Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Wards 12 and 19, Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board

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

Our purpose

To check that people in Wales 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**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of two wards at the Royal Glamorgan Hospital within Cwm Taf Morgannwg University Health Board on the 6 and 7 November 2019. The following hospital sites and wards were visited during this inspection:

- Ward 12
- Ward 19

Our team, for the inspection comprised of three HIW Inspectors (one of whom led the inspection), two clinical peer reviewers and one lay reviewer, who was also a member of HIW.

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

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

2. Summary of our inspection

Staff on both wards were professional and committed to working collaboratively to provide patient care, and we found there was good leadership on the wards.

Patients generally reported a positive experience, and were treated with dignity and respect. However, patients and staff felt there was not always enough staff available, which could affect the standard of patient care.

We found evidence that the health board was not fully compliant with all Health and Care Standards in all areas. In addition, mandatory training compliance was poor.

We had immediate concerns with some aspects for the delivery of safe and effective care for patients, as we found that the required checks on resuscitation equipment and medication fridges had not always been completed as per health board policy.

This is what we found the service did well:

- Staff were endeavouring to provide patients with safe and effective care
- Information was available to inform patients of how to raise a concern or complaint
- Ward staff were mostly positive regarding the ward managers and the support they received from them
- The health board was actively trying to reduce the number of vacancies on the wards and the wider hospital.

This is what we recommend the service could improve:

- Ensuring that patients' dignity and privacy is maintained
- The completion of patient documentation in full
- The checking and documenting the checks for controlled drugs
- Increasing the levels of mandatory training compliance.

We had immediate concerns about patient safety that were dealt with under our immediate assurance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. This was in relation to checking of resuscitation equipment and fridge temperatures as per the health board policy.

Details of the immediate improvement we identified are provided in Appendix B.

3. What we found

Background of the service

The Royal Glamorgan Hospital is located in Llantrisant and forms part of services provided by Cwm Taf Morgannwg University Health Board. The health board was formed on the 1 April 2019 and covers the areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

The health board has a catchment area for healthcare services for a population of approximately 450,000 people. Acute, intermediate, primary, community and mental health services were all provided. Services were delivered in a variety of settings, including three acute hospitals; Royal Glamorgan, Prince Charles and Princess of Wales Hospitals.

The Royal Glamorgan Hospital provides acute emergency and elective medical and surgical services together with a range of diagnostic facilities.

Ward 12 is a designated acute medical ward, and also cares for patients with dementia. The ward is able to care for a maximum of 28 patients at any one time, and has four bays with six beds and four individual patient side rooms. There were no vacant beds at the time of our inspection.

Ward 19 is a designated acute medical (respiratory) ward. The ward is able to care for 28 patients at any one time, and has four bays with six beds and four individual patient side rooms. At the time of our inspection there were no vacant beds, and those admitted presented with respiratory illness and other medical conditions including patients with dementia.

HIW last inspected wards 12 and 19 of the Royal Glamorgan Hospital on the 13 and 14 March 2018.

The key areas for improvement we identified at the last inspection included the following:

Staff insufficiency and staff retention resulted in HIW issuing an immediate assurance letter. Some of those issues are outlined below:

- We found that there were 57.26 full time equivalent registered nurse vacancies at the Royal Glamorgan hospital at the time of our inspection. Of that number, 6.40 related to ward 12 and 6.73 related to ward 19
- As a result, both wards were heavily reliant on a high percentage of agency/bank nurses and Health Care Support Workers

(HCSWs). Where it wasn't possible to secure registered nursing staff, the health board provided both wards with an increased number of HCSWs to try and assist, as far as possible. HCSWs were limited in their role; additional work having to be undertaken by existing registered nurses

- The above issues were reported by staff to have existed for approximately 12 months, and had resulted in reduced team-working and increased pressure on substantive registered nurses

- In addition, conversations with HCSWs indicated that there were many occasions when they felt they had insufficient time to provide care safely. This impacted on patients' dignity and on the ability of staff to provide care in a timely way.

The health board supplied HIW with a response to the immediate assurance letter, the content of which provided us with assurance that prompt and appropriate action would be taken.

The purpose of this inspection was a routine inspection and included follow-up on the above improvements identified at the last inspection.

The views of patients were also obtained and we reviewed other aspects of the care as described in the relevant sections throughout the report.

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.

Overall, feedback from patients about the services they had received was generally positive.

Staff were endeavouring to provide patients with safe and effective care, when faced with considerable day to day challenges of the complex and unpredictable needs of the patients, together with staff vacancies.

Improvements were required regarding some aspects of patient dignity and privacy.

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

> *"Staff are absolutely brilliant. Nursing staff very good."*

> *"Nurses in particular are over worked. They have been great but I have noticed that they are often short staffed which puts a lot of pressure on them and sometimes the patients suffer due to delays with for example pain relief medication."*

Patients who completed a questionnaire rated the care and treatment provided during their stay in hospital as nine out of ten. Nearly all respondents agreed that staff were always polite and all agreed staff listened to them and to their friends and family. Most agreed that staff had always talked to them about their medical conditions and helped them to understand them.

During the inspection we noted some health promotion leaflets were displayed including smoking cessation posters, although this was minimal on ward 12. Further information could be provided on display for patients, carers and their families.

Whilst there was evidence of bilingual signage, we noted that the NHS Wales Putting Things Right[1] process poster was only available in English. The hospital should make further arrangements to provide further bilingual signage and information in Welsh and to help staff make an 'Active Offer'[2].

Staying healthy

Both wards promoted protected meal times. This ensured that patients were not unduly disturbed during meal times, to ensure adequate nutritional and fluid intake. However, for patients who would benefit from the support of their relatives, they could stay to help with feeding as required.

We observed mealtimes and saw staff assisting patients in a calm, unhurried and dignified way, allowing patients sufficient time to chew and swallow food. We also saw staff providing encouragement and support to patients to eat independently.

We saw good interactions between staff and patients, with staff attending to patients' needs in a discreet and professional manner. We saw staff spending time with patients, and encouraging and supporting them to do things for themselves, thus maintaining their independence.

However, we noted that there was little in the way of activities to stimulate patients during their stay on the ward. Nursing staff had provided an activity for one patient to undertake (drawing). The health board should consider ways to extend the provision of activity for all patients, but in particular for those with dementia, to further aid their well-being and health improvement.

Improvement needed

The health board must consider how to provide patients with a wider range of activities.

[1] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

[2] An 'Active Offer' means providing a service in Welsh without someone having to ask for it. http://gov.wales/topics/health/publications/health/guidance/words/?lang=en

Dignified care

During the inspection, we considered how patient privacy and dignity was taken into account and maintained by staff. All the patients who completed a questionnaire, agreed staff were kind and sensitive when carrying out care and treatment. A majority felt they were given a choice by staff about which method they could use if they needed the toilet, and that when necessary, staff helped with their toilet needs in a sensitive way. Patient comments included:

> *"The staff on ward are great, it's the service I've had with the pain I'm not happy with. All they seem to want to do is discharge me home in pain and not sort out problem while I'm here."*

> *"All nursing staff have been great during my care and cannot do enough for all the patients, my only observation would be that they are under staffed and there is a lot of pressure on them."*

We spoke with patients on the ward, and one patient commented that whilst the ward staff respect patient privacy when giving personal care, there had been two instances where other healthcare professionals did not alert the patient or staff before entering, when the curtain was closed. Additionally, we were informed that one patient did not have access to a shower for two weeks, although patients were provided with washing facilities daily in their bed areas.

