Hospital Inspection (Unannounced)

Morriston Hospital / Paediatric Services – Oakwood Ward and Ward M,

Swansea Bay 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 Morriston Hospital within Swansea Bay University Health Board on the 21 and 22 January 2020. The following hospital sites and wards were visited during this inspection:

- Oakwood ward (medical ward)
- Ward M (children's surgical ward)

Our team, for the inspection comprised of two HIW Inspectors, two clinical peer reviewers and two lay reviewers. The inspection was led by a HIW inspection manager.

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

Overall, we found evidence that the service provided safe and effective care.

However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas. This included ensuring that there was sufficient oversight of the day to day activities on the wards.

This is what we found the service did well:

- Patients and their families were positive about the care and treatment provided during their time on the wards
- We saw professional and kind interaction between staff and patients, and care provided in a dignified way
- Visiting arrangements meant that patients were able to maintain contact with their families and friends, according to their wishes
- Arrangements were in place to maintain the safety of patients in the areas we visited
- Overall, we found patient records were of a good standard, easy to navigate and informative
- Ward staff on both wards were cohesive and had a good relationship with ward managers.

This is what we recommend the service could improve:

- The environment and footprint of the wards to be updated to ensure patients' dignity can be maintained at all times
- All patients should be discharged in a timely manner
- Secure storage of information to prevent unauthorised access and to uphold patient confidentiality
- A review of staffing rotas to ensure that staffing levels are safe and effective to meet the needs of the service
- Audit activity being carried out on the ward.

3. What we found

Background of the service

Morriston Hospital is located within Swansea Bay University Health Board. The health board covers a population of approximately 390,000 in the Neath Port Talbot and Swansea areas of South West Wales.

Morriston hospital is located on the outskirts of Swansea. It provides a range of acute surgery and medicine for patients of all ages including inpatient, outpatient and day services.

Oakwood ward is a 16 bedded ward caring for children from birth to 16 years. Occasionally children over the age of 16 years are seen if they are still under the care of a paediatric consultant or known to the Child and Adolescent Mental Health Service (CAMHS). Oakwood ward provides care to children with varying health care needs ranging from acute medical admissions to children with complex chronic needs. Children can also have planned day case admissions for scans or intravenous infusions[1]. Within Oakwood ward there is a four bedded high dependency area (HDU) which cares for children requiring closer observation and monitoring.

Ward M is a 24 bedded ward which cares for children from birth to 16 years of age requiring elective surgery. The ward also caters for emergency surgical admissions and occasional medical admissions. Specialities covered on this ward include ear nose and throat (ENT), urology and maxillofacial surgery. The ward contains a four bedded observation bay to monitor children post operatively who require a higher level of observation which includes cleft lip and pallet surgery.

There is also a paediatric assessment unit (PAU) which accepts children referred as an emergency via a general practitioner, midwife or the emergency department. Following assessment, children or young people may then be

[1] An IV infusion is a controlled administration of medication into your bloodstream.

admitted to hospital or discharged home. The PAU did not form part of our inspection.

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.

Most patients and their parent/carer told us they were happy with the care and support provided to them. We observed polite, friendly and supportive interactions between staff and patients.

Visiting arrangements meant that patients were able to maintain contact with their families and friends, according to their wishes.

However, we observed staff having difficulties in maintaining patients' dignity at all times, due to the environment and footprint of the wards.

We also noted that patients are not always discharged in a timely manner.

During the inspection we spoke to a number of patients and their parents/carers. Most of the patients we spoke to were under five years of age. Comments made by their parents/carers are contained throughout this report.

Staying healthy

We saw that information was displayed for patients on notice boards and in leaflets in the corridors on the wards. Information included areas of health promotion such as diabetes, breastfeeding and e-cigarettes. However, there was little information available on topics such as mental health and social media awareness. Most of the information appeared out of date and written in a language more appropriate for parents and older teenagers and did not incorporate the varying age range of children on the wards.

We saw staff providing support to patients and parents/carers in managing their health and wellbeing. One parent told us staff had explained to them and their child the importance of staying healthy by ensuring they were hydrated and eating healthily.

Improvement needed

The health board must ensure that up-to-date health promotion information is available for patients of all ages.

Dignified care

During the course of our inspection we observed staff speaking to patients and their parents/carers with kindness and respect. We saw staff introduce themselves to children and young people and address them by their preferred name. Staff spoke to children in a warm and friendly manner, appropriate to their age. Patients we spoke to told us that staff were caring and friendly, had treated them with dignity and taken time to support them throughout their stay.

During our inspection, we invited staff to complete a HIW questionnaire. We received 27 completed questionnaires from staff. Most staff who completed a questionnaire agreed that the privacy and dignity of patients is always or usually maintained.

We observed staff protecting the privacy and dignity of patients as far as possible. Curtains were pulled around patient beds in the multi-bedded bay areas whilst staff were providing them with personal care and during personal conversations. However, on one occasion, members of the inspection team overheard a sensitive discussion between staff and a patient and their relative/carer during a medical round. The conversation took place within a shared bedded bay area with the curtains pulled around the bed. This meant there was a possibility that other patients or parents/carers could hear discussions taking place if patients were spoken to in the room when others were present.

We saw there was no designated quiet room or area on either ward for use if staff needed to have sensitive conversations with patients and parents/carers. A quiet room would enable staff to provide support to families, and allow families to have time together in private, away from the busy ward areas, preserving their dignity.

The visiting arrangements on both wards meant that patients were able to maintain contact with their families and friends, according to their wishes. Staff also told us that one parent/carer per patient were allowed to stay overnight on pull-out beds, or on chairs next to the patient's bed. We saw that space around the beds within the multi-bedded bay areas was limited. This meant that the dignity of parents/carers who stayed overnight in these areas could be compromised.

We observed teenagers situated on the wards amongst children of younger ages. Whilst there is a playroom area available for younger children, there is no area or room on either ward suitable for teenagers to spend time away from their beds. This may have a negative impact on their psychological and social needs during their stay in hospital. We also saw a teenage patient situated on a multi bedded bay area on Oakwood ward amongst other patients who were aged approximately five and under. We observed the teenager kept the curtain closed around the bed the majority of the time we were conducting our inspection which may have caused a feeling of isolation. Whilst we recognise the environment provides challenges in terms of space we recommend that a designated area for older children and teenagers is considered.

One parent we spoke to described how they had to walk through a multi-bedded bay area to access the parent facilities. They told us they felt uncomfortable invading other patients' and their families' privacy. The current layout means that one of the multi-bedded bay areas, and an open ward area where children have their meals, was being used by parents to access their facilities. This meant that, in order to maintain some privacy, patients on the multi-bedded bay area had to close their curtains.

