Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Glangwili General Hospital / Paediatric Ambulatory Care Unit and Cilgerran Ward, Hywel Dda University Health Board

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

Our purpose

To check that people in Wales 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 Glangwili General Hospital within Hywel Dda University Health Board on the 4 and 5 March 2020. The following hospital sites and wards were visited during this inspection:

- Paediatric Ambulatory Care Unit (PACU)
- Cilgerran ward
- Children's High Dependency Care Unit

Our team, for the inspection comprised of two HIW inspectors, two clinical peer reviewers and one lay reviewer. 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 the privacy and dignity of patients and their parents/carers can be maintained at all times.

This is what we found the service did well:

- Patients and their families/carers told us they were happy with the care received
- We observed professional and kind interaction between staff and patients
- Good arrangements for the reporting and management of clinical incidents
- Staff we spoke to were happy in their roles
- A reported good multidisciplinary team working environment.

This is what we recommend the service could improve:

- Some areas of the footprint of the wards which have a negative impact in maintaining patients' privacy
- Communication with patients and their families/carers to ensure they receive consistent and clear information about their treatment and care
- How the environment within PACU can be updated and tailored towards children
- Required staff are provided with up-to-date level two fire safety training
- A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication.

3. What we found

Background of the service

Glangwili General Hospital is located in Carmarthen in Carmarthenshire and forms part of the health care services provided by Hywel Dda University Health Board (the health board). The health board provides healthcare services to a total population of around 384,000 throughout Carmarthenshire, Ceredigion and Pembrokeshire.

The Paediatric Ambulatory Care Unit (PACU) is a 24 hour a day, seven day a week service as part of the acute paediatric service within the Women and Children's Directorate. The unit has been set up to provide a rapid assessment and treatment of children and young people from 0-16 years in a dedicated paediatric environment. The patient age may go beyond 16 years for those under the care of a paediatric consultant. The unit accepts children referred as an emergency via a general practitioner, midwife or the emergency department. Following assessment, children or young people may then be admitted to Cilgerran ward or discharged home. The service provides rapid assessment and stabilisation of all general paediatric emergency admissions, plus scheduled elective provision for reviews, outpatient and day cases.

Cilgerran ward is a 24 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). Cilgerran ward provides care to children with varying health care needs ranging from acute medical admissions to children with complex chronic needs. The ward also caters for both medical and surgical elective and emergency admissions. Within Cilgerran ward there is a three bedded high dependency unit (HDU) which cares for children requiring closer observation and monitoring.

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 told us they were happy with the care and support provided to them. Overall, we observed polite, friendly and supportive interactions between staff and patients.

Information was readily available and clearly displayed to ensure patients and their families/carers better understood their rights in terms of raising concerns or complaints about their care.

Improvements are required to ensure patients' privacy and dignity is maintained at all times.

During the inspection we distributed HIW questionnaires to patients and parents/carers to obtain their views on the services provided. A total of 45 were completed by parents/carers, and a further ten were completed by patients. We also spoke to patients and their parents/carers during the inspection. Comments included the following:

> *"The staff are caring and friendly"*

> *"All the staff here were incredible, it was my sons first time in hospital and a terrifying experience for all, they were reassuring, helpful and kind hearted, making a very difficult time so much easier!"*

Staying healthy

The inspection team 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, the WEE challenge (hydration information for parents) and flu information.

We saw that, whilst there was some information designed specifically for children within the PACU waiting area, the majority of the information was more appropriate for parents and teenagers. There was also little information available on topics such as mental health and social media awareness. We recommended

that a range of health promotion information for all ages should be made available in all areas.

Improvement needed

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

Dignified care

During 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 were clearly visible to patients on both wards and we saw them speak to patients in a friendly, calm manner which was appropriate to their age. Staff members were attentive to the needs of both the families and the patients and would ask questions to ensure that any discomfort or distress could be addressed.

During our inspection, we also invited staff to complete a HIW questionnaire. We received 25 completed questionnaires. All respondents agreed that the privacy and dignity of patients is always maintained. Staff we spoke to were aware of the need for discretion in communications about personal information with patients.