Another patient we spoke with raised a concern related to the urine container attached to their catheter. The container was changed by a doctor and the used container was left on floor. The patient asked the doctor to remove this, however, the doctor said they would ask a nurse to remove it. It was still there later in the day and the patient felt this to be embarrassing and unhygienic.

Patients had a choice of what to eat and drink from a set menu, and had access to water, which was in easy reach. At meal times, patients were sat up and had their bed tables cleared, cleaned and placed within reach. Patients were also offered hand wipes/washing prior to their meals, and did not have to wait long for their meals, once the meal trolley arrived. The food looked appetising and was hot.

Staff who completed a questionnaire were satisfied with the quality of care they were able to give to patients. Nearly all staff who responded agreed patients and/or their relatives were always or usually involved in decisions about their care. They also said that the privacy and dignity of patients was maintained, despite the negative comments from patients, and most said patient independence was promoted.

Each bed had washable privacy curtains that could be closed to provide patients with privacy. We noted the washable curtains were removed as required when soiled or where the patient moved from the ward. However, the health board should consider the use of disposable bedside curtains to help maintain infection, prevention and control.

Patient bathrooms were available to both male and female patients. However, the signage on the bathroom doors could be improved to make them more recognisable to poorly sighted or confused or disorientated patients. In addition, we were concerned to identify that not all bathrooms were marked as male or female use, and we were also told that each gender used any bathroom. There is a risk that if a door was not locked, then a female patient may enter a bathroom in use, by a male or vice versa, thus impacting on patient dignity.

Continence assessments within the patient notes that we reviewed were inconsistent on both wards. This may prevent the appropriate care being provided to patients with or without the required continence needs.

For patients with dementia, we saw that the ward used the Forget Me Not[3] initiative for the appropriate patients.

Improvement needed

The health board must ensure that:

- Patient dignity is maintained at all times, particularly when curtains are drawn
- Urine containers are removed from bed areas when no longer in use
- Appropriate continence assessments are undertaken and documented appropriately
- Patients have access to showers on a regular basis
- Patient bathrooms are designated as ether male or female, and signs are clearly visible on the doors to identify this.

[3] https://www.forgetmenotdementia.co.uk/

Patient information

Directions to the ward were generally clear with signage to the relevant ward, although on two occasions the inspection team were asked by visitors, which ward was which, possibly owing to the ward sign being located near the ceiling.

On ward 19, the notice boards were well populated with patient information on the corridor approaching the ward, and most information was bilingual. There was smoking cessation information and health promotion advice, including keeping mobile to help prevent blood clots. However, on ward 12, there was far less information available to patients. The notice boards had some literature on display but there was no health promotion literature available.

Both wards had an electronic Patient Safety at a Glance (PSAG) Board, and these were used across the hospital site. The boards contained information about individual care needs and relevant standardised icons, to highlight individualised patient needs. There was no patient identifiable data on the board, thus ensuring patient confidentiality. However, we noted that the symbols were not fully up to date, for example, not all relevant patients had a symbol to identify that they were confused. The PSAG board was an area of noteworthy practice and were valuable tools for communication.

Improvement needed

The health board must ensure that:

- Noticeboards are regularly checked to ensure that all relevant up to date information is displayed, including health promotion documentation
- The PSAG board is kept up to date.

Communicating effectively

Around half of patients who completed the questionnaire agreed they were offered the option to communicate with staff in the language of their choice. Nearly all respondents agreed that staff were always polite, all agreed staff listened to them and to their friends and family and that staff called them by their preferred name.

During the inspection, we saw that staff were very pleasant to patients and took the time to speak with them. We also saw that staff were generally aware of the need for discretion in communicating personal information with patients. However, we witnessed a conversation at the reception desk, where a staff member was discussing very sensitive and private information with a patient,

which was in an open forum and possibly overheard by other patients and visitors. We raised our concerns regarding this issue with senior managers.

The head of nursing had recently arranged training for staff in relation to improving compassionate patient care on the wards. This scenario based training was provided by the Royal College of Nursing, and was well attended by staff on both wards.

Improvement needed

The health board must ensure that all staff maintain patient privacy and confidentiality when communication with patients.

Timely care

The nurse call bell system in use was effective in alerting staff to the relevant patient, since the bed number was displayed at the reception desk. All of the patients who completed the questionnaire confirmed that they had access to a nurse call bell, and most agreed that staff would come to them when they called. One patient we spoke with stated that staff generally provide assistance however, there were occasional delays in response, when staff were addressing the needs of other patients.

Within the HIW staff questionnaires, staff were given a number of statements relating to patient care, and were asked to rate how often they applied in their experience. Most respondents said they were at least usually able to make suggestions to improve patient care however, a minority said they felt involved in decisions which affected them, and a similar proportion said they were never involved. The majority of respondents said they were, on some occasions, unable to meet all the conflicting demands on their time at work, and around a quarter said they were unable to meet demands.

Individual care

Planning care to promote independence

Through discussions with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their daily care needs. Patients also told us that staff assisted and provided care when it was needed. We saw staff encouraging and supporting patients to be as independent as possible. For example, staff encouraged patients to walk and assisted them to eat and drink independently.

We also saw that patients were supported to change out of their nightwear during the day, in order to maintain their dignity, promote independence and assist with their rehabilitation and preparation for safe discharge.

There was clear evidence of transfer of care and discharge planning. The discharge process was well documented in both medical and nursing notes. However, we were told that the process for prompt discharge was often impeded by the lack of available beds in other community hospitals or nursing homes, and by the lack of social care provision for patients to be discharged to their own address.

The hospital implemented the initiative called, This is Me. This is a simple form for anyone receiving professional care, and who is living with dementia or is experiencing delirium or other communication difficulties. The form can provide details about a person living with dementia, and provides an easy and practical way of recording who the person is. However, we found that this was only completed for one patient, and only one line completed on the form in that instance. Where it would have been applicable, we did not see forms completed for other patients. Whilst it was clear from observations that staff clearly know their patients, this information would be useful for temporary staff new to the ward.

We saw that mobility aids were placed close to patients as applicable, so that they could use them without having to ask staff for assistance

People's rights

Discussions with patients and staff revealed that there were defined times for visiting, and there was a notice of the visiting hours at the entrance to the wards. We were also informed that on occasions when family members had to travel long distances to the hospital, or when children wished to visit during school days, they were able to visit at any reasonable time, by negotiating this with the ward staff.

Family or carers, where applicable, were able to provide patients with assistance and be involved in their care in accordance with their wishes and preferences. Staff told us that these arrangements would be recorded in patient notes, to ensure that all members of the ward team were informed.

For patients who wished to exercise their religious beliefs, there was a chaplaincy service available and a multi-faith room opposite the entrance to ward 19.

Listening and learning from feedback

All staff who completed the questionnaires stated that patient experience feedback through patient surveys was regularly collected. A majority said they

received regular updates on the patient experience feedback. A majority of staff said that feedback was used to make informed decisions within their directorate or department.

We spoke with the Patient Advice and Liaison Service (PALS) at the hospital, whose role was to ensure that there was an emphasis on obtaining peoples' views on the care and services provided to patients. The PALS staff said they carry out a number of patient surveys themselves, and recent examples include the Admissions Unit, Mental Health Unit and the Emergency Department. They look for trends and concerns or complements about particular departments, which they discuss at team meetings, and then feedback to relevant department senior teams. They had not received any concerns about wards 12 or 19 in the last 12 months.