Staff told us that plans were underway to transform the open ward area where children had their meals. Given the shortage of space available within the wards to provide privacy to patients, in particular older children and teenagers, and their parents/carers we advise that consideration is given to how to best utilise this open ward area.

Improvement needed

The health board must:

- Consider how the privacy of patients can be maintained if staff have discussions in the multi-bedded bay areas
- Consider how the dignity of parents/carers can be maintained when staying overnight within the multi-bedded bay areas
- Consider how the privacy and dignity of patients and parents/carers can be maintained in the event that staff need to have sensitive conversations with them
- Consider how the privacy and dignity of older children and teenagers can be improved

- Consider the layout of the wards and access to the parents' facilities in order to maintain patients' privacy.

Patient information

The inspection team found that directions to the wards were clearly displayed throughout the hospital, meaning that patients were able to find their way easily. However, there were no visible signs on the wards to direct patients and families to facilities available to them on the wards. Staff told us that patients and their families are shown where the facilities are upon their arrival on the wards. Visiting hours were clearly displayed on the wards.

We saw notice boards which displayed information regarding the staff on both wards. This included staff names and their designation. This would assist patients and their parents/carers in identifying the staff involved in their care.

Improvement needed

The health board must ensure that signage within the wards is reviewed to ensure that it is easy for patients and their carers/families to locate the facilities.

Communicating effectively

We saw staff speaking to patients in a sensitive and courteous manner, taking into account the individual needs of the patient. All communication we observed was in line with the patient's stage of development. We also saw staff positively engage with families. We observed families approach staff for assistance, who responded in a supportive and enthusiastic manner.

However, one parent we spoke to expressed a lack of clear communication from staff regarding their child's diagnosis and treatment. We informed managers of this who gave their assurance that they would remedy this situation for the patient and parent.

Staff we spoke with were aware of the translation services within the health board and how they could access these to support patients whose first language may not be English. Welsh speaking staff were also available and could be identified by their lanyards which showed they could have a conversation in Welsh. We observed staff being proactive in providing as much care and interaction in Welsh

as they could to meet the communication need of first language Welsh speaking children and young people. We also saw bilingual posters and display boards in the corridors on both wards.

Nursing staff and managers told us play nurses are a vital part of the ward team and play an important and positive role in children's experience in hospital. We observed the play nurses spending quality time with patients, encouraging play and actively engaging and listening to parents.

We spoke to play nurses who told us about the role they have in the patient's journey to theatre through the use of distraction and imagery. This enables patients to have a less stressful experience from the anaesthetic process through to surgery. We also saw a play nurse patiently talk a child through the procedure they were about to undergo to help put them at ease. The inspection team also viewed a short film which has been developed by staff to alleviate any worries or anxieties a child may have with regards to attending hospital for surgery. We considered this to be a useful communication tool in preparing children for surgery and demonstrating how a stressful experience can be made fun, safe and reassuring.

Staff told us that, in some instances, the play team create a development play plan for patients in an age appropriate language and style to help them and their families/carers understand their care and journey through the department. Staff told us of an example when an individual care plan included all areas of development to include sensory, physical and emotional. This enabled the patient to have a visual display of the care being provided.

We saw a children's programme on a television in the playroom being played through the use of Makaton[2]. We advise that further use of non-verbal communication skills, to include posters and storytelling, would be beneficial for children who may experience difficulties with communication skills.

Most staff members who completed questionnaires agreed families are always or usually involved in decisions about their child's care.

[2] Makaton is a language programme designed to provide a means of communication with individuals who cannot communicate efficiently by speaking

Medical and nursing handovers were held separately, and we were able to attend both. We observed effective communication in discussing patient needs and care plans, with the intention of maintaining the continuity of care.

Timely care

We spoke to patients and parents/carers who told us that support was available from staff in a timely manner. We were told that staff were attentive to their children's needs and provided support.

We saw within the sample of patients records we reviewed that there are challenges in accessing consultants or middle grade doctors to authorise patient discharge. Many patients have diverse needs and are managed by multidisciplinary teams. The large number of healthcare professionals involved then makes planning for discharge more complex. This means that patients are not always discharged in a timely manner.

Improvement needed

The health board must consider discharge planning arrangements to ensure patients are discharged in a timely manner.

Individual care

Planning care to promote independence

We were told that patients are assessed upon admission to the wards to identify and address their requirements to maintain their independence whilst in hospital. We spoke to staff who said that patients are encouraged to be active and given equipment when required to help them walk, move, eat, hear and see.

Within the sample of patient records we reviewed, we saw that patients had a written assessment of their needs completed to identify their individual care and support requirements. We saw that written plans of care were in place which were being regularly reviewed.

We observed staff supporting a patient and their parent/carer to understand the administration of the patient's medications. This would encourage and enable the parent/carer to care for their child following their discharge by having the knowledge to continue with the administration of medication at home, thus promoting their independence.

The service has a specialist lead diabetic nurse who told us that patients diagnosed with diabetes can be admitted to the ward for between four and six days. This is to provide the child with the knowledge and skills to be able to self-administer medication. We were told that support is also provided to children following their discharge, both at home and at school. This would enable the chid to maintain their independence in their day to day life.

People's rights

The inspection team saw the environment in the playroom was tailored towards younger children and there was no separate area designated for older children and teenagers. As referred to earlier in the Dignified Care section of this report, older children/teenagers do not have a room or area where they can spend time to relax away from the busy ward areas. On both wards, we observed older children/teenagers had a tendency to keep the curtain closed around their bed which may be due to a lack of privacy when in bays. A recommendation in relation to this has been made earlier in this report.

We also considered that the playroom would be unable to accommodate a child who required wheelchair access. This was due to the limited space available within the playroom.

Within the playroom, we saw a wide range of toys, puzzles and books to assist with the development of younger children. However, activities for older children were limited and provided through the use of technology. We advise the health board should provide activities consistent with the range of ages of the children on the wards.

We saw a visual timetable displayed on the wall in the playroom. This is a useful tool to enable children to be independent and help motivate them by making it clear what will be happening during the day. We also saw a display board on the wall depicting the patient's journey in a question and answer format.

Staff told us if a patient is on a ward for an extended period of time, a play nurse will make a learning developmental play plan available for them. In instances where older children were on the ward for longer, we were told that formal educational opportunities were organised by the patients' school.

Staff told us that patient's individual spiritual and cultural needs are assessed at the time of their admission to the wards. Staff told us they are in close contact with various multi faith leaders to provide advice and support for children, young people and their families. Staff also expressed that they encourage the celebration of other religions' calendar holidays through the activities provided for patients.

Listening and learning from feedback

Staff and managers told us that they would aim to deal with any complaints at source, with a view to resolving them quickly. Bilingual leaflets were displayed in both ward areas relating to the NHS Putting Things Right complaints procedure for patients to follow should they have concerns about their care. Information was also available providing details of the Community Health Council (CHC). The CHC can provide advocacy and support to patients in raising a concern about their care. Information on raising concerns and advocacy support was also available on the health board's website.