Overall, 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, whilst on Cilgerran ward, members of the inspection team saw a staff member administering care to a child in a multi-bedded area, with the curtain open. This meant there was a possibility that other patients or visitors could also have observed this.

We observed staff speaking to parents/carers regarding their child's care in a professional tone, lowering their voice to ensure that others within the vicinity could not hear the conversation. However, on one occasion in the PACU waiting area, a member of staff called across the room to a parent to enquire why their child was there. This meant that other people could have overheard possible sensitive and personal information relating to the child. We also overheard staff talking to parents behind a curtain in a bay area within PACU, despite staff making efforts to keep their voices low.

We considered whether the environment could affect the dignity of children and young people. We saw areas of good practice, with staff making efforts to

separate boys and girls within the adolescent area of Cilgerran ward to maintain their privacy and dignity. However, due to the footprint of the ward, access to the outdoor garden area of the ward was gained from an entrance within the adolescent area. This meant that patients and their parents/carers had to walk passed some patients located within the multi-bedded bay area in order to get outside which could have a negative impact on their privacy and dignity. We also saw that the footprint of the ward meant that patients from bays and cubicles at the far end of Cilgerran ward have to walk through a bay of patients to access the toilets or showers.

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 are allowed to stay overnight on pull-out beds, or on chairs next to the patient's bed. We also spoke to staff who said that if a patient is in the HDU within Cilgerran ward, staff make efforts to enable two parents/carers to stay with the child if required.

Nearly all parents/carers who completed questionnaires agreed staff are always polite to their child and most agreed staff are always polite to the family. Most respondents agreed staff listen to their child and to the family and nearly all respondents said staff call their child by their preferred name.

Improvement needed

The health board must:

- Ensure that staff draw the curtains around patient beds at all times when administering care
- 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 the layout of the wards and access to the outdoor garden area and toilets and showers in order to maintain patients' privacy.

Patient information

We saw notice boards which displayed information regarding staff roles on both wards. There was also a board in Cilgerran ward which displayed the names of staff on duty on the ward that day. This would assist patients and their parents/carers in identifying the designation of staff involved in their care. We advised it would be beneficial for patients and their parents/carers to have photographs of staff on duty to assist with identifying staff.

We saw instructional posters displayed at the entrance and throughout the corridors of both wards. These included visiting hours, when meals are served and directional cues (toilets, playroom, outside garden area). However, we advised the posters could be more child-friendly in design and moved to visible locations on the wards for children to see. This would assist patients and their parents/carers to find their way easily.

Staff told us that, upon their admission to the Cilgerran ward, patients and their families are given an orientation tour of the ward to show them where the facilities are located.

Communicating effectively

All patients who completed questionnaires said staff had been friendly towards them. Patient comments included:

"The staff are caring and friendly"

"The nurses and doctors are so kind".

Most parents/carers who completed questionnaires agreed staff listen to their child and to the family, though a few disagreed. Nearly all said staff call their child by their preferred name.

The inspection team observed staff spending time with children, young people and their families/carers, talking to them about their stay and helping them to understand their care and treatment. We also saw staff interacting with patients and ensuring they were comfortable and providing consistent reassurance whilst providing them with care.

We saw staff speaking to patients in a sensitive and courteous manner, taking into account their individual needs. All communication we observed was in line with the patient's stage of development. However, we observed one member of staff speak very briskly to a child whilst trying to carry out a medical procedure. The child appeared upset, and a play specialist assisted by positively communicating and engaging with the child. Through positive communication, the procedure was completed.

Some parents we spoke to on Cilgerran ward expressed there was no consistency in which members of staff they spoke to and what information they were given in relation to their child. This resulted in the parents feeling confused. We recommend clearer communication in providing parents and carers with information regarding their child.

Staff told us that, upon admission, patients are asked whether they would prefer their care to be provided in Welsh or English. Staff then work to accommodate that need both verbally and in written form. We observed staff being proactive in providing as much care and interaction in Welsh as they could to meet the communication need of Welsh speaking children and young people. Welsh speaking staff were identifiable by wearing a badge to indicate they were bilingual. Around half of respondents who completed questionnaires agreed they were asked which language their child prefers to speak.