The PALS team also receive comments from social media. They provide, Have your Say leaflets in public areas throughout the hospital, and leaflets drop boxes are also available. The PALS staff work with the Community Health Council (CHC)[4] and they communicate issues when needed. They can also refer patients to CHC for advocacy support.

During the inspection we noted two instances of learning from feedback in the minutes of the head of nursing's patient experience and quality meetings. We were told that following a partnership and dignity visit by the CHC on ward 12, they identified that nursing staff morale was poor, the team present felt that they were not supported adequately, and that there was poor continuity of staffing due to the high number of vacancies.

Due to the complexity of the patients and the number of vacancies on ward 12, we were told that this had a negative impact on the general well-being of staff, as well as impacting on timely patient care. As a result the senior management team met with the deputy chief operating officer, and a decision was made to close six beds on the ward from the 24 June 2019 for 4 weeks, and to monitor this on a daily basis. This was to help alleviate the staffing issues due to vacancies to support staff and to improve patient care. The beds had been reopened at the time of the inspection, and the vacancies on the ward had reduced to 10. However, we discussed this number with the ward staff and senior managers,

[4] www.wales.nhs.uk/sitesplus/903/home

and plans are in place to continue with recruitment on an ongoing basis, until all posts are filled.

Since a separate HIW inspection in the early part of 2019, the minutes state that a, Have Your Say Board was implemented. The board incorporated signposting for patients, when they may have concerns to raise, and what staff have done as a result of the concerns. This was implemented throughout the hospital. The board also included information on other departments within the hospital.

Within the main corridor there was an Appreciation Board, where patients and staff could nominate individuals for something that they have done above and beyond their normal work. We saw that within the meeting minutes we reviewed, this had a positive impact on staff.

Patients and their representatives also had opportunities to provide feedback on their experience of services provided, through face to face discussions with staff.

There was a formal complaints procedure in place, which was compliant with the NHS Wales Putting Things Right process. Putting Things Right leaflets were available on both wards.

The health board and the hospital were trying to encourage staff to participate in the Let's Talk Culture[5], where it wanted to hear from all staff about their experiences and ideas to reshape the organisation. This was being completed in two ways, through participation in a survey and to sign up for workshops.

[5] https://cwmtafmorgannwg.wales/lets-talk-culture/

Delivery of safe and effective care

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

Staff were striving to deliver a good quality, safe and effective care to patients within very busy wards, and we identified some good processes on both wards that we inspected. However, we were not assured that all the processes and systems in place on both wards, were sufficient to ensure that patients consistently received an acceptable standard of safe and effective care.

Safe care

Our immediate concern regarding the resuscitation equipment and medication not being checked regularly, and the poor arrangements for daily checking and temperature recording of the medication fridges on both wards, was dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Managing risk and promoting health and safety

We found that the wards were well maintained and were generally clean and tidy. Most of the patients who completed a questionnaire also agreed the wards were clean and tidy.

We found that the housekeeping cupboards were locked, and cleaning products or other hazardous chemicals were stored securely to prevent unauthorised access.

The main doors off the main hospital corridor to access the wards, were locked when we initially arrived at the ward. However, there were instances where the door was open during the day, particularly during patient visiting times. In discussion with staff they stated that the doors were always locked at night, but not during the day.

All bed areas had chairs and foot stools for patients and all appeared in a good condition. The bed areas were generally clear of clutter as were the corridors in the ward. It was noted that nursing staff were visible in patient areas throughout the inspection.

During the inspection we noted that some patient property was stored in the sluice area, as there was no other area to store this. We were informed that the wards periodically returned uncollected patient property to the facilities department, or if staff have been unable to arrange with the patient or their relatives, to collect.

Preventing pressure and tissue damage

During the inspection we reviewed a sample of patient care records on both wards. We found that all patients had been assessed for their risk of developing pressure ulcers, using the Waterlow Risk Assessment, which gives an estimated risk for the development of a pressure sore in a given patient. Each patient assessed as at risk of developing a pressure ulcer, had evidence of an appropriate skin assessment. Nursing staff also demonstrated an understanding of the risk for developing pressure ulcers and the prevention of them.

There were instances where the documentation was incomplete on ward 19, as the evaluation of assessment was not evident in repositioning charts which are used to prescribe regular pressure relief, and which also records when skin has been assessed for signs of pressure damage.

Specialist pressure relieving equipment, such as air mattresses and air cushions was available and being used as appropriate.

On reviewing the monthly patient safety summary report for the medicine directorate for September 2019, it highlighted that there was a weekly pressure ulcer scrutiny panel chaired by the Head of Nursing or Senior Nurse. Within this panel, any pressure ulcers that had developed during a patient's admission, was scrutinised by the panel, and learning form this was shared across all nursing teams.

The senior nurse and the tissue viability nurse[6] had also been working together with the ward nursing teams, to ensure that the required management plans for the appropriate patients were in place.

[6] Tissue Viability Nurses provide support and education in wound care and pressure damage prevention to enable healthcare professionals to provide evidence based and cost effective care.

Improvement needed (also identified in the previous report)

The health board must ensure that regular re-positioning of patients, and the appropriate self-care arrangements, are clearly recorded.

Falls prevention

We reviewed a sample of patient records on each ward, and saw that patients had been assessed for their risk of falls. Patients deemed at risk were sometimes moved into a bay if appropriate, where a HCSW would be present at all times where possible. This was to monitor and assisst those patients at a higher risk of falling. We also saw that up-to-date care plans were in place for those at risk of falls, and if a patient fell, an electronic incident form was completed via a system called Datix, which is a patient safety software for incident reporting and adverse event reporting. Staff also informed us that there was a referral process in place if required, to the health board specialist falls service.

We saw that the patient safety and quality summary report for October

2019 showed that 51 of the 188 reported falls across the eight wards within the medicine directore, occured on wards 12 and 19. This was during the period of April to October 2019. The report also highlighted that the corporate head of nursing was undertaking quality improvement work around falls prevention, and targeting all of the acute medical wards.

As highlighted above, all instances of falls were reported on Datix, and we reviewed the Datix incidents, and noted examples that incidents were investigated, and any lessons learned were made known to staff, through staff meetings.

We reviewed the minutes of the health board senior nurse meeting from October 2019, which highlighted that a new baseline audit tool will be implemented on all wards in the helath board, which will include patient information regarding falls. The new audit tool was designed to help measure standards of falls risk assessment & associated care-planning, within the inpatient setting.

Improvement needed

The health board must ensure that:

- Patient falls risk assessments are completed and updated including re-assessments

- Measures are put in place to reduce the number of falls and minimise the risk of falls.

Infection prevention and control (IPC)

As highlighted earlier, we found that the wards were well maintained and were generally clean and tidy. However, we did note that the main hospital corridors appeared quite dusty and appeared dirty in some areas throughout our inspection.

On the wards, there were four patient side rooms, which were mainly used to isolate patients who may have an infection or are suspected as having an infection. During the inspection, we were informed of a patient who may have an infection, so was isolated in a side room. However, we saw that the door for this particular side room was left open. Ideally the doors should be closed to limit the risk of cross infection, but we were informed that the doors were left open so that staff could observe the patient due to their risk of falls.

On inspecting the ward environments, we noted that the floor corners of all toilet areas and hinges behind doors, appeared dusty or dirty. Door handles appeared clean, but we wiped dust off some surfaces, such as hand rails, soap dispensers and the top of doors.

