that there are clear patient post-operative plans in place. The health board is required to provide HIW with details of the action taken to ensure that ward staffing levels are on display to the public, in accordance with this aspect of the Nurse Staffing (Wales) Act 2016.		plans within the new Ormis system. In the interim, a clear post-operative note will be included within the surgical operative note. This will be communicated to all Orthopaedic Surgeons via Directorate. Complete - The ward staffing levels sign was removed for deep cleaning it is now on display on Ward D7E. All appropriate wards within Scheduled Care have the staffing levels displayed.	Clinical Director Mr Aled Evans, Clinical Director Senior Nurse - Laura Thomson	 31st March 2019 Complete
The health board is required to provide HIW with details about how it will ensure that a structured patient handover takes place from the operating theatre to recovery.	3.2 Communicating effectively	A structured handover report will be explored and developed through a task and finish group – this will include input form Scrub nurses, surgeons, recovery nurse and anaesthetist	Senior Nurse – Judith Willis	June 20th 2019
The health board is required to provide details of the action taken/to be taken, to ensure that communication between clinical	5.1 Timely access	Rota to be put in place, including the Hip Fracture Nurse and Advanced Nurse Practitioner for Trauma & Orthopaedics	Senior Nurse - Laura Thomson	31st March 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
teams and wards is effective.		(T&O), to ensure attendance at daily Trauma Board meetings. This role will include communication and feedback to relevant ward managers post meetings. Ongoing communication in relation to changes in the order of lists will be communicated to the wards.	Lorna Mcatee, Senior Operating Department Practitioner (ODP)	Ongoing
The health board is required to inform HIW whether an extension to the patient's Deprivation of Liberty Safeguards (DoLS), authorisation has been agreed within ward C7 East. The health board is also required to provide comments about how it will prevent such instances occurring in the future. The health board is required to provide HIW with details of how it will ensure that trauma meetings are multidisciplinary and impact positively on patients' quality of life, in	6.1 Planning Care to promote independence	The patient was reassessed by RAID (Rapid Assessment, Interface and Discharge) team and deemed to have capacity. A DoLS was no longer required. DoLs training to be arranged for Ward staff on C7E by Mathew Watkins – this training will be opened up to staff in Scheduled Care. This will improve awareness and process to ensure the DoLS process is adhered to. Participants at the trauma meeting include theatre nurses, orthopaedic surgeons & juniors, hip fracture nurse, anaesthetist. Nurse (ward) representation to be identified	Senior Nurse - Laura Thomson Senior Nurse - Laura Thomson Senior Nurse - Laura Thomson	Complete – January 2019 31st May 2019 31st March 2019 with review in 6 months

Improvement needed	Standard	Service action	Responsible officer	Timescale
accordance with the health and care standards. The health board is required to inform HIW of the action taken to ensure that patients' personal details are protected within the operating theatre suite. This is, in accordance with General Data Protection Regulation (GDPR).		for the daily trauma meeting – a rota will be developed identifying a named nurse for this purpose. There will be representation for the 2 trauma wards – C5E and C7E. Ongoing review for effectiveness. Upgraded ORMIS theatre management system will require individual log ins for all persons using it. Information governance training compliance is currently 79%. Staff undertook Information Governance (IG) face to face training at audit day on February 12th. Further sessions planned with an aim for 95% compliance. Practice Educator will provide monthly report for Theatre Directorate meeting. In conjunction with anaesthetic, orthopaedic and theatre directorates, an alternative venue for the trauma meeting will be explored – this would include security and promote confidentiality of discussions held within the meeting.	Dr Paul Nichols, CD Theatres Senior Nurse – Judith Willis Mr Aled Evans, Clinical Director -	March 2020 (to complete) May 31st 2019 June 30th 2019
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken/to be taken to ensure that the following matters are addressed with regard to NatSSIPs and the WHO surgical safety checklist: • There was no formal checklist in use, in relation to Stop Before you Block. In addition, patient consent was not checked at this point; a verbal check only taking place	2.1 Managing risk and promoting health and safety	The WHO document is used to record surgical site marking Patient identity and site is checked verbally. Stop before you Block posters are to be circulated to all theatres. These are already visible in some areas. Lead Support for Blocks nominated. This role will include further development and formalising of a 'Stop Before you Block' checklist. In addition, a block trolley (grab and go) will be implemented.	Gareth Pocock – ODP Gareth Pocock - ODP	Complete April 30th 2019
• In instances where the original operating surgeon was replaced by another surgeon as the list		A full team re brief will take place when a surgeon is replaced and the in theatre white board will be updated. The senior theatre scrub nurse will be responsible for updating	Senior Nurse –	