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. A staff member described to us an occasion when they used the service to obtain a translator as a child's parents were unable to speak English.

We were told by staff that individual patient 'My health passports' had been developed and introduced. The passport is specific to the individual patient which includes children receiving palliative care, complex health conditions and disabilities. We saw the language used within the passport is easy to read, can be understood by all ages, and visual images are used within the different sections of the passport. The passport remains with the patient eliminating the need for them to reiterate their details and circumstances at different appointments and settings.

We also saw the use of iPad applications to communicate care needs with patients. Children were able to tap images, for example, to express what degree of pain they were in. This was particularly important for children who may have language and literacy difficulties to assist with understanding their care.

Improvement needed

The health board must ensure that:

- All staff positively communicate and engage with patients at all times
- Patients and their families/carers receive consistent and clear information about their treatment and care.

Timely care

We saw that patient observations were recorded on a recognised national chart to identify patients who may become unwell or develop sepsis. However, during a previous HIW inspection at another hospital within the health board area, it had been identified there was no clear paediatric sepsis guideline or pathway in place.

Managers told us that, as a result of the previous HIW inspection, this work had now been prioritised and the development of the guideline progressed. We were told the paediatric sepsis guideline should be in place across the health board area by the end of March 2020.

The inspection team reviewed a sample of patient records and identified that patients who attended PACU without pre-booked appointments were booked in, assessed and examined in a timely manner.

Individual care

Planning care to promote independence

We spoke to staff who told us that patients and their family/carers are actively encouraged to provide assistance with and be involved in the patients care at all times. 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. Most patients who completed questionnaires agreed they have the opportunity to ask questions and get involved in their care and around half of parents said they knew who their child's key worker and consultant was.

We saw within a sample of patient records we reviewed that patient care plans were based on individual patient care and support requirements. We also saw that discharge packages were put in place to cater for individual needs.

Most parents/carers who completed questionnaires agreed that when their child needs to go to the toilet, they are enabled to do so as independently as possible. They also said that staff help their child with toilet needs in a sensitive way when required. We saw that one of the bathroom facilities on Cilgerran ward had been updated to allow disabled access and was equipped with facilities which included an assisted lift to gain entry to the bath.

We spoke to play staff who told us they rotate the toys in the playroom to ensure they are age appropriate for the patients on the ward. We were told that patients are encouraged to be active and are given equipment to help them walk, move, eat, hear etc. Staff told us a paediatric physiotherapist works clinically on the ward to provide treatment to patients who require physical rehabilitation.

We saw the environment within the PACU was not tailored towards children. It was plainly decorated, very clinical in appearance, and not conducive to a paediatric setting. We were told by senior managers that work was in progress to improve the environment and make it more suitable for children and adolescents.

The service has a specialist lead oncology nurse. They told us the oncology team provide support on a daily basis to oncology patients across a large geographical area with an on-call service available on weekends. In order to maintain their competency, the ward staff attend a formal training session in Cardiff every three years and receive an annual update from the lead oncology nurse.

We were told that Latch (a Welsh children's cancer charity) had funded the conversion of a cubicle on Cilgerran ward to an en suite in order to support the management of neutropenia patients (paediatric patients with cancer). Staff told us that an audit had been undertaken to establish the time taken to deliver antibiotics for neutropenia patients who attend the ward. We were told that, overall, the results were good however it was identified there had been occasional delays. As a result, parents were encouraged to telephone the ward ahead of their attendance to the ward and staff would follow protocol and prepare documentation, prescription and ensure drug availability to ensure timely care.

Improvement needed

The health board must consider how the environment within PACU can be updated and tailored towards children.

People's rights

Within the playroom, we saw a wide range of toys, puzzles, painting activities and role play areas to assist with the development of younger children. A reading corner provided a range of books in English and Welsh, for children of all ages to encourage speech and language development.

We also saw a designated area aimed towards adolescents where they can spend time to relax away from the busy ward areas. This area provided a range of activities, however we considered more hands on activities should be made available as the majority that were available involved screen time.

We saw a spacious, safe outdoor garden area with a number of activities to encourage development and physical health.