Whilst ward 12 looked generally clean and tidy, there was evidence of a dirty seat in the shower room, and in addition, there was dust on the high level surfaces, such as light canopies above the bed spaces. We discussed this with cleaning staff, who informed us that they were unable to clean these areas whilst a patient was in the bed underneath, and were unable to move the beds by themselves. In addition, they said that ward equipment such as shower chairs, should be cleaned by the ward staff. We raised the issue with the ward senior team, who consequently spoke with the housekeeprs about the need to communicate with the nursing staff if areas cannot be cleaned, or they require assistance to move furniture.

We reviewed both the wards' weekly and daily cleaning schedules, and these appeared incomplete at times.

Ward 12 has an IPC champion,who undertakes weekly hand hygiene audits and trains new staff on adequate hand hygiene.

Personal protective equipment, such as disposable aprons and gloves, were available and being used appropriately to maintain effective infection prevention and control. Appropriate facilities were in place for the safe disposal of clinical waste, including medical sharps such as needles. Hand washing and drying

facilities were available throughout the wards, together with hand sanitising gel. Effective hand hygiene is essential to help prevent cross infection.

Mandatory training compliance for infection prevention and control was only 37% for ward 12 and 61% for ward 19. Further reference is made to training complaince under the Quaity of Management and Leadership section of this report.

Improvement needed

The health board must ensure that:

- An appropriate risk assessment is undertaken for situations when side room doors are left open, where an infected patient is admitted, and the door cannot be closed
- The ward and hospital environments are maintained and kept clean
- Cleaning schedules are completed
- Housekeeping staff liaise with the nursing team when equipment or furniture requires moving to maintain adequate cleaning
- All staff complete IPC training.

Nutrition and hydration

Food was delivered in a timely manner throughout the day, and appeared to meet dietary needs of all patients, however, there were some issues with some patients being able to eat their food in a timely manner.

We observed staff providing assistance to patients at lunch time, by positioning the patients and helping them where applicable, with eating and drinking. Despite staffs' best efforts to feed patients at meal times, this was delayed for some patients due to staffing levels and the high level of dependency on the wards. We noted that in a bay with six patients, where four patients needed help with feeding, there were only two nurses available. This meant that some patient food was not as warm as it should be, due to the delays in feeding patients.

We observed a HCSW supporting and feeding patients in a dignified manner, that is, taking their time, using encouraging words and good positioning.

We saw there was a good choice of food on the menu and patients could choose what they wanted to eat based on individual risk factors, for example, individuals with swallowing difficulties. We found the food looked appetising, hot and smelt

good. We saw that water jugs and cups were placed on bedside tables and within easy reach of patients. Staff were also seen to be assisting patients to drink at other times during the inspection.

Nutritional risk assessments had been completed for all patient records reviewed and where appropriate, food / fluid intake was being monitored and recorded. On ward 12, there was an initiative in place using different coloured lids on water jug, to identify where patients had monitoring in place. This included blue lids for normal fluid intake, yellow for patients requiring assistance and fluid balance recording, and red lids for patients requiring additional thickening agents..

Care plans had been developed where applicable and a referral made to the dietician and the speech and language therapy[7] service as required. We also noted that the Malnutrition Universal Screening Tool (MUST)[8] risk assessments were completed, apart from one patient on ward 19, and there was also one instance where a MUST score had not been recorded for three weeks for a patient on ward 19. We were informed that the patient was considered a low risk although the food chart indicate the patient was refusing food and fluids.

Improvement needed

The health board must ensure that:

- There are sufficient provisions in place, to provide patients with assistance to eat and drink in accordance with their needs
- Patient MUST assessments are fully completed and updated in a timely manner.

Medicines management

We considered the arrangement on both wards for medicines management. For this we inspected the areas where medication was stored and also the preparation of medication at ward level and the prescription and administration process.

[7] Speech and Language Therapy Services

[8] Malnutrition Universal Screening Tool

The health boards policies and procedures for medication management and medication storage were available electronically. We saw that all medication, including Controlled Drugs (CDs), were stored securely. They were situated in locked cupboards within a locked room, and medication trolleys and fridges were also locked.

We observed medication rounds on the wards, and saw evidence that the process was completed safely, and the medication trolley remained secure at all times.

We saw that all patients were wearing identificaton bands. Staff checked the medication, dose and patient armband, but did not always check the expiry date on the blister pack strips. Patients were handed the medication to take whilst the nurse was in the same bay, and were positioned appropriately, in readiness to take the medication.

On ward 19, it was noted however, that medicines were left at the bed side for patients to take when they were ready. We had concerns with this, so immediately addressed this with the ward manager.

We saw that Intravenous (IV) fluids were appropriately signed for and recorded on the appropriate records. We reviewed the medication administration record, and noted a number of errors or omissions as follows:

- Some medical signatures were illegible and did not record a bleep number or print of name, to identify the signature
- There were gaps on charts where medications may or may not have been given, with no reason for the omission documented. In addition, there were some dates and times omitted for Once Only medication, thus increasing the risk to patient safety, as the patient may receive a second dose too soon
- Patient names were present on the front page of the chart, but were not consistently recorded as required, on each page of the medication charts
- Allergies and weights were not recorded in every chart we reviewed
- Where applicable, oxygen was prescribed by a doctor, but was not fully completed with start dates of medication absent.

There were arrangements in place for accessing medications out of hours, and this included controls for obtaining controlled drugs, in line with the health board policy.

The CDs were recorded in a specific CD book, but a weekly balance check of the CDs, had not been completed as per hospital policy. There were delays by up to two months for some checks, and there were occasions where the checks were carried out by a registered nurse and a pharmacist, whilst the policy states this should be undertaken by two registered nurses.

Improvement needed (also identified in the previous report)

The health board must ensure that:

- Expiry dates are checked on all medication prior to administration
- Medication is not left unattended at a patient bedside
- The All Wales Medication Charts are completed correctly and in full in accordance with professional code of conduct, and health board policy
- A weekly check of CD stock balance is completed, as directed by the health board's policy
- Self-medication by patients is adequately assessed and documented.

Safeguarding children and adults at risk

There were safeguarding policies and procedures in place to promote and protect the welfare of children and adults who were vulnerable or at risk. Mandatory training compliance for safeguarding children and adults was at approximately 50% on both wards. Further comments relating to training compliance is highlighted in the section, Quality of Managament and Leadership.

We were told that there were no active safeguarding issues on either ward at the time of the inspection. Patients also stated that they felt safe and would be comfortable in speaking to a member of staff if needed.

During our inspection, there were some patients who required one to one nursing support. This meant that HCSWs were required to remain with the patient 24 hours a day, to maintain their safety and well-being.

Any patient requiring this level of observation was therefore deprived of their liberty and requires a mental capacity assessment[9] under the Mental Capacity Act 2005[10]. If it was identified that a patient lacks capacity, then staff need to complete a Deprivation of Liberty Safeguarding (DoLS)[11] application and referral to the Independent Mental Capacity Advocate (IMCA)[12], and an appropriate care plan to accompany this. This must then be available within the patient notes.

We identified clear evidence that an assessment was carried out with the relevant patients and this was documented appropriately within the patient record. Both ward managers had a good understanding of DoLS and which patients were subject to DoLS.

Improvement needed

The health board must ensure that all staff complete the relevant level of safeguarding training for children and adults.