We saw that patients were encouraged to provide feedback in a variety of ways. This included a health board feedback initiative poster, a survey accessible via a QR code or through a paper feedback form. A board for younger patients to write their feedback was also on display. Patient and parent/carer feedback was displayed on boards within the wards, along with suggestions for change. The feedback contained many positive comments provided by patients and families, expressing their thanks to staff on both wards. We saw that some feedback included reference to chairs needed replacing on the wards as their covers were broken. This is referred to in the Infection Prevention and Control section of this report and a recommendation has been made. It was disappointing to see that remedial action had not been undertaken to resolve this issue.

The wards used a Tops and Pants washing line feedback system for younger children to provide their views on their experience. This meant they could draw on a top, for positive feedback, or pants, for negative feedback. These comments were available to be considered by staff teams to make changes to improve the service.

All staff who completed HIW questionnaires agreed their organisation collected patient feedback, and nearly all agreed they received updates on feedback. A majority of staff agreed patient feedback was used to make decisions within their department.

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, arrangements were in place to maintain the safety of patients in the areas we visited.

Arrangements were in place for the safe management of medicines. However, we identified improvements were needed in relation to the consistency on the daily checks of the refrigerator temperature at which medication was stored on Ward M.

Information was not always being managed or stored securely, to prevent unauthorised access and to uphold patient confidentiality.

Safe care

Managing risk and promoting health and safety

Overall, the unit appeared to be clean and appropriately lit, however the environment is tired and in need of attention. The environment and the layout of the wards poses a number of challenges for management and staff in providing safe and effective care which are highlighted within this report. Staff also highlighted to the inspection team the poor facilities available to them on the wards. This includes their toilet facilities, staff room and the room used for shift handovers, all of which were dated and too small for their requirements.

We reviewed the health board's risk register and saw it had been identified in December 2009 that the environment within Oakwood ward and Ward M was not fit for purpose. We were assured that the risk is being regularly monitored and action taken where possible to minimise those risks. Staff told us they had been informed the wards were only considered as temporary when they were moved there over ten years ago. Issues regarding the layout of the children's wards and PAU had also been highlighted to the health board as a result of a previous HIW inspection of the wards in 2015. At that time, we were told that these areas would be considered in accordance with the health board's overall estates development strategy. We recommended that the health board should progress with its strategy to develop the children's wards and PAU.

We spoke to managers and reviewed documents which reflected that a project group has been set up to consider options for the development of an integrated paediatric urgent and emergency care centre (PUCC) inclusive of the PAU and both paediatric wards. Whilst this is positive for the future of paediatric services within the hospital, the project is in its infancy and no timescales have been confirmed for the implementation of the development. In the meantime, we recommend the service must continue to identify, monitor and act on the risks caused by the poor environment. This will ensure that patient's health, safety and welfare are promoted and protected.

The inspection team saw that arrangements were in place to maintain the safety of patients in the areas we visited. Entry to both wards was gained via an intercom system. We observed staff asking visitors the reasons for their visit before allowing them to enter the wards. We also saw patients wearing identification wristbands. This would minimise the potential risk of medication error and/or patient identification error should clinical investigations be required outside of the ward environment.

A guideline was in place across the health board for the promotion of safety and prevention of abduction of babies. However the policy was out of date and in need of review.

A notice on the resuscitation trolley confirmed that it contained latex free equipment. This meant the risk of anaphylaxis in an emergency situation was minimised in the event that a patient had a latex allergy.

Staff told us, the day prior to our inspection, a member of staff on Ward M had required urgent assistance with a patient. They had sounded the emergency bell; however there was no other staff member immediately available to assist on the ward and the bell could not be heard from Oakwood ward. Subsequently no-one came to their assistance, however the member of staff acted effectively in responding to the patient's needs on their own. It was also identified that no rebreather bag had been available within reach for the staff member to use.

We discussed this with a senior member of staff who was unaware of the incident. We were later informed that the incident had been appropriately recorded on the health board's incident reporting system. The matter was immediately referred to the estates department who identified remedial action to amplify the sound of the emergency bell to ensure that it can be heard from Oakwood ward. We were assured this work would be carried out as a priority. We also recommended that

rebreather bags are made easily accessible for use in the event of a patient emergency in accordance with Resus UK standards for paediatric acute care[3].

We saw the door to the cleaning cupboard between Dyfed Ward and Oakwood Ward was not securely locked and the safe inside the cupboard was also unlocked and accessible. The cleaning trolley which contained cleaning equipment and substances was located in the corridor outside the cupboard. We also saw the sluice located behind the nurses' station on Ward M was not locked and bottles of hand washing solution were accessible. The cleaning trolley on the ward had also been left unattended. These issues could pose a risk of unauthorised access to hazardous substances to patients and visitors.

Improvement needed

The health board must ensure that:

- It continues to identify, monitor and act on any risks identified due to the environment to ensure that patient's health, safety and welfare are promoted and protected
- The policy for the promotion of safety and prevention of abduction of babies is reviewed
- Action is taken to ensure the emergency bell on Ward M can be clearly heard on Oakwood ward
- Rebreather bags are easily accessible in every bay
- All cleaning equipment and supplies are stored appropriately and securely.

Preventing pressure and tissue damage

We considered the prevention of pressure and tissue damage for patients on both wards. We found within the sample of patient records we reviewed that

[3] https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/#paed

efforts were made to prevent patients from developing pressure sores. We saw that patients were risk assessed for pressure ulcer risk on admission where appropriate, and a care plan developed and documented in line with the risk assessment score.

Falls prevention

In the sample of patient records we reviewed, we saw that efforts had been made to asses and identify patients at risk of falls. Where appropriate, patients had been assessed for their risk of falls and an up-to-date plan of care, tailored to the patient implemented and evaluated.

Infection prevention and control

We noted that the clinical areas of the wards inspected appeared visibly clean and uncluttered. Domestic staff were seen to be present at various times of the day. We did however find areas some areas where improvements were needed to overall infection control arrangements.

Whilst we saw that all areas of both wards were clean, there were inconsistencies in the completion of cleaning schedules by domestic staff in both wards. This meant that we were not assured that regular cleaning of the wards was taking place which could potenially cause an increased risk to infection.

We saw a number of chairs within the wards were torn and the internal foam filling exposed. We saw a minimum of eight damaged chairs which included some within cubicles that are used for isolation. This is an infection risk, and the chairs must be repaired or replaced. We spoke to managers who informed us that this issue had been escalated to the estates team, however the chairs had yet to be replaced.