Most parents/carers who completed questionnaires agreed there are sufficient activities for their child and sufficient facilities for parents. Most patients who completed questionnaires also said there was enough entertainment and things to do on the ward suitable for their age.

We spoke to staff who said that individual play plans are developed for patients who are staying on the ward for a prolonged period of time. We were told that

emotive and directional cards can be used if verbal communication is limited and an interactive whiteboard can be used for children/young people to physically write their wants or needs if they do not communicate verbally.

We also saw that Makaton[1] is used on the wards. This is beneficial for children who may experience difficulties with communication skills.

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 able to seek the advice and support of religious leaders in the area for children, young people and families/carers. Through discussions with staff, it was evident that they expressed a desire to meet all of the needs of their patients including their religious preference.

We saw the ward has a rainbow suite for patient with mental health needs. Staff told us that this is funded and staffed by child and adolescent mental health services (CAMHS) with the fundamentals of care being provided by ward staff. We also saw there was a room next door which was used for providing counselling when required. However, due to the footprint of the ward, patients had to walk through the ward and through a multi-bedded bay area to get to the rainbow suite. This area is not easily observed from the main ward corridor and is far away from the nurses stations.

Improvement needed

The health board must consider the location of the rainbow suite on the ward.

Listening and learning from feedback

We saw that patients and their parents/carers were encouraged to provide feedback in a variety of ways. Feedback questionnaires were available for parents/carers and patients to complete and place into an anonymous box provided. A 'what you said, what we did' board was displayed in CiIgerran Ward.

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

This clearly demonstrated the suggestions and improvements that had been made by staff teams to the service as a result of the feedback provided.

We spoke to members of the patient advice liaison service (PALS) team who are based at the hospital. They told us that patients and families can complain directly to them by telephone, email or in writing if their complaint has not been resolved at ward level. The PALS team said they try to resolve complaints locally at the time the complaint is received. We were told that a member of the PALS team attends Cilgerran ward and PACU to gather feedback from patients and their families. The results are collated and presented to ward managers to action.

Nearly all staff who completed questionnaires told us patient experience feedback was collected. Most respondents said they received regular updates on the patient experience feedback and all said feedback is used to make informed decisions within their directorate or department.

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). Staff told us they will direct children, young people, families and carers to the CHC should they need to. 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. Information was also available on how to contact the PALS team.

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. However, the environment and footprints of the wards posed challenges to staff and management.

We found areas for improvement with regards to infection prevention and control across the wards.

A separate drug storage and preparation room should be made available to PACU to ensure patients confidentiality and safety.

The service described good arrangements for safeguarding procedures, including the provision of training.

Safe care

Managing risk and promoting health and safety

Overall, the unit was clean and appropriately lit, however the environment is tired and in need of attention. The environment and ward footprint poses a number of challenges for management and staff in providing safe and effective care which are highlighted within this report.

We saw excellent processes in place to manage risk, which included regular audits of handwashing and infection control.

Staff told us that they had lost the ward's main store room as a result of ongoing development work at the hospital. This meant that some larger items were now stored in the corridors due to a lack of space within the temporary storage unit. This could be a hazard to both patients and their families and cause difficulties for wheelchair users. We recommend that additional storage area is provided for the use of the ward.

On the first day of our inspection, we saw the door to the cleaning cupboard on Cilgerran ward was not securely locked. We also observed two cleaning trollies which contained cleaning equipment and substances left unattended in the ward corridor. These issues could pose a risk of unauthorised access to hazardous substances to patients and visitors. These issues were raised immediately and

action was taken to rectify the situation, details of which can be found in Appendix A.

The inspection team saw that arrangements were in place to maintain the safety of patients in the areas we visited. One entrance facilitated access to both Cilgerran ward and PACU via an intercom system. We observed staff asking visitors the reasons for their visit before allowing them to enter the wards. Anyone wishing to leave the wards require staff to swipe them out, or to be buzzed out via the intercom system. Staff told us that patients and their parents/carers are made aware of the safety measures upon their admission. 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. We also observed call bells were in use and within easy reach for patients and their parents/carers.

We saw the ward had a three bedded high dependency unit (HDU) which was located off the main corridor and cared for children requiring closer observation and monitoring.