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

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

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

[12] The local authority, or the NHS decision maker must make a referral if a patient is un-befriended (has no 'appropriate' family and friends who can be consulted), and has been assessed as lacking the capacity to make a decision about: Serious medical treatments, Long-term moves (more than 28 days in hospital or more than 8 weeks in a care home) and Deprivation of Liberty Safeguards (DoLS).

Medical devices, equipment and diagnostic systems

We found that the ward had the appropriate equipment in place to support the needs of the patients on the wards, which included walking frames, commodes, monitoring equipment and hoists. Where additional equipment was needed, staff we spoke with said there was always availability of this in the hospital.

We noted that there was a hoist and bed maintenance contract in place and there were labels on the equipment on the wards, showing that the checks had been completed as required.

Of particular note was the use of an assistive listening device called Sonido Digital Listener[13], supplied by Action on Hearing Loss[14]. Patients, who required such assistance could use this equipment, at their bedside.

Effective care

Safe and clinically effective care

There was evidence that pain was being assessed, and relieved with medication and the effects evaluated. Patients also had up-to-date pain scores completed. In addition, pain was being managed with suitable analgesia, and was administered as prescribed on a regular basis.

Nearly all staff members who completed a questionnaire said that if they were concerned about unsafe clinical practice they would know how to report it, and most said they would feel secure raising concerns. A majority felt confident that their organisation would address their concerns once reported, and also agreed they would be happy with the standard of care provided by the organisation, if a friend or relative needed treatment, and very few disagreed.

We saw evidence of audit activity being regularly undertaken. The results of the hand hygiene audits were reviewed by the ward manager and discussed in the

[13] The Sonido portable amplifier is designed to help the user hear conversations and other sounds (like the TV) more clearly. By pointing the Sonido in the direction required it will it will amplify the sound the users wants to hear and reduce the background noise from everywhere else.

[14] http://www.actiononhearingloss.org.uk/about-us/

ward managers meeting, emails of the minutes were also sent to all staff on the ward.

All staff were made aware of any changes to clinical guidelines and policies and procedures via group emails, as well as being discussed during ward meetings. However, we were informed that urgent issues would be discussed on the same day.

The ward nurse staffing establishments were compliant with the Nurse Staffing Levels (Wales) Act[15] (2016), and this was displayed at the entrance to both wards. The ward managers told us that the establishment was increased to comply with the act.

If there were occasions, due to the increase acuity and dependency of patients, which required the need for additional staff, the ward managers stated that additional staff were requested. However, additional staff were often not available. We were told that this was because, authorisation from senior nurses for additional staff was only given at late stages. Thus, reducing the ability to obtain staff at short notice.

Improvement needed

The health board must ensure that additional staff are requested in a timely manner and provided to requesting wards, when required.

Quality improvement, research and innovation

Discusson with the staff on both wards revealed that there had recently been a project in place relating to the discharge medication review called the SORY Project. This project was implemented to enhance the process for patients to ensure they were well prepared and discharged in an appropriate and timely manner. Staff stated that whilst the funding for this project had been removed, they were endeavouring to continue with this practice, as they believed it was working well.

[15] Nurse Staffing Levels (Wales) Act 2016

Information governance and communications technology

There was a system in place to ensure patient data was effectively and safely stored. Patient records were stored in designated lockable trollies to prevent inappropriate or unauthorised access to the notes. We observed that records were normally located by the reception desk. We did not see any instances where records were left unattended, thus reducing the risk of breaching patient confidentiality and inappropriate and unauthorised access to patient data.

Training compliance for information governance, based on the electronic staff records, was 69% for ward 19 and 60% for ward 12. Further information on training compliance can be seen later in this report.

Record keeping

We reviewed the content of five patient records on ward 12. Both medical and nursing records were well organised, chronological and easy to follow. However, bedside notes did not have the same structure or order, and were difficult to navigate.

We considered the content of four patient records for ward 19, and noted that whilst they were legible, initials and signatures were difficult to read, and it would be difficult to identify who made the entry. Entries were signed and dated most of the time, however, following discussions with ward staff, they recognise that there were delays in the ability to complete some documentation, if clinical care was a priority.

Care plans were generic and not individualised for specific patient needs. When we reviewed the records, they did not always give detail on how the patient was progressing and responding to care. Additionally, in one instance the instructions above the patient bed did not align to the care required for the patient, for example, the bed notice said the patient should sit up in a chair, but the patient notes state that the patient was on bed rest due to issues with their blood pressure.

For both wards there was evidence of a brief written handover, although the teams were mainly reliant on the verbal handover. Whilst the quality of the verbal handover was not questioned, there would not be the ability to evidence this at a later date.

Improvement needed (also identified in the previous report)

The health board must ensure that:

- Patient care plans are regularly updated and evaluated
- Staff apply legible, identifiable signatures, each time entries are made into the patient records.

Quality of management and leadership

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

We found evidence of good leadership and management amongst nursing staff. Ward staff were mostly positive within the questionnaires and those who we spoke with, regarding their managers, and the support they received from them.

Overall, compliance with completing mandatory training on both wards was below the target set by the health board.

There were a number of vacancies against the establishment within both wards inspected, and this extended to the wider hospital site and health board. The health board were active in trying to resolve this situation.

Governance, leadership and accountability

During our inspection, we invited staff working on the ward to provide their comments on topics related to their work. This was done mainly through a HIW questionnaire, we also spoke with a number of staff during the course of our inspection. In total, we received 29 completed questionnaires, which were received from staff undertaking a range of roles and disciplines on the wards.

Staff were asked in the questionnaires to rate how often a number of statements relating to their organisation applied in their experience. Nearly all staff who completed a questionnaire said they know who the senior managers were in the organisation. However, only half said there was always or sometimes effective communication between senior management and staff. There was a significant difference in the responses between both wards, with most staff on ward 19 saying there was always effective communication, and very few agreed on ward 12. Some staff comments included:

> *"The senior nurse is very supportive and shows concern towards staff and patients, she is approachable, friendly and professional."*

> *"I always feel supported when working on the ward which is why I choose most of my shifts on this ward."*
>
> *"There is a bullying culture within senior management, towards ward staff. They make decisions that appear to be unfair"*
>
> *"It feels that senior management do not consider patient feedback and opinion especially with staffing levels. When senior management are told of staff shortages, other staff struggles are not taken into consideration."*

Most staff who completed a questionnaire said the organisation always or usually encourages teamwork. Again there was a significant difference in the answers between wards 12 and 19, with far more staff in ward 19 answering, always to this question, compared with few on ward 12. The majority who answered felt the organisation was always or usually supportive and a few answered never. One member of staff commented:

> *"The organisation appears to believe more about reducing complaints by relatives and certain patients than supporting their staff who make decisions based solely on patient care and safety. Unfortunately, some patients and relatives do not like to be empowered, have their independence promoted or told how to improve by complying with recommendations. Therefore, occasionally complain and the organisation will support the complaint, rather than the professional with rational"*

In contrast to this comment, a majority agreed front line professionals who deal with patients were empowered to speak up and take action when issues arise. Also a majority said there was always or usually a culture of openness and learning within the health board, that supports staff to identify and solve problems.

Most staff who responded, thought the health board always or usually has access to the right information to monitor the quality of care, and a minority answered never. Most agreed the organisation acts on concerns raised by patients, and a majority also agreed they would recommend the organisation as a place to work..

A clear management structure was in place, and senior staff described clear lines of reporting to the wider health board management. Roles, responsibilities and lines of accountability were also described. Staff we spoke with felt supported by their ward managers and spoke highly of them, on both wards.