We were assured that a process was in place for ensuring that children's toys, books and other play equipment were regularly cleaned. This means they are as clean and safe as possible for children to use.

We saw that personal protective equipment (PPE) such as disposable gloves and aprons was available in all areas and was being used by all healthcare professionals to reduce the risk of cross infection.

The service does not have a separate en-suite room available for patients should there be a requirement for barrier nursing. Patients are cared for in a bay within the high dependency unit with a requirement to share facilities with other patients. This meant there was a risk of infection being transferred to other patients.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow. We saw staff washing their hands appropriately and using hand sanitiser gel when needed. We saw that there were no hand gel sanitisers available at child level. We were told by managers that previously hand gel sanitisers had been placed at a lower level, however children would freely access it causing it to become a slip hazard.

Whilst all of the bathroom facilities were noted to be clean, the majority were in need of updating. We also saw that the floor around the bins in the bathroom and toilet on Ward M were stained with rust.

Infection prevention and control training was mandatory for staff. Nearly all staff indicated in their questionnaires that they had undertaken learning and development in infection control prevention in the last 12 months.

We spoke to managers who said that monthly audits in respect of infection control were completed on both wards; however, due to winter pressure, staffing challenges, and the need to prioritise clinical care, audits had not been undertaken on a consistent basis. We were shown a sample of infection control audits for previous months which showed high compliance. We also saw the results of previous audits were displayed to patients at the entrance to both wards. The results of regular hand hygiene audits were also displayed which showed high compliance.

We spoke to staff and all were able to describe the 5 moments of care.[4] Through discussion, staff also demonstrated good knowledge of the procedure to take in the event of a needle stick incident.[5] This would assist both staff and patients in being protected from preventable healthcare associated infections.

[4] The '5 Moments of care' for Hand Hygiene approach defines the key moments when health-care workers should perform hand hygiene.

[5] Injuries from needles used in medical procedures are sometimes called needle-stick or sharps injuries.

Improvement needed

The health board must ensure the following:

- Consistent completion of cleaning schedules
- All damaged chairs within both wards are replaced
- Infection control audits should be completed consistently, in line with policy and the results displayed on the wards wherever possible.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met. We saw that patients' individual nutritional needs were assessed in line with the All Wales nutrition care pathway[6]. Parents/carers were encouraged and supported to assist their child with eating and drinking when required.

We observed meal times and saw that patients were given a choice of food, however the choice of food was not appealing to young children. One patient told us that the breakfast choice was limited, and that the hot food was served tepid or warm. We also saw children refusing every choice of food available at lunchtime. We were told by staff that patient meal choices were currently being reviewed, with the intention of providing finger food for younger children and better healthy meal options to maintain patients' nutritional needs. We were also told that a trolley service was going to be introduced to provide patients with access to healthy option snacks inbetween mealtimes.

We spoke to staff who had identified occasions when parents/carers were unable to eat and drink whilst on the wards as they are not provided with food. Staff said it had been recognised that parents/carers did not want to be apart from their child on the wards. Managers told us a scheme was being considered to enable parents/carers to enjoy meals with their children and also access food outside of mealtimes. We saw that parents/carers were able to access hot drinks from the visitors kitchen area.

[6] All Wales Nutrition Care Pathway for hospitals details the pathway for the nutrition screening of patients on admission and the nutritional care throughout their hospital stay.

Staff told us that they were able to cater for patients who had specific dietary requirements to ensure that appropriate food was available for them.

We saw posters displayed emphasising the ban on hot drinks being carried around the wards. This will reduce the risk to children of burns and scalds from hot drinks in line with the Safe Tea campaign[7].

Meals were served from a trolley in an eating area in an open ward located between Oakwood ward and Ward M. Staff told us that the food trolley did not enter the wards as some of the patients were nil by mouth prior to undergoing surgery.

We saw that patients had access to water within easy reach. A water station was available on Oakwood ward and in the PAU and cups and jugs were readily available. Children were encouraged by staff to ask for refills or to help themselves if they were old enough. One patient we spoke to expressed a feeling of independence in being able to get their own food and drinks.

Medicines management

Overall, we found arrangements in place for the safe management of medicines used within the clinical areas that we visited. We observed staff following the health board's policy on medicines management including the use of red flag aprons[8] and quiet time to calculate medication dosage. We saw documentation to show that medicine management quality assurance audits were undertaken to help ensure standards were maintained.

The inspection team observed good practice in all areas of medical administration. We reviewed the completion of the All Wales Drug Charts and noted consistent accurate recording to include patient names and when drugs had been prescribed and administered. All records reviewed were being recorded contemporaneously and appropriately signed and dated.

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[7] SafeTea is a national campaign to raise awareness of the risk of hot drink burns to young children, giving practical tips on how to prevent them, and improve burn first aid.

[8] Staff wear disposable red aprons to indicate they are in the process of preparing or administering medication to patients and they should not be distracted or interrupted during these processes.

We saw evidence of good practice with ward staff checking patients identification bands against drug charts prior to the administration of medication. This would minimise the potential risk of medication error and/or patient identification error. We also saw the recording of childrens height, weight and age. This is used to identify if a child is under or over weight for body maturity which would require the medication dosage to be altered accordingly.

The wards had a dedicated pharmacy technician who would visit daily during working hours to collect drug charts and medication requirements for patients to take home. Medication is returned in a timely manner, thus supporting the timely discharge of patients. We were told that there was an on call pharmacist available for accessing medicines out of office hours. We also saw documentation which reflected that regular controlled drug audits were conducted on both wards by a health board pharmacist.

The health board policy on medicines management was easily accessible to all staff electronically on the intranet. The policy included information on the safe administration of medication and safe storage, prescription and dispensing of drugs.

However, the inspection team found inconsistencies on Ward M on the daily checks of the refrigerator temperature at which medication was stored. This meant we could not be assured that any discrepancies in storage temperatures as advised by manufacturers, were being identified and escalated. It was positive to note that staff reacted quickly and promptly to address the issues we raised.

Our concerns regarding this issue were 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.

We also observed a member of staff administer medication to a patient within the playroom. We discussed this with senior managers who confirmed that any form of medicine administration was not permitted in the playroom. We were assured that this would be dealt with and all staff reminded of the importance of appropriate administration of medication to patients, in line with the health board's policy.

Improvement needed

The health board must ensure that all administration of medication to patients is in line with its medicines management policy.

Safeguarding children and adults at risk

We saw that the health board had policies and procedures in place to identify, promote and protect the welfare of children and adults who were vulnerable or at risk.

We spoke to staff who confirmed they were aware of the safeguarding lead. They also said they would be comfortable in approaching colleagues in order to report concerns.

Safeguarding training was mandatory for staff on the wards. Most staff who completed questionnaires said they had received recent safeguarding training. We also were also assured that compliance figures for safeguarding training for staff on both wards was high.