Improvement needed	Standard	Service action	Responsible officer	Timescale
progressed, there was no evidence of re-briefing (Standard 7)		the white board. This action will be communicated to theatre teams.	Judith Willis	May 31st 2019
• There is a need to ensure that each patient is subject to discussion. This is, in order that the possibility of missing important information is minimised (point 7 Standard 7)		For patients that have not already been discussed, a full re-briefing on an individual basis for those added to any trauma lists with all team members will take place.	Mr Aled Evans, Clinical Director (CD), T&O	May 31st 2019
• The record of each safety briefing - to include a list of operating team members (point 6 Standard 7)		Upgraded ORMIS IT Systmem will be used to record the Safety Briefing, including the Staff present at the safety briefing.	Dr Paul Nichols, CD, Theatres	March 31st 2020
		Until ORMIS is upgraded the Theatre team members present during briefing will be recorded on the theatre white boards.	Judith Willis, Senior Nurse	30th September 2019
		A full list of the Trauma team for the day are listed on the white board outside theatre	Judith Willis, Senior Nurse	March 31st 2019
		Changes to the operating list will dictate that		

Improvement needed	Standard	Service action	Responsible officer	Timescale
We could not find any evidence to demonstrate that changes to the operating list, were discussed with the operating team (as on day one of our inspection)		a further brief takes place with all operating team members which is also conveyed to ward staff in terms of list order (identified in previous action)	Judith Willis, Senior Nurse	March 31st 2019
• The health board needs to make provision to discuss patients who have not yet been admitted to the hospital, at the time of safety briefings (point 7-Standard 7)		The proposed procedure and equipment are referenced in the morning briefing, this will be followed by a subsequent re-brief following the patients admission.	Mr Aled Evans, CD, T&O	September 30th 2019
• Staff were completing checklists and other theatre records without fully completing the practical aspects associated with the		The completion of both practical and documented aspects of the checklist will be reinforced to all relevant staff in the next audit day. Further education will be provided to staff via the practice educator.	Judith Willis, Senior Nurse	April 30th 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
required safety checks • Debriefing was not routinely performed (point 1 Standard 13) • The health board is required to provide HIW with details of how it will ensure that staff who report incidents, receive feedback.		Full debrief will be carried out for every list and will be signed off by a senior member of the theatre team. This will be audited monthly. Datix feedback of incidents will be an agenda item for the department staff meetings on audit day. In this way staff will be updated and learning can be shared.	Dr Paul Nichols, CD, Theatres Senior Nurse – Judith Willis	March 31st 2019 May 31st 2019 - ongoing
The health board is required to describe the action taken/to be taken, to ensure that all necessary, consistent steps are taken to prevent patients from developing skin/pressure damage whilst in the operating theatres.	2.2 Preventing pressure and tissue damage	All patients are positioned appropriately on suitable gel mattresses. Sufficient gel pads are available for use. Waterlow score is recorded pre, peri and post op. Also recorded on SBAR for ward handover. Hovermatt sheets to transfer vulnerable patients are utilised which can be inflated throughout long procedures to allow pressure relief. The presence of pressure ulcers has been included in the pre-op checklist to heighten	Senior Nurse – Judith Willis Senior Nurse –	Complete - ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		awareness of existing pressure ulcers. Awaiting print.	Judith Willis	May 31st 2019