We identified clear lines of communication through ward meetings and other sources. There were monthly audits completed by ward and senior managers, which included the environment, patient records and care delivery. Results were fed back to the ward teams, and any trends identified and shared across the wider site.

Staff described the system for reporting and investigating patient safety incidents. Arrangements were described for providing reports and action plans to senior managers within the health board to promote service improvements.

Around half of staff told us in the HIW questionnaires that they had seen errors, near misses or incidents in the last month that could have hurt staff, and a minority had seen errors, near misses or incidents that could have hurt patients. Most respondents said they had reported an incident the last time they had seen one.

A majority of respondents agreed staff who were involved in incident were treated fairly and most agreed that their organisation encourages them to report these. Also, a majority of respondents agreed the organisation would treat reports of an incident confidentially, and few disagreed. However, a few said that the organisation would blame or punish the people who were involved in such incidents.

A majority of staff that completed a questionnaire agreed action would be taken on incidents identified, and none disagreed. A majority of respondents also agreed they were informed about errors, near misses and incidents that happen in the organisation, and were given feedback about changes made in response to these , although a few disagreed.

Throughout our inspection, and during the concluding inspection feedback, senior staff present demonstrated a commitment to learn from the inspection, and to make improvements as appropriate.

Improvement needed

The health board must ensure that consideration is given to the negative staff comments and issues identified within the Governance, Leadership and Accountability section of the report, for both wards inspected, and must inform HIW of the plan to address these issues. Consideration must also be given to such staff feedback throughout the organisation.

Staff and resources

Workforce

Vacancies and absences

As highlighted earlier, there were several qualified nursing vacancies on both wards, with 10 vacancies in ward 12 and five in ward 19. The senior management team were very conscious of the vacancies, and we were told that there were 94 registered nurse vacancies across the hospital site.

Sickness absence was approximately nine percent in each ward. Although the absence for a particular staff group on ward 19 was over 20%. This resulted in a heavy reliance on temporary staffing, particularly in addition to that required for the current vacancies.

The health board is currently involved in overseas recruitment, and the first cohort of nurses arrived in September 2019. The overseas nurses were working as unregistered nurses, until completion of their objectives, practical experience and successful completion of their Objective Structured Clinical Examination (OSCE). This was mandatory, before receiving their Nursing and Midwifery Council Pin number, and being able to practice independently as a registered nurse in the UK. The health board was also pursuing further opportunities of recruiting from overseas in the very near future.

Many of the staff we spoke with during the inspection felt that there were not always enough staff available, and this could affect the level of care provided to patients. It was recognised within the hospital that nursing was very challenging on the ward, due to the patient acuity and dependency. It was suggested by staff that patients may feel there were staff shortages, and one of the patients who we spoke with raised concerns regarding staff shortages.

Senior staff told us that where there were last minute staff shortages, they may obtain staff from other wards, following a risk assessment based on patient acuity and dependency of other areas, if bank and agency staff were unavailable. The ward staff told us that they felt supported by senior management to ensure the nurse staffing levels were met.

Support to staff

There was evidence from speaking to staff and for staff questionnaires that the majority of staff felt supported by their immediate manager... Some staff comments included:

“My ward manager is very supportive and approachable. She encourages all members of staff and I feel I can count on her always.”

“I always feel supported when working on the ward which is why I choose most of my shifts on this ward.”

Most staff who completed a questionnaire agreed that their manager always or usually encourages them to work as a team, and that their manager can be counted on to help them with a difficult task at work. Some comments from staff included:

“The manager is very supportive and also works as part of the team in helping out whenever we're short staffed and most times works directly on the ward in providing care to the patients.”

“The ward manager and deputy ward manager of the ward are outstanding in their roles and are always happy to help when needed.”

Some comments regarding senior managers within the staff questionnaires, highlighted only a minority felt that senior managers always or usually involve staff in important decisions. In addition, a minority said management always or usually act on staff feedback. However, a majority said management were always or usually committed to patient care, although a few said they never were.

We were provided with an example of a staff nurse induction pack and junior staff nurse objectives, which must be completed within the first year working on the ward. Staff were assessed from level one to five, that related to basic level of knowledge to fully competent.

During the inspection we noted that senior ward staff were visible on the ward, helping other nursing staff when needed. They also had a detailed knowledge of the patients and their needs. Senior hospital staff also said that they were visible on the various wards of the hospital.

Training and development

Nearly all staff who completed a questionnaire indicated that they had undertaken mandatory training in Health and Safety, Fire Safety and Infection Control. Most also said they had undertaken training in the Mental Capacity Act, Deprivation of Liberty Safeguards, Dementia and Privacy and Dignity. Most also said that training or learning and development always or usually helped them to do their job more effectively, and that it helped them to stay up to date with professional requirements and deliver a better experience for patients.

The mandatory training compliance report, however showed that compliance was only 43% overall on ward 12 and 54% on ward 19. The lowest percentage compliance by subject being resuscitation at 5% and violence and aggression at 24% on ward 12, and 21% in resuscitation and 33% in moving and handling on ward 19.

We were informed that this was partly due to the wards availability of training dates in some subjects, although the head of nursing assured us this was currently being addressed. Ward managers also stated that some of the staff were night staff, who were unable to attend mandatory training during the day, and we were told that the night staff were offered day shifts to undertake elements of the mandatory training, although this had clearly not been undertaken. Senior staff also told us that all ward staff were given six hours a month to complete their mandatory training, although this appeared to be ineffective.

Most respondents told us they had an appraisal, annual review or development review, of their work in the last 12 months. Most said their learning or development needs were identified at reviews. Nearly all said that their manager always supported them to achieve these needs. The information supplied from the electronic staff records showed an 86% appraisal compliance rate in ward 19 and 63% in ward 12.

Health and well-being

A majority of staff who completed a questionnaire agreed that their job was good for their health, and few disagreed. A majority also agreed that their immediate manager took a positive interest in their health and well-being, and around half agreed their organisation takes positive action on health and well-being.

Most respondents said that the organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Improvement needed

The health board must ensure that:

- Current recruitment plans, and methods of how the current staffing deficit throughout the hospital is managed on a day to day basis, are shared with HIW
- All staff regardless of shift patterns, complete all aspects of mandatory training, and other training relevant to their role and area of work.

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.

4. How we inspect hospitals

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

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Immediate improvement plan

Hospital: Royal Glamorgan Hospital

Ward/department: Wards 12 and 19

Date of inspection: 6 and 7 November 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
Delivery of safe and effective care				
During the inspection we reviewed arrangements for the checking of resuscitation equipment and medication on wards 12 and 19. We saw that some records of checks by staff had been maintained. However, there were a number of gaps in the records for the equipment and medication on both wards. We also saw that the percentage of staff who had completed resuscitation training was low on both wards, and for ward 12 this was under five percent. This demonstrated that resuscitation equipment and medication had not always been checked daily, as per the local policy. The lack of regular checks meant there was a risk to patient safety, whereby the resuscitation trolley equipment and medication may not be ready for use, in the event of a patient emergency. We also reviewed the arrangements for the checking of the medication fridges on both wards. We saw that some records of checks had been maintained. However, there were a number of gaps in the records for the fridge temperatures and the daily checks on both wards.				