Most parents/carers who completed questionnaires agreed staff had taken into account their child's previous medical history, and discussed their child's care plan with them, and few disagreed. Most respondents also agreed staff encouraged them to ask questions about their child's care.

Preventing pressure and tissue damage

The inspection team saw that processes and risk assessments were in place to deal with and the prevention of pressure damage. We saw evidence of appropriate individual completed skin risk assessments and care plans within the sample of patient records we reviewed, along with ongoing monitoring of pressure areas.

Falls prevention

We saw that efforts had been made to assess and identify patient who were at risk of falls. Where appropriate, patients had been assessed for their risk of falls, however there were no patients at risk within the patient records we reviewed. We also saw that babies and infants had been assessed and those requiring cots or bed sides identified.

Managers told us that a new falls risk assessment document was in the process of being developed. Once implemented, we were told that an audit would be carried out to ensure that all staff were completing them appropriately where necessary.

Infection prevention and control

We noted that the clinical areas of the wards inspected appeared visibly clean. Staff worked collaboratively to keep the environment clean and domestic staff were seen to be present at various times of the day. Nearly all respondents who completed questionnaires agreed the ward was clean and tidy. We did however find areas some areas where improvements were needed to overall infection prevention and control arrangements.

We saw both adolescent and junior shower rooms were located off the main ward corridor. Whilst they appeared clean, they were in need of updating as there were broken tiles, broken seals and uneven floor surfaces which would prevent them from being fully cleaned. We saw the flooring coverage in most of the bays was in a poor state of repair and severely worn and torn. We also saw the floor within the cleaning cupboard was worn, uneven and the bottom trim was damaged.

The inspection team considered the footprint and environmental factors within the ward were a challenge to staff in the delivery of safe and effective care. The wards have only one sluice which is located the other end of the ward to the inpatient beds and the adolescents area. This meant that there was a risk associated with carrying waste items the length of the ward to dispose of. As previously referred to in this report, there was also only limited storage available within a portacabin. Staff told us there were recurrent problems with the storage facility as there was mould on the walls, water seeping under the flooring and the toilets located within the portacabin were reported to be regularly out of order due to blockages. One of the toilets was out of order and unable to be used during our inspection.

We also saw that some windows on Cilgerran ward were taped up and unable to be opened as the catches were broken. A senior manager told us the environmental issues had been risk assessed and highlighted to the health board in May 2019. We reviewed the health board's risk register and saw the environmental risks had been identified and monitored and action taken where possible to minimise those risks.

We saw a number of pull out beds that parents/carers sleep on when staying overnight were torn and the internal foam filling exposed. This included beds within PACU and Cilgerran ward. This is an infection risk, and the pull out beds must be repaired or replaced as they cannot be cleaned to infection control standards. We were told by staff that 14 new pull out beds had been ordered.

The service does not have a separate en-suite room available for patients should there be a requirement for barrier nursing. Staff told us patients are required to

either use a commode or a bathroom located across the corridor which is placed out of action for general 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.

We saw that patients and visitors to the wards are encouraged to follow good hand hygiene. We saw a poster with the five moments of hand hygiene on the corridor for parents to read. 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. Hand sanitiser was readily available in the corridors and at the entrance of cubicles and all were well stocked. Leaflets were available which highlighted the encouragement and importance of hand hygiene. We also saw posters and display boards with bright colours, bold fonts, simplistic language and short sentences and phrases to encourage children and young people to wash their hands.

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.

Improvement needed

The health board must ensure the following:

- Consider the provision of additional storage space
- Ensure the bathroom tiles, seals and the uneven flooring within the wards are either fixed or replaced to ensure that effective cleaning can be carried out
- Consider the provision of an additional sluice
- Continue to identify, monitor and act on the risks caused by the poor environment
- All damaged pull out beds within both wards are replaced.

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 upon admission and in line with the All Wales nutrition care pathway. Where necessary, we saw that referral to a dietician had been made.