The health board is required to describe the action taken/to be taken to ensure that all patients are fully assessed for their risk of falling.	2.3 Falls Prevention	Senior nurse to audit documentation weekly to ensure all risk assessments are undertaken on both elective and trauma wards. Ward managers to undertake one patient, one day audits which will review compliance with all aspects of patients documentation and assessments and also includes the suitability of the environment and their well-being. Ongoing audit of risk assessments will be undertaken locally through the Health & Care Standards Audit (HaCSA). These are completed annually with ongoing audit through the one patient, one day audits described above.	Senior Nurse - Laura Thomson Ward Manager D7E - Sandra Burnett, C5W - Tony Goodwin, C7E - Kannan Pandian Divisional Nurse (Interim) – Linda Jones	Commencing February 1st 2019 – ongoing Commencing February 1st 2019 – ongoing 23rd April 2019
The health board is required to provide HIW	2.4 Infection Prevention and	Works and estates referral made to order lock	Ward Manager D7E - Sandra	31st March 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
with details about the action to be taken, to prevent unauthorised access to harmful substances stored in the housekeeper's cupboard (ward D7 East). The health board is required to ensure that there are suitable procedures in place to replenish hand sanitising gel dispensers within wards. The health board is required to inform HIW as to how it will ensure that staff adhere to all aspects of its Infection Prevention & Control (IPC) policy (in particular, the requirement for staff to be bare below the elbow in the workplace and the wearing of theatre scrubs, outside of the theatre environment, in public areas).	Control (IPC) and Decontamination	for housekeeping cupboard door. Ward managers to allocate a staff member daily to check hand sanitisers at entrance to wards and to replace when empty Ongoing audit of hand gel will be undertaken through the Health & Care Standards Audit (HaCSA) A joint letter from the Health Boards Nurse & Medical Director, CEO has been issued reinforcing Bare Below Elbow (BBE). An audit of uniform (with particular reference to BBE) has been devised and will be completed initially on a weekly basis across the Scheduled Care Division. Zero tolerance for theatre staff to be outside the theatre in scrubs unless they are	Burnett Ward Managers – C7E, C5W, D7E Divisional Nurse (Interim) – Linda Jones Divisional Nurse (Interim) – Linda Jones Senior Nurse – Judith Willis	Complete 23rd April 2019 Complete Complete – ongoing March 31st 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		travelling to a different department. IPC issues to be discussed at departmental meetings. The Health Board are re-launching the Uniform Policy in conjunction with International Nurses Day. This will reinforce uniform policy Health Board wide. Infection Prevention & Control compliance training is currently 77% within Theatres, a memo has been sent to team leaders with an expected target of 95% compliance	Nurse Director ABUHB Senior Nurse – Judith Willis	May 12th 2019 March 31st 2019
The health board is required to inform HIW of the action it will take to ensure that patients are not without food or drink for longer periods than necessary, prior to surgery. The health board is required to provide HIW with details of how it will ensure that nil by mouth signs are appropriately and consistently used in the wards.	2.5 Nutrition and Hydration	Multidisciplinary trauma board meetings should clarify patient's theatre time and Nil By Mouth (NBM) status. This should be communicated to the wards and patients provided with fluids/food if appropriate. Ward Nurses to ring theatres regularly (every meal time) to check on timeliness of operating lists and to clarify if surgery is proceeding. If not proceeding or delayed, patient to be given food and drink immediately. Also, ward nurses to clarify	Senior Nurse Laura Thomson Ward managers Senior Nurse Laura Thomson Ward managers	March 31st 2019 March 31st 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		when the operation will be undertaken to ensure patient is kept NBM appropriately. NBM signs to be designed and used throughout orthopaedic wards on all patients who are planned for surgery.	Senior Nurse Laura Thomson Ward managers	March 31st 2019