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
This demonstrated that temperature controlled medication had not always been checked daily and the temperature recorded, as per the local policy. The lack of the regular checks and recording of the temperature meant there was a risk to patient safety, whereby the medication may not have been stored at the appropriate temperature to make sure they remain viable for use. In addition, the medication fridge on ward 12 was in a poor condition with numerous areas of rust visible, there were stains inside the fridge, and the door seal was weak.				
The health board is required to provide HIW with details of the action it will take to ensure that: The appropriate checks on both resuscitation equipment trolleys are completed and recorded daily as per local policy. This must also be extended to all other areas within the health board.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and clinically effective care	• Ward and Department Managers will ensure that the Resuscitation Trolley including the presence of the Emergency Medication Boxes is checked on a daily basis in line with Cwm Taf Morgannwg UHB Resuscitation Policy. The responsible person checking the trolley has to sign to evidence the process has been followed. • The Senior Nurses responsible for the wards and Departments across the Acute Areas of the RGH will monitor the compliance daily Monday to Friday and addresses any noncompliance	Head of Nursing, Royal Glamorgan Hospital (RGH)	30 November 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
		immediately. The Site Managers on a Saturday, Sunday and Bank Holidays will check that the Resuscitation Trolley and Emergency Medication Check compliance is completed in the absence of the Senior Nurse. • Senior Nurses will undertake twice weekly audits in clinical areas to ascertain compliance as part of the Patient Safety and Quality checklist. • The Resuscitation Trolley and Emergency Medication compliance for all wards and Departments will be discussed each morning as part of the briefing at the "Patient Safety Huddles" led by the Head of Nursing or the Deputy. • Assurance will be sought in relation to compliance across all clinical areas within the Health Board, along with supporting evidence	Executive Director of Nursing, Midwifery & Patient Care	30 November 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action it will take to ensure that: The appropriate checks on both resuscitation equipment trolleys are completed and recorded daily as per local policy. This must also be extended to all other areas within the health board.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and clinically effective care	• Ward and Department Managers will ensure that the Resuscitation Trolley including the presence of the Emergency Medication Boxes is checked on a daily basis in line with Cwm Taf Morgannwg UHB Resuscitation Policy. The responsible person checking the trolley has to sign to evidence the process has been followed. • The Senior Nurses responsible for the wards and Departments across the Acute Areas of the RGH will monitor the compliance daily Monday to Friday and addresses any noncompliance immediately. The Site Managers on a Saturday, Sunday and Bank Holidays will check that the Resuscitation Trolley and Emergency Medication Check compliance is completed in the absence of the Senior Nurse.	Head of Nursing, Royal Glamorgan Hospital (RGH)	30 November 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
		• Senior Nurses will undertake twice weekly audits in clinical areas to ascertain compliance as part of the Patient Safety and Quality checklist. • The Resuscitation Trolley and Emergency Medication compliance for all wards and Departments will be discussed each morning as part of the briefing at the "Patient Safety Huddles" led by the Head of Nursing or the Deputy. • Assurance will be sought in relation to compliance across all clinical areas within the Health Board, along with supporting evidence	Executive Director of Nursing, Midwifery & Patient Care	30 November 2019

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

Service representative:

Name (print): **Greg Dix**

Job role:	**Executive Director of Nursing, Midwifery and Patient Care**
Date:	**18 November 2019**