Staff told us parents/carers were encouraged and supported to assist their child with eating and drinking when required. If a patient is admitted who requires support when eating and drinking nursing staff are able to intervene and provide support. If nursing staff are busy then play staff are also happy to help provide support at mealtimes. About half of respondents who completed questionnaires agreed staff help their child to eat, if they need assistance, and few disagreed.

We observed meal times and saw that patients were given a choice of hot food which was served at their bedside. Staff told us the food menu is rotated on a four week basis and patients are encouraged to order healthy options, alongside their main meal. A range of child friendly options was available. We saw that the food appeared hot, appetising and appropriate for selected age ranges. We also saw that cutlery and crockery was provided tailored to the patient's age. We were told that if patients are hungry outside of mealtimes they are able to provide additional snack foods from a refrigerator which is situated in the ward kitchen and used specifically to store food for patients. Parents are also able to store food for their children within the refrigerator.

Most respondents agreed the food has been child friendly, with appropriate portion sizes, and very few disagreed. However, one parent commented:

> *"The food choices on the menu are not great. It is a very adult orientated menu. Children who are ill do not want to eat big meals at set meal times."*

A majority of the patients who completed questionnaires agreed they liked the food on the ward, and around a third disagreed.

Staff told us that children and young people are provided with water jugs and cups on admission onto the ward. Parents/carers are able to fill the jugs with water whenever they please and staff regularly bring around more water so that patients stay hydrated. Additionally, we were told that staff are vigilant about whether the water in the jug is fresh or if it has been sat there for a prolonged period of time. Patients we spoke to also expressed feeling confident and comfortable in requesting fresh water from staff. A variety of age appropriate cups were available for patients.

A majority of respondents who completed questionnaires agreed staff help their child to drink if they needs assistance, and few disagreed. Most respondents also agreed their child always had access to water on the ward.

Where appropriate, we saw that fluid intake was being monitored and fluid charts were completed, easy to follow and up to date.

We also saw within the sample of patient records we reviewed that allergies and intolerances are considered and catered for. Staff told us there is also the provision of a separate vegan menu.

Medicines management

We considered the arrangements for the safe storage of medications throughout both wards. We saw that, whilst the controlled drugs within the medication room on Cilgerran ward were secure within a locked room, the locks on some of the doors to the drugs cupboards were broken. We also saw a storeroom where IV fluids were stored did not have a lock. These issues were raised immediately and action was taken to rectify the situation, details of which can be found in Appendix A.

The inspection team considered the main treatment room within PACU. The room is used as a multipurpose room to include drug storage, preparation and administration, as an office and documentation store room, a treatment room for examination of children and taking blood samples from patients. This meant that, if a patient was being treated within the room, there were occasions when they could be interrupted if a staff member required access to medication or documentation. We spoke to staff who told us that this issue had previously been risk assessed and issues identified in terms of patient confidentiality and staff checking medication without interruption. We saw documentation which reflected that the identified risk had been highlighted to the service directorate in 2016 following a number of incidents which included the mislabelling of a blood sample. We recommend that a dedicated drug storage and preparation room is made available to PACU to ensure patients confidentiality and safety.

The inspection team observed good practice in 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. We saw that patients were supported, where necessary, to take their medication. We also saw staff provide parents/carers with support to understand medications being given to patients upon their discharge from the wards.

We spoke to the ward dedicated pharmacist who visits the paediatric wards daily from Monday to Friday to collect drug charts and medication requirements for patients to take home. Medication is returned in a timely manner, so supporting the timely discharge of patients. We were told that there was an on call pharmacist available for accessing medicines out of office hours along with an emergency drugs cupboard which could be accessed by the site team. The pharmacist told us that Cilgerran ward was one of the best in the hospital for reporting drugs errors on datix (the health board's incident reporting system) and the ward have an excellent learning and no blame culture.

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.

Improvement needed

The health board must ensure that consideration is made to the provision of a dedicated drug storage and preparation room on PACU.

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 were asured that confidence in the safeguarding process was demonstrated.

We spoke to the lead nurse for safeguarding children who told us that any practitioner from across the health board can access a single point of contact from the safeguarding team for support and advice between the hours of 9am to 5pm from Monday to Friday. We were also told that a member of staff from the safeguarding team are available to provide advice and support on the paediatric ward on a daily basis.