Medical devices, equipment and diagnostic systems

Overall, we found arrangements in place for the safe management of medicines used in the clinical areas we visited. We saw that medicines were securely stored when not being used.

However, we found an otoscope[9] (a piece of equipment used to look inside the ear) on a trolley on Oakwood ward which was out of date. This was escalated to senior staff and the matter appropriately dealt with.

We saw that both wards had equipment and medical devices to meet the needs of patients. However, we spoke to staff who told us of occasions when specific items of equipment had not been readily available on the wards when required. We were told that the ordering of stock could be challenging, as there was no individual responsible for the role and resources did, on occasion, run out. Around a third of staff who completed questionniares said they always or usually have adequate materials, supplies and equipment to do their work and the remainder said they sometimes do.

We found processes in place to ensure that equipment is cleaned and maintained to ensure they are appropriate for their intended use.

[9] A piece of equipment used to look inside the ear

Improvement needed

The health board must ensure that:

- All equipment is regularly checked within appropriate timescales to ensure it is in date and safe for use
- A system is in place to ensure that all necessary equipment is readily accessible to staff on the wards to ensure the provision of safe and effective care.

Effective care

Safe and clinically effective care

Based on discussions with managers and a number of staff on both wards, it was highlighted to the inspection team that there was a current shortfall in staff. This is referenced further, and a recommendation made, in the Workforce section of this report. Whislt we acknowledged efforts are underway to recruit additional staff, we saw a good cooperative team approach by staff in supporting each other to cover shifts across both wards and the PAU. It was positive to see that staff are flexible, willing to work additional shifts, and cover other wards. We were also told that a consultant and registrar is available 24 hours a day, seven days a week on Ward M. Both ensure the delivery of safe and effective care.

In the patients records we reviewed, we found that patient pathways are achieved and staff are delivering effective care. This was also reflected in the few number of surgical procedures that had been cancelled. We also noted that preparation of patients for theatre followed required processes and we were assured of safe and good practice in this area.

The inspection team observed ward staff, at the point of admission, discussing with patients and their family/carers the planned pathway for the patient to include the discharge process. This was considered to be good practice.

Through discussions with staff on Ward M, it was evident that staff are alert to sepsis and implementing national guidance on prompt treatment of this condition.

Staff could also demonstrate how to locate the health board's policy on sepsis[10]. However, staff we spoke to on Oakwood ward had a mixed understanding of the paediatric sepsis pathway. We recommended that efforts are made to raise the profile and understanding of the sepsis pathway within this ward.

Improvement needed

The health board must ensure that all staff have a good understanding of the paediatric sepsis pathway.

Quality improvement, research and innovation

We were told that the health board was the first health organisation in the UK to adopt a children's charter. The charter is underpinned by the values laid out in the United Nations' Convention on the Rights of the Child.[11] It sets out 10 promises that let children and young people know they will be respected, listened to and looked after when receiving treatment within the health board. Information relating to the children's charter was visible on both wards and on the health board's website.

We were also told the service has a youth advisory panel. They are a group of 20 young people from across south Wales who are dedicated to improving health services for children and young people. We were told that members of the youth panel, along with a patient experience nurse, carry out unnanounced '15 steps'[12] audits of the wards and provide feedback on their view of the service from a patient's persepctive. Managers told us that positive efforts are made to adapt the service model for children and young people in line with feedback received from the audits undertaken. Members of the youth advisory panel also sit on

[10] Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.

[11] The United Nations Convention on the Rights of the Child (CRC or UNCRC) is a human rights treaty which sets out the civil, political, economic, social, health and cultural rights of children.

[12] The 15 steps challenge focusses on seeing care through the eyes of a patient or parent/carer and exploring their first impressions.

interview panels for managers within paediatric servcies, including the roles of matron and head of nursing.

Staff told us that the health board had previously taken part in PUMA[13] research trials with local universities and clinical research centres. Evidence of this was visible to patients in ward information guides and through discussions with staff.

Information governance and communications technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations (2018) within the unit. We found within Oakwood ward and Ward M that patient information was not being managed or stored securely, to prevent unauthorised access and to uphold patient confidentiality. This is because patient records were stored in trollies that were not locked, and there were times when staff were not present in these areas. This meant there was a risk that patient information could be accessed by patients or visitors on the wards.

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

The internal intranet was informative for staff, with a wide range of accessible paediatric and medical clinical policies and procedures. Staff we spoke to told us that they could be easily accessed on the intranet. This meant that staff were able to retrieve, review and use all policies.

Record keeping

We considered a sample of patient records within both wards. In total, nine records were reviewed. Overall, we found patient records were of a good standard, easy to navigate and informative. Patient records were further supported by a separate fluid chart, nursing care plans, nutrition, manual handing and risk assessment, drug chart and separate observation chart.

[13] A research study which compared the child health outcomes and death rate in the UK with other European countries

Two of the patient records we reviewed did not include seperate pain assessment recording, despite pain being a key aspect of the patient's management. This was discussed with a manager who noted that pain mangement is frequently included in the patient's nursing care plan as opposed to in the appropriate document. We recommend, as best practice, that pain management should be recorded in the pain management observation chart and patients and their families/carers involved in pain intensity recording.

Improvement needed

The health board must ensure that pain management is appropriately recorded within patient's 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 the service had in place a number of regular meetings to improve services and strengthen governance arrangements.

There was insufficient oversight by the management of wards to be confident that there was a robust process in place for audit activity.

Ward staff on both wards were cohesive and had a good relationship with ward managers which demonstrated good team working. However, we recommended that senior management review staffing rotas to ensure that staffing levels are appropriate to the provision of safe and timely care.

Governance, leadership and accountability

The childrens service group had in place a number of regular meetings to improve services and strengthen governance arrangements. Such meetings included monthly paediatric clinical risk meetings which were held at Morriston hospital. We saw that agenda items for discussion included reported incidents, investigations and their findings, updates on the risk register and information governance.

Other meetings included monthly assurance and learning meetings and quality and safety committee meetings, as well as childrens services board meetings and paediatric leads meetings. Staff told us that all-staff meetings had taken place in the past, however there had been difficulties with staff attendance due to balancing staff service committments.

We were told by managers that feedback from meetings was given to ward staff verbally by the ward sisters. This would take place during a daily ‘camp fire’ meeting which included short, sharp information about patients and issues for the day. We were told it also included information relating to significant changes within the health board, compliments from patients or families, areas of good

practice, audits, and complaint themes. In addition, we were told that some information is relayed to staff by e-mail or displayed on notice boards within the staff room.

We spoke to staff who described the process for reporting incidents, errors or near misses on the health board's incident recording system. Staff said they felt encouraged and supported to report serious incidents, however some said they do not always get feedback on lessons learnt afterwards.