Appendix C – Improvement plan

Hospital: Royal Glamorgan Hospital

Ward/department: Wards 12 and 19

Date of inspection: 6 and 7 November 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 must consider how to provide patients with a wider range of activities.	1.1 Health promotion, protection and improvement	• Present to all senior nurses and ward/department managers at the Governance meeting on the 8th January 2020 to initiate discussion, shared learning and agree future action. • Adoption and implementation of the Enhanced Supervision Framework Patient Record; this ensures that nursing staff record all activities implemented for patients. • Audit the use of the document as part of the monthly "Point Review" to provide assurances that provisions are in place for patients. • Re circulate the handbook for carers (Caring for the Confused) to the ward/department managers in order that the document is discussed in their next ward/department meeting. This will raise staff	Head of Nursing	Completed 13th January 2020 13th January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		awareness of the importance of implementing “This Is Me” document and encouraging patients to dress during the day time in line with #endpjparalysis. • Meet with the ward manager from Seren ward-care of the elderly; in the Mental Health Unit to explore other approaches that can be implemented across the acute wards and departments. • Record the usage and implementation of activities in the nursing documentation and specifically in the Enhanced Supervision Framework Record and this will be audited as part of the monthly. “Point review”.	Senior Nurse	28th February 2020 28th February 2020
The health board must ensure that: • Patient dignity is maintained at all times, particularly when curtains are drawn • Urine containers are removed from bed areas when no longer in use • Appropriate continence assessments are undertaken and documented appropriately • Patients have access to showers on a regular basis	4.1 Dignified Care	• Undertake spot checks across areas of responsibility to ensure there is compliance with maintaining dignity. • Undertake ad hoc “Real Time” surveys which monitors dignity and the outcomes are immediately reported for appropriate action. • Agenda the discussion; the maintenance of dignity at the ward/department meeting. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Undertake weekly “Environmental Audit” and monitor compliance of “Daily Cleaning” schedule to ensure a clean and uncluttered patient environment is	Senior Nurse Patient Advice & Liaison Officer Senior Nurse	Completed 28th February 2020 28th February 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Patient bathrooms are designated as ether male or female, and signs are clearly visible on the doors to identify this.		maintained, especially the removal of continence equipment from the bed areas. • Renewal of male and female signage to the bathrooms. • Undertake spot checks twice a week during the month of January, February and March 2020 to ensure that all patients have mandatory risk assessments undertaken. The frequency of auditing will be reviewed dependent on the findings and reported via the Governance meeting. • Agenda for discussion; to ensure access to toilet and bathroom facilities is discussed with patients on arrival to the ward and reinforce as necessary to patients during their inpatient stay. Minutes of the meeting with a signatory list will provide assurances of staff awareness raised. • Undertake a number of bespoke training sessions in January, February and March 2020 to improve staff knowledge, skills and competency. • Undertake monthly “Point Review” audit to monitor mandatory patient assessments. Any trends of non-compliance are identified and an overarching action	Ward Manager Ward Manager Senior Nurse Continence Advisor	28th February 2020 Completed 28th February 2020 31st March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		plan is devised and reported via the Governance Meeting. • Implement bi monthly Patient Satisfaction audit where dignity and the delivery of basic nursing care is key to the survey. The frequency will be reviewed dependent on findings and reported via the Governance Meeting. • Ensure all members of the nursing team undertake "Dementia Training". Compliance is addressed through the PDR process and monitored monthly via clinical business meetings to provide assurance.	Senior Nurse	28th February 2020
The health board must ensure that: • Noticeboards are regularly checked to ensure that all relevant up to date information is displayed, including health promotion documentation • The PSAG board is kept up to date.	4.2 Patient Information	• Agenda for discussion that it is the responsibility of the ward/department manager to monitor the information displayed on the noticeboards. Minutes of the meeting will provide assurance. • Include notice board checks into the weekly cleaning schedule to provide assurance. • Undertake spot checks to monitor compliance.	Senior Nurse	28th February 2020
The health board must ensure that all staff maintain patient privacy and	3.2 Communicating effectively	• Complete mandatory training "Information Governance" and monitor through the PDR process.	Senior Nurse	28th February 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
confidentiality when communication with patients.		Assurance is provided via monthly clinical business meeting. • Report all data protection breaches via the UHB Incident Reporting Procedure and identified trends reported via the Governance Meeting.		
Delivery of safe and effective care				
The health board must ensure that regular re-positioning of patients, and the appropriate self-care arrangements, are clearly recorded.	2.2 Preventing pressure and tissue damage	• Agenda for discussion; complying with the All Wales Pressure Ulcer Guidance. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Undertake spot checks to monitor compliance with repositioning of patients in line with their care plan. The frequency will be reviewed dependent on findings and trends will be reported via the Governance Meeting. • Undertake weekly Scrutiny reviews. Trends are reported via the Governance meeting and the UHB's Quality Assurance Committee. • Review the nursing documentation during nurse patient handover. Any trends are reported via the monthly ward/department meetings.	Senior Nurse	28th February 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Undertake monthly “point review” audit monitoring mandatory patient assessments. Any trends of non-compliance are identified and actioned proactively and reported via the Governance Meetings. • Complete pressure ulcer training and this is monitored through the PDR process and reported monthly to the senior nurse.		
The health board must ensure that: • Patient falls risk assessments are completed and updated including re-assessments • Measures are put in place to reduce the number of falls and minimise the risk of falls.	2.3 Falls Prevention	• Agenda for discussion; complying with the Falls Policy. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Undertake spot checks to monitor compliance of falls risk assessments. The frequency will be reviewed dependent on findings and trends will be reported via the Governance Meeting • Undertake monthly “Point Review” audit monitoring mandatory patient assessments and ongoing care plans. Any trends of non-compliance are identified and actioned proactively. • Review the nursing documentation during nurse patient handover. Any trends are reported via the monthly ward/department meetings.	Senior Nurse	8th January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Trial falls management equipment to support the reduction in falls.	Head of Corporate Nursing	31st March 2020
The health board must ensure that: • An appropriate risk assessment is undertaken for situations when side room doors are left open, where an infected patient is admitted, and the door cannot be closed • The ward and hospital environments are maintained and kept clean • Cleaning schedules are completed • Housekeeping staff liaise with the nursing team when equipment or furniture requires moving to maintain adequate cleaning • All staff complete IPC training.	2.4 Infection Prevention and Control (IPC) and Decontamination	• Agenda for discussion; compliance with Infection Control policies. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Communicate with the IPCT for support and advice for any deviations in care delivery in order that a robust risk assessment is completed. • Undertake spot checks to monitor compliance of the policy. The frequency will be reviewed dependent on findings and trends will be reported via the Governance Meeting. • Agenda for discussion compliance with the cleaning schedules. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Undertake spot checks to monitor compliance of Infection Prevention Control policies. The frequency will be reviewed dependent on findings and trends will	Senior Nurse	28th February 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		be reported via the Infection Prevention Control meeting. • Complete Infection Prevention Control training and monitor through the PDR process and report compliance via the monthly clinical business meetings.		
The health board must ensure that: • There are sufficient provisions in place, to provide patients with assistance to eat and drink in accordance with their needs • Patient MUST assessments are fully completed and updated in a timely manner.	2.5 Nutrition and Hydration	• Agenda the "Drink a Drop" campaign, "yellow lid" Team Hydrate initiative and the "icon" alert for the electronic board. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Undertake spot checks to monitor compliance of the initiative. The frequency will be reviewed dependent on findings and trends will be reported via the Governance Meeting. • Agenda the Protected Mealtime Procedure. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Escalate any noncompliance with the policy in order that resources can be deployed to an area to support patients during mealtimes.	Senior Nurse	28th February 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Report any noncompliance via the UHB Incident Reporting policy and review trends via the Governance Meeting. • Undertake monthly "Point Reviews" audit to monitor mandatory patient risk assessments. Any trends of non-compliance are actioned and reported via the Governance Meeting. • Undertake bi monthly patient satisfaction surveys specifically addressing nutritional and hydration. Any trends of non-compliance actioned proactively and reported via the Governance Meeting.		
The health board must ensure that: • Expiry dates are checked on all medication prior to administration • Medication is not left unattended at a patient bedside • The All Wales Medication Charts are completed correctly and in full in accordance with professional code of conduct, and health board policy	2.6 Medicines Management	• Agenda compliance with the UHB Medicines Management policy. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Undertake monthly "Point Review" audit to monitor medicines management. Any trends of non-compliance are actioned proactively and reported via the Governance Meeting. • Complete CD drugs checks weekly. • Incorporate the CD check into the weekly cleaning schedule checks.	Senior Nurse	28th February 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• A weekly check of CD stock balance is completed, as directed by the health board's policy • Self-medication by patients is adequately assessed and documented.		• Undertake spot checks and review the frequency dependent on the findings. Report trends via the directorate Governance Meeting.		
The health board must ensure that all staff complete the relevant level of safeguarding training for children and adults.	2.7 Safeguarding children and adults at risk	• .Introduce a 6 hour make-up shift where staff are rostered to access the IT suite to complete training. • Complete training and monitor through the PDR process and report via the monthly clinical business meetings.	Senior Nurse	Complete
The health board must ensure that additional staff are requested in a timely manner and provided to requesting wards, when required.	3.1 Safe and Clinically Effective care	• Agenda the UHB's Roster policy. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. The timeliness supports block booking of key staff in order that consistency of staff may be achieved to support delivery of a high standard of nursing care. • Review staffing and patient acuity daily at the beginning of each shift in line with the Nurse Staffing Act and redeploy staff appropriately. A database of all staff movements is maintained to provide assurances.	Senior Nurse	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • Patient care plans are regularly updated and evaluated • Staff apply legible, identifiable signatures, each time entries are made into the patient records.	3.5 Record keeping	• Agenda NMC Code. Minutes will be available including a signatory list to provide assurances that staff awareness has been raised. • Commence documentation training. • Undertake monthly "Point Review" audit and monitor nurse documentation. Any trends of non-compliance are actioned proactively and report via the directorate Governance Meeting.	Senior Nurse	28th February 2020
Quality of management and leadership				
The health board must ensure that consideration is given to the negative staff comments and issues identified within the Governance, Leadership and Accountability section of the report, for both wards inspected, and must inform HIW of the plan to address these issues. Consideration must also be given to such staff feedback throughout the organisation.	Governance, Leadership and Accountability	• Encourage staff to attend the CEO Sessions "Let's Talk" and pro-actively encourage staff to complete the staff survey. • Undertake regular unannounced visits to the wards. The frequency of the visits will depend on trends identified in order that appropriate support is provided. • Undertake PDR's for all staff and identify and manage training needs. • Undertake appropriate leadership training and development. • Undertake monthly meetings with a formal agenda. The minutes and a signatory list will provide assurance.	Head of Nursing Ward Manager Senior Nurse	Complete 31st March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Encourage staff to complete the staff survey and participate in “Every Voice Counts”.		31st May 2020
The health board must ensure that: • Current recruitment plans, and methods of how the current staffing deficit throughout the hospital is managed on a day to day basis, are shared with HIW • All staff regardless of shift patterns, complete all aspects of mandatory training, and other training relevant to their role and area of work.	7.1 Workforce	• Provide a formal workforce report to the monthly Nursing Workforce Group Meeting. • Attend all recruitment events. • Complete a rolling advert specific to the ward speciality. • Participate in the “Overseas Recruitment” process. • Provide monthly exception reports to the bi-monthly Establishment Meetings. • Manage staffing deficits as described in detail Standard 3.1. • Manage training as described in 2.7. • Rotate staff regularly between days and nights in order that staff training can be achieved.	Head of Nursing	Complete

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

Service representative

Name (print): **Deborah Matthews**

Job role: **Head of Nursing**

Date: **8 January 2020**