Staff we spoke with were aware they can approach the safeguarding team who are there to offer support and advice. Staff were also aware that if they considered a safeguarding referral was required, there should not be any delay, in making the referral and then updating the safeguarding point of contact of the action taken.

We were told that every computer within the health board has a safeguarding icon which allows staff to access information which includes an enquiries page,

key documents, lessons learned, competency booklets, noticeboard and a link to the All Wales safeguarding procedures.

We were told that safeguarding training was mandatory for staff on the unit. All staff who completed questionnaires said they had received recent safeguarding training. We were also assured that compliance figures for safeguarding training for staff on the unit was high.

The lead nurse for safeguarding children told us that the health board was leading on the development of dealing with bruising on non-moving children. We were told that a task and finish group had been set up and they were working closely with Cysur[2] within the safeguarding region to develop a clear and precise pathway of dealing with non-mobile children. We were told that this piece of work was in its final stages of development and should be completed in May 2020.

Medical devices, equipment and diagnostic systems

The inspection team considered the arrangements for the checking of emergency equipment on both wards. We found that required daily checks of the resuscitation trolley were being carried out appropriately. However, we found that the full contents check of equipment on the sealed emergency resucitation trolley were being completed on a monthly basis whilst the check list document noted that checks should be carried out weekly, or after the equipment had been used. We checked the health board's resuscitation policy which reflected that checks should be completed weekly. This meant that the checks were insufficient as they were not being completed on a weekly basis. We spoke to senior managers who told us that the policy had been updated and ratified to reflect that full contents checks were to be completed monthly, or when the seal had been broken and the emergency equipment used. Prior to the end of our inspection, we were assured that the processes being conducted for monthly checks were in line with the new policy.

We saw the unit had equipment and medical devices which were appropriate to meet the needs of patients. Staff we spoke to described the process of how to clean and decontaminate equipment. All staff we spoke to said that reusable

[2] Cysur is the Mid and West Wales Regional Safeguarding Children Board

equipment is cleaned prior to and after use which was confirmed through our own observation. All equipment we examined looked visibly clean.

We found processes in place to ensure that equipment is maintained to ensure they are appropriate for their intended use. Staff we spoke to could also explain the process for reporting equipment that was faulty.

Effective care

Safe and clinically effective care

Throughout our inspection we were assured that all aspects of care we observed showed evidence of the delivery of good, safe and effective care. Staff we spoke to said they felt they have enough time to provide care safely and always prioritise patient care. They all agreed that the only limits to the provision of safe and effective care was the footprint of the ward.

We reviewed documentation which demonstrated the clinical audits that take place on the unit each month. This included a paediatric early warning score (PEWS) document audit, hand hygiene, infection control, bare below the elbow compliance and medicine management audit. We were also told that fundamentals of care audits, health care standards audits and monthly compliance with paediatric care indicators are monitored. We saw evidence displayed on the notice board within the staff room of high compliance in all areas.

In the sample of patient records we reviewed, it was evident that pain assessment and management is a priority of patient care. We saw that patients have their pain management needs promptly assessed upon their admission. Staff we spoke to were confident with the pain assessment tools. We were also told that the play specialists play a role in the management of procedural pain such as blood taking.

Most respondents who completed questionnaires agreed staff had done everything they could to assist their child with pain management and very few disagreed. One patient commented:

> *"I've been well looked after by the nurses and they have tried to make my time as pain free as possible"*

Quality improvement, research and innovation

We spoke to the Senior Nurse Quality Assurance Manager who told us that a strategic group had been set up to adopt a children's charter to the health board. The charter is underpinned by the values laid out in the United Nations'

Convention on the Rights of the Child[3]. 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. We were also told that the health board has a lead palliative health care nurse, and a palliative care play specialist.

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. Overall, we found that patient information was being managed or stored securely to prevent unauthorised access and to uphold patient confidentiality. However, we saw a trolley located in the corridor of Cilgerran ward which was unlocked and contained sensitive patient information. There were times when staff were not present in these areas which meant there was a risk that patient information could be accessed by patients or visitors on the wards. This issue was raised immediately and action was taken to rectify the situation, details