Around a third of staff who completed questionnaires agreed that staff who reported errors were treated fairly, although a third disagreed. Most respondents agreed their organisation encouraged staff to report incidents and near misses and two disagreed. Around 40% of respondents said the organisation blames or punish people who are involved in errors or near misses. One staff member commented:

> *"We are not always made aware of the outcomes of reporting incidents and at times are made to feel 'wrong' when reporting, especially if related to staffing levels and acuity."*

Around half of respondents agreed that when errors are reported the organisation takes action to ensure they won't happen again. Around half of staff agreed they were informed about errors and near misses, and the same number of staff said they are given feedback about changes made as a result of reported errors. One staff member commented:

> *"Very rarely get feedback from incidents when we report them, let alone other staffs incident reports."*

Given these comments from staff, the health board needs to consider the issues raised in this area.

We considered the audit activity being carried out on the ward, to ensure that essential activities were being undertaken. Whilst it was evident that audits were taking place, we could not be assured of their frequency and consistency. This is demonstrated by findings earlier in this report which include the following:

- Inconsistencies on the daily checks of the refrigerator temperature at which medication was stored
- Arrangements for security of patient information
- Inconsistent completion of cleaning schedules
- Inconsistent infection control audits being undertaken.

We were not assured that there was sufficient oversight by the management of wards to be confident that there was a robust process in place for audit activity, to help demonstrate a safe and effective service.

Improvement needed

The health board must:

- Consider the culture and learning around incidents, including ensuring that learning is shared with all staff in an open, non-punitive environment
- Ensure there are robust audit processes in place for ward activities, and that there is sufficient oversight of this within the health board.

Staff and resources

Workforce

Discussions with senior managers reflected there was a shortage of nursing staff. We were informed there was a total shortage of 3.6 working time equivalent Band 5 nurses on Ward M. We were told the posts were due to be advertised on TRAC[14] during February of this year, with a view to staff being in post in April. Senior managers told us staff shortages were also partly attributable to staff sickness and the need to fulfil maternity leave on the ward. Senior managers said that staffing levels on the wards were being managed by a reliance on bank staff and the goodwill of existing staff working additional shifts to cover. We were told that nursing staff were considered to be fluid across both wards and the PAU, and staff would be asked to move when required to cover shortfalls on the wards. We were also told that, on occasion, the paediatric burns/plastic surgery ward would close and patients moved, enabling staff to cover shortfalls on Oakwood ward or Ward M.

Staff we spoke to, and those who completed questionnaires, commented that they were regularly understaffed. Staff told us that they felt unsupported at times during night shifts and weekends due to a lack of higher grade nurses on duty.

[14] NHS recruitment system

We were also told that the skill mix of staff on night shifts and weekends were often less experienced staff.

We spoke to senior managers who said that efforts were made to have a more senior supernumerary member of staff on duty on the weekends, however, that was not always possible. They added that the matron and head of nursing are always contactable by telephone on the weekends wherever needed, and staff did call them for advice when needed.

Around half of the staff who completed questionnaires said there were only sometimes enough staff to enable them to do their job properly. Some of the comments received from staff included:

> *"Staffing issues are paramount. Daily acuity is carried out with minimal feedback - only if you ask - we are aware that we are short staffed, mixed messages given about how many WTE's we are down on. No clear answer as to when this will be resolved/rectified by advertising for jobs."*

> *"Staffing levels are very demanding, and have been for a long period of time."*

We saw regular recording and monitoring of daily acuity using the All Wales Acuity tool to ensure that staffing levels and staff location on the wards were monitored and in assessing high observation and patient dependency needs. From a review of staff rotas we found that, due to the number of staff vacancies, a ward manager was frequently working shifts in a clinical capacity. This meant that they were unable to fulfill their supernumerary role in providing clinical leadership to ward staff. Senior managers told us that, once the vacancies have been filled, the ward manager will revert to a supernumerary position. This will be in line with the Interim Paediatrics Inpatients Nurse Staffing Principles (Wales)[15] which supports that a ward manager will be supernumerary.

[15] A set of interim guiding principles to support the planning of nurse staffing levels in paediatric inpatients services issued from the Chief Nursing Officer/Nurse Director NHS Wales to all Health Boards in Wales in June 2019. It is not expected for Health Boards to become fully compliant immediately, but to work towards achieving the principles.

We recognise that efforts are ongoing to fill staff vacancies, however, in light of the concerns received from some staff regarding staffing levels and the requirement for the ward manager to work in a clinical capacity, we recommend that senior management review staffing rotas. This will ensure that staffing levels are appropriate to the provision of safe and timely care.

The inspection team also saw that facilities for staff on both wards were not of a high standard. This included the staff room, toilet facilities, and the handover room. Whilst the inspection team noted that low staffing levels and the poor environment had a negative impact on staff morale, we were reassured to establish that this had not had a negative impact on the patient experience within the wards that we visited. This demonstrated the commitment and professionalism of staff to the patients and families, their role, and the health board.

We saw that the ward staff on each ward were cohesive and had a good relationship with ward managers. This demonstrated good team working and supported the provision of safe and effective care. We also received positive feedback from staff questionnaires regarding teamwork. Most respondents said their manager always or usually encouraged them to work as a team. Some of the comments received from staff included:

> *"Brilliant manager. She is very approachable. Has been very supportive of my development as a newly qualified nurse. I feel very happy in my place of work"*
>
> *"Very supportive manager who always has her door open"*
>
> *"My immediate line manager is the reason I stay in my job. Her and the matron".*

Around half of staff who completed questionnaires said that communication between senior management and staff were always or usually effective. The same number said senior management sometimes involve staff in decisions. A third of respondents said management always or usually act on staff feedback, and around a third said they never do. Based on discussions with ward staff, and from the feedback in the staff questionnaires there is a need for improvements in communication between senior managers and ward staff.

We spoke to the practice development nurse who was enthusiastic and knowledgable in her role and the training requirements of staff. We saw a wide range of educational support available for both registered and

unregistered staff and a clear engagement in ensuring ward safety and competency of staff who deliver care.

We saw that all new staff, both registered and non-registered, are provided with an individual induction orientation pack. This includes a portfolio of competencies, development opportunities available and an explanation of the health board's appraisal process. Staff are issued with a training passport document which documented the mandatory training required. The service holds an annual mandatory and statutory training day, and a paediatric skills day which includes medication management and IV drug administration.

In addition, we saw staff were required to complete mandatory E-learning which included infection contol and safeguarding. Staff could also access additional E-learning applicable to their role, which included breastfeeding training. We saw that staff were also required to complete a competency booklet and maintain a portfolio of evidence.

We reviewed staff compliance with statutory and mandatory training and identified inconsistencies in compliance for staff on both wards. We were assured that e-learning compliance was at a high level. However, we noted that the percentage of staff who had attended a skills day up until January 2020 was low.