The health board is required to provide HIW with details of how it will ensure that all patients transferred to theatre are accompanied by their medication chart The health board is required to inform HIW about how it will ensure that drug storage fridge temperatures are recorded on a regular basis.	2.6 Medicines Management	A prompt on the pre-op checklist indicates need for prescription chart. All staff to be reminded (ward staff at ward meeting, theatre staff at audit day) Fridge temperature recording charts to be re-issued to wards. Ward manager to allocate a staff member each shift to record fridge temperature. Audit of recording of fridge temperatures to be undertaken within HaCSA on an annual basis	Senior Nurse Laura Thomson & Judith Willis Senior Nurse Laura Thomson Senior Nurse Laura Thomson & Ward Managers Divisional Nurse (Interim) – Linda Jones	April 30th 2019 Complete Complete Ongoing as part of audit cycle.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Pharmacy omnicell has temperature control function and this is visible on the display, the machine will alarm if temperature is outside set parameters	All theatre staff	Ongoing
The health board is required to inform HIW of the action taken/to be taken to ensure that all staff complete mandatory safeguarding training.	2.7 Safeguarding children and adults at risk	All ward managers to ensure ward staff have completed safeguarding training This will be monitored ongoing on Electronic Staff Record (ESR)	Senior Nurse – Laura Thomson	31st March
The health board is required to inform HIW of the action taken to ensure that faulty equipment within the wards is repaired in a prompt manner, in support of patient care.	2.9 Medical devices, equipment and diagnostic systems	The following to be discussed at ward meeting: All observation machines/ pumps etc that need service/repair to be referred to medical electronics as soon as identified as not working Delays in repairs or condemned equipment to be escalated to senior nurse. All condemned equipment to be replaced.	Senior Nurse – Laura Thomson	31st March 2019 – ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with a description of the action it will take regarding the following: • The storage of surgical instrument trays We found that there was no standardisation of anaesthetic emergency algorithms		Health and safety competent person to ensure at least 6 monthly audit undertaken of all ward equipment checking working condition and service history. It is acknowledged that storage space within Theatres is an issue and this is on the theatre risk register. The installation of Omnicell has resulted in a de clutter of all storage areas which has resulted in an improvement for the tray storage areas. This issue has been revisited following the HIW inspection and work with Hospital Sterilisation & Decontamination Unity (HSDU) will continue to minimise tray stock held within main theatres. Work was previously undertaken to update and standardise the algorithms in line with Anaesthesia Clinical Services Accreditation (ACSA). An inspection of the presence of these algorithms in main theatres has	Judith Willis, Senior Nurse, Theatres Lorna McAtee – ODP	Ongoing Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The intubating laryngeal masks, were out of date (located on the difficult airway trolley) • There were no capnographs[56] in use in the recovery area of the theatre suite. This could impact on patients' safety whilst recovering from general anaesthesia		resulted in some replacements with all theatres now displaying the standardised list of algorithms in accordance with ACSA. The laryngeal masks were immediately removed and sent to HSDU and replacements added to the trolley. There are recent changes to the Difficult Airway Society Guidelines. A new checklist is in progress. Checking of the difficult airway trolley is on the Operating Department Practitioner's (ODP's) checklist kept in the annexe. This is checked twice daily Capnography is available in theatres and is	Judith Willis, Senior Nurse	Complete May 31st 2019