Most staff who completed a questionnaire said training or learning and development always or usually helps them to do their job more effectively and most said it helps them to stay up to date with professional requirements. Most staff said it always or usually helps them to deliver a better experience for patients and service users.

Discussions with managers revealed that there was an established system in place for the completion of staff personal appraisal development reviews (PADR). That meant there was a formal mechanism in place to consider whether previous training had been effective. Appraisals were also considered to be a useful forum for identifying future staff training needs. Figures presented showed that only 56% of staff on Ward M and 50% of staff on Oakwood ward had received a PADR between April and December 2019. These figures may be attributable to low staffing levels and a lack of time by managers to complete staff appraisals.

Most staff who completed a questionnaire said 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, and a majority that their manager supports applications for specialist training or

additional training. Staff also suggested training they would find useful, including makaton and sign language, oncology, violence and aggression, and catheter insertion.

We spoke to managers who confirmed that staff are made available for training as often as possible. However, we were informed that this is not always possible due to staff having to cover shifts and therefore training leave is postponed and rescheduled to another date. In particular, managers told us there have been on-going issues with the release of staff to attent Paediatric Immediate Life Support (PILS) and Emergency Paediatric Life Support (EPLS) training. This was confirmed in the overall compliance figures for both wards. However, managers confirmed that there is always one EPLS trained member of staff on duty across the paediatric wards at any given time. The Interim Paediatrics Inpatients Nurse Staffing Principles advise that at least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS. Senior managers told us the service is working towards this. We were also told that training in paediatric resuscitation was provided to registered nurses as part of the skills day, and an 'acutely ill child' study day is also held.

We considered staff wellbeing and whether staff were able to acccess to occupational health if the need arose. Most staff who completed questionnaires told us they were aware of the occupational health support available within the health board and how to access it. However, staff we spoke to said that there was an unnacceptable waiting time to obtain an appointment. One member of staff commented in their questionnaire:

> *"Although I am aware of occupational health it is extremely difficult to obtain an appointment."*

Improvement needed

The health board must ensure that:

- A review of staffing rotas is undertaken to ensure that staffing levels are safe and effective to meet the needs of the service
- A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication
- Staff are provided with opportunities to complete mandatory training and attend PILS and EPALS training

- The health board must ensure all staff receive timely annual appraisals
- Consideration is given to staff wellbeing and accessibility to occupational health support when required.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, 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.

5. 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: Morriston Hospital

Ward/department: Oakwood Ward and Ward M

Date of inspection: 21 and 22 January 2020

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 it will take to ensure that: Medicines are stored at appropriate temperatures and regular checks of medicine fridge temperatures are maintained in line with the health board's policy.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	All Nursing staff reminded of policy relating to checking temperature of medicine fridge. Daily Checklist for ward staff revised and shared with the nursing team. In addition Matron to use new quality check list weekly to include checking of drugs fridge. Area now compliant with Swansea Bay Medicine management policy. PSN 5.2.6 Page 40 /May 2019. Ward assurance reviews to be shared with Singleton Delivery unit,	Head of Nursing Matron Ward Sisters All registered Nursing Staff	Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Learning and assurance, sisters and leads meeting. Report this immediate improvement plan to the Quality and Safety Governance Group to share the learning Health Board wide.		
The health board must provide HIW with details of the action it will take to ensure that: There are appropriate systems in place to maintain the security and confidentiality of patient information at all times, in order to prevent unauthorised access.	3.5 Record Keeping	All staff reminded of Information Governance policy. Health Board Information Governance lead has been contacted and will be undertake check audit. Compliance of Mandatory and e-learning training checked across all areas. All staff who are not compliant with information governance training to be trained within the next four weeks Health Board Governance lead to undertake an audit on 5th and 12th February 2020 which consists of a number of sections:	Clinical Lead Acute Paediatrics Consultant Paediatrician Head of Nursing Matron Ward Sisters All registered Nursing & Medical Staff	Completed Check Audit planned with IG Lead for Health Board

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• Interview with the HoD / Manager • Observational audit of the area / ward. • Interviews with 2 staff. Notes trolley has been removed from Ward M on 22nd January 2020 and is now placed in a room with a key pad lock and the trolley also has a locked lid. To accommodate the notes trolley the treatment room on Ward M will be refigured to accommodate the trolley. The surgical team have been informed of the change in practice and it has also been added to the agenda for Paediatric Surgical Committee to feedback the change in practice and the findings of the HIW visit Ward M now compliant with Swansea Bay Health Board policy on		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		standards to maintain the security of health records Ward assurance reviews and all local audits to be shared at learning and assurance, Sisters, leads and local risk forum meetings. Report this immediate improvement plan to the Quality and Safety Governance Group to share the learning Health Board wide.		

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: Eirlys Thomas

Name (print): Eirlys Thomas

Job role: Head of Nursing, Children's Services

Date: 30 January 2020

Appendix C – Improvement plan

Hospital: Morriston Hospital

Ward/department: Oakwood Ward and Ward M

Date of inspection: 21 and 22 January 2020

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 ensure that up-to-date health promotion information is available for patients of all ages.	1.1 Health promotion, protection and improvement	Health promotion displays across the acute care service. Children's services involved in smile campaign and play staff display seasonal displays for safety in the sun. Swansea bay have worked with RCPCH to develop a booklet on 'How to Adult' this promotes health and wellbeing for young people going to college/University on staying healthy. Advice and support information available within the ward areas	Matron/ head of Nursing & Play Staff	Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must: • Consider how the privacy of patients can be maintained if staff have discussions in the multi-bedded bay areas • Consider how the dignity of parents/carers can be maintained when staying overnight within the multi-bedded bay areas • Consider how the privacy and dignity of patients and parents/carers can be maintained in the event that staff need to have sensitive conversations with them • Consider how the privacy and dignity of older children and teenagers can be improved • Consider the layout of the wards and access to the parents' facilities in order to maintain patients' privacy.	4.1 Dignified Care	Quiet room being developed for patients and families in order to support privacy within paediatrics. Discussion around the use of headphones during wards with parent groups and staff • Due to the layout of the wards this is difficult. This will be taken into account with the re development plans for the ward templates. It is envisaged that the spaces between beds will be larger with space for parents. There are plans to develop more cubicle capacity. Staff encouraged to have sensitive conversations away from the ward bay • As part of the re development of clinical area there will be provision for facilities for young people. All nursing staff consciously allocate bed spaces according to age of the child • Ward layout is a priority for children's services. • Discussions are already underway across the health board and	Ward staff/ Matron, Head of Nursing and Medical clinical Lead Health Board Director of planning & Singleton delivery unit, Children's services management team	August 2020 April 2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		are a priority within children's services IMTP. Option appraisal completed		
The health board must ensure that signage within the wards is reviewed to ensure that it is easy for patients and their carers/families to locate the facilities.	4.2 Patient Information	Swansea Bay youth forum to undertake a 15 step review and advise on signage. This will be incorporated into the re development programme, however any advice from the youth forum will be acted on directly	Head of Nursing Patient experience CNS, Swansea Bay Youth	November 2020
The health board must consider discharge planning arrangements to ensure patients are discharged in a timely manner.	5.1 Timely access	Surgical discharge planning needs to be addressed. Currently there is nurse led discharge for some patients. This will need to be discussed at surgical committee to expand to other specialities	Matron , Sister surgical ward and Surgeons, Practice educator	August 2020
Delivery of safe and effective care				
The health board must ensure that: • It continues to identify, monitor and act on any risks identified due to the environment to ensure that patient's health, safety and welfare are promoted and protected	2.1 Managing risk and promoting health and safety	Q&S audits undertaken by the Matron All issues relating to the environment datex reported. The environment is on children's services and HB wide risk register. Any issues escalated to the	Head of Nursing Matron children's services Morriston	Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The policy for the promotion of safety and prevention of abduction of babies is reviewed • Action is taken to ensure the emergency bell on M ward can be clearly heard on Oakwood ward • Rebreather bags are easily accessible in every bay • All cleaning equipment and supplies are stored appropriately and securely.		Singleton delivery unit quality and Safety group. Risk register re viewed by MDT quarterly. The HB has a policy for the abduction of children. This was shared at the visit. This will need to be re viewed this year The emergency bell across the paediatric template has been explored and action taken to ensure that this can be heard across the floor during an emergency, work not yet complete. Waiting on conformation of cost Re-breath bags available now at each bed side. Matron undertaken weekly checks to ensure compliance Actioned by Domestic services. Lock placed on cleaning cupboard. Locks to be place on dirty utility doors within Oakwood and ward M	Head of Nursing/ Matron children's services Matron Children's services Matron children's services Matron Children's service	December 2020 May 2020 Completed February 2020 April 2020
The health board must ensure the following:	2.4 Infection Prevention and	Domestic Cleaning schedules being reviewed with domestic services across paediatrics. Equipment cleaning	Head of Nursing / Matron	March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Consistent completion of cleaning schedules • All damaged chairs within both wards are replaced • Infection control audits should be completed consistently, in line with policy and the results displayed on the wards wherever possible.	Control (IPC) and Decontamination	schedule for nursing staff in place. This is checked by Matron and Sisters as part of quality assurance check lists Infection control quality assurance audits undertaken by Matron fortnightly, Monthly infection control audits undertaken by wards. Results displayed at the entrance to the ward, as observed during visit, paper copies of all audits were shared at the time of the visit	Ward Sisters / Matron	Complete and ongoing
The health board must ensure that all administration of medication to patients is in line with its medicines management policy.	2.6 Medicines Management	Medicine management was observed at the time of the visit. It was identified that there was good practice in line with the medicine management, however there was inconsistencies with daily checks of the refrigerator temperature on ward M. This was actioned at the time and included in our quality audit tool, a checking chart has also been put in place.	Head of Nursing / Matron	Completed. January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • All equipment is regularly checked within appropriate timescales to ensure it is in date and safe for use • A system is in place to ensure that all necessary equipment is readily accessible to staff on the wards to ensure the provision of safe and effective care.	2.9 Medical devices, equipment and diagnostic systems	All equipment checked weekly to ensure that it is cleaned if not in use and maintenance schedule checked and recorded Following the visit 3 individuals have been identified to ensure stock levels are maintained. All are trained in ordering via Oracle	Ward Sisters/ Matron Matron	Completed January 2020 Completed January 2020
The health board must ensure that all staff have a good understanding of the paediatric sepsis pathway.	3.1 Safe and Clinically Effective care	This was discussed following the visit with named lead consultant. Sepsis 6 posters ordered. Nurse Education programme to be commenced to introduce sepsis pathway. The staff are using the principles of recognition of the sick children and the RCN standards for clinical observations.	Head of Nursing/ Matron/ Clinical educator and Clinical lead for Paediatrics	September 2020
The health board must ensure that pain management is appropriately recorded within patient's records.	3.5 Record keeping	Quality audits to include pain management audit. Ward Managers to check and ensure completion. Spot audit to be completed in April 2020	Ward Sister / Matron	End April 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must: • Consider the culture and learning around incidents, including ensuring that learning is shared with all staff in an open, non-punitive environment • Ensure there are robust audit processes in place for ward activities, and that there is sufficient oversight of this within the health board.	Governance, Leadership and Accountability	Monthly risk meetings moved to ward areas to encourage attendance. Feedback given to reporters following submission of datex report undertaken. Learning events undertaken following serious incidents. Incidents and complaints training provided by Unit at skills days during 2019-20 Quality assurance audits in place and any lessons learnt shared at Learning and Assurance meetings.	Head of Nursing, Matron and Service manager children's services Head of Nursing/Matron / ward Sisters	Completed February 2020 In Place
The health board must ensure that: • A review of staffing rotas is undertaken to ensure that staffing levels are safe and effective to meet the needs of the service • A review of the adequacy of communication channels between senior managers and staff is	7.1 Workforce	Nurse staffing act extended to Paediatrics April 2021. Staffing within the ward areas reviewed in line with the interim paediatric in-patient staffing principles from the All wales staffing group. Head of nursing has undertaken papers to escalate the deficit Ward meetings in place, feedback given daily via huddles e mail	Unit Nurse Director/ Head of Nursing Ward Sister/Matron	April 2021 In place

Improvement needed	Standard	Service action	Responsible officer	Timescale
undertaken to ensure effective communication • Staff are provided with opportunities to complete mandatory training and attend PILS and EPALS training		All staff attend Mandatory / Skills study days. E learning compliance 86%. EPLS two yearly difficulty in securing spaces, however we undertake stabilisation and management of the critically ill child. There are also MDT scenario training in place	Sisters/Matron	October 2020
• The health board must ensure all staff receive timely annual appraisals		In place for all staff compliance needs addressing due to workload and vacancies over the winter period. Plans in place to improve. This is discussed monthly at unit confirm and challenge meetings.	Ward Sisters/ Matron/ Head of Nursing	April 2020
• Consideration is given to staff wellbeing and accessibility to occupational health support when required.		All staff are made aware of wellbeing service. Senior Management team will be commissioning wellbeing team to undertake some on site workshops with staff. Any delays in OH referral escalated to Singleton delivery unit	Head of Nursing/ Clinical Manager for Children's services	May 2020

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): Eirlys Thomas

Job role: Head of Nursing Children's Services

Date: 12 March 2020