[56] Capnography is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Its main development has been as a monitoring tool for use during anaesthesia and intensive care.

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Sufficient numbers of PK Alaris[57] pumps and blood gas monitors[58] were not readily available for staff to use when caring for patients.		portable so can transfer with patient. Training needs analysis for recovery staff will be undertaken and a training programme implemented if required for nursing staff ODP's to receive refresher training on capnography on audit day The number of pumps (and other necessary) equipment is being reviewed in conjunction with the Department of Anaesthesia. When this review is completed any deficiencies highlighted will be addressed by a procurement process. In the event that pumps are not available a system is in place	Lorna Mcatee, senior ODP Paul Nichols, CD, Theatres Paul Nichols, CD, Theatres	May 31st 2019 – ongoing June 30th 2019 January 2020

[57] The Alaris PK Syringe Pump provides the user with an infusion tool for the administration of drugs for anaesthesia.

[58] A blood gas test measures the amount of oxygen and carbon dioxide in the blood.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		to receive pumps from Day Surgery. A blood gas machine is being procured for Main Theatre, to be situated in the emergency Annexe area. In the interim ICU is in close proximity and will be used for Arterial Blood Gasses (ABG's).		
The health board is required to provide HIW with details of the action to be taken to ensure that staff are aware of all elements of the assessment and management of peri-operative hypothermia. The health board is required to inform HIW about how it will ensure that the recording of patients' pain scores are reviewed and consistent within wards.	3.1 Safe and Clinically Effective care	Temperature monitored pre op in theatre and recovery. There are enough Bair huggers available for patients when required. A refresher session on hypothermia to be provided at next audit day Pain score on the NEWS chart is the standard* all wards should be adhering to when documenting the assessment of a patient's pain. Divisional Nurses to liaise with pain team to ensure all pain assessments used in the HB reflect this. To discuss in ward meetings. *for patients with cognitive impairment and/or Learning Disability there are alternative assessment of pain tools in use.	Senior Nurse – Judith Willis Senior Nurse – Laura Thompson Divisional Nurse – Linda Jones Divisional Nurse	31st May 2019 31st March 2019 31st March 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
			– Linda Jones	
		Pain scores to be audited annually via HaCSA, more frequent audit to be completed during the one patient, one day audits undertaken by ward managers and Senor Nurses		On-going
The health board is required to inform HIW about how it will ensure that patient information, is held in strict confidence at all times, within the wards.	3.4 Information Governance and Communications Technology	The patient status at a glance board on D7E has been moved to the staff room, therefore it is no longer on display to the public.	Senior Nurse – Laura Thomson	Complete
		All wards will be reminded to log off and lock computer screens when not in use.	Senior Nurse – Laura Thomson	31st March 2019
		Pre-op theatre notes are now kept in a cabinet on the ward and are no longer left in areas where they might be viewed.	Senior Nurse – Laura Thomson	Complete
The health board is required to inform HIW about how it will ensure that patients' confidential details are protected within the anaesthetic room.		Patients names will be removed from the white board as an identifier. This will be communicated to staff and followed up with spot checks to ensure compliance.	Senior Nurse – Judith Willis	31st March 2019 - ongoing
		Upgraded ORMIS theatre management system will require individual log ins for all	Senior Nurse –	31st March 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		persons using it. Theatre staff to be reminded of their responsibility to log out of PCs at the next audit day Briefing to take place in anaesthetic room and doors to be shut when it is taking place. Trauma theatre has a portable white board and following briefing this board is moved into theatre so isn't visible to patients. Consideration to be given to utilising portable white boards in all theatre areas. Patient confidentiality to be added to agenda for department meeting for next audit day Information governance training compliance is currently 79%. Staff undertook IG face to face training at audit day on February 12th - further sessions planned to achieve 95% Practice Educator will provide monthly report for Theatre Directorate meeting.	Judith Willis Senior Nurse – Judith Willi Senior Nurse – Judith Willis Senior Nurse – Judith Willis Senior Nurse – Judith Willis	 31st March 2019 31st May 2019 31st May 2019 30th April 2019
Quality of management and leadership				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with a description of how it intends to address the following: • Surgeons and anaesthetists were not fully engaged with the key/practical steps necessary to deliver safe care for patients undergoing invasive procedures • There was a lack of consistency in the way which the trauma list was managed (for example-there was a lack of ownership) • Clinical (orthopaedic) job plans did not support continuity of care, or the delivery of consultant led care for the whole emergency pathway • There was no structured post-operative review of ward patients • There was no evidence of (orthopaedic) consultant led ward	Governance, Leadership and Accountability	A task and finish group has been convened with all relevant stakeholders and led by the Divisional management team. This group will aim to address all the improvement points for Governance, Leadership and accountability identified by the HIW team.	Dr Andy Bagwell , Divisional Director	30th September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
rounds with multidisciplinary input.				
The health board is required to provide HIW with details of how it will ensure that staff are provided with adequate mandatory/relevant training within wards and the operating theatre environment.	7.1 Workforce	Staff to be allocated time on roster to undertake and complete mandatory training. Training compliance in theatres is monitored by the Practice Educator. A new database is under development and will enable monthly reports on compliance which will be sent to Team Leaders for action. Practice educator to update Theatre Manager with monthly compliance. Theatre secretary will generate compliance report from ESR for display in department A programme of education for audit days will be compiled and sent to all team leaders two weeks in advance to ensure appropriate attendance from theatre staff. This programme will target key areas of low compliance, allow training on new equipment and provide refresher training for current practice.	Senior Nurse Laura Thomson Senior Nurse – Judith Willis Senior Nurse – Judith Willis Senior Nurse – Judith Willis	March 31st 2019 - ongoing March 31st 2019 – ongoing March 31st 2019 – ongoing March 31st 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale

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): Dr Andy Bagwell

Job role: Divisional Director

Date: March 8th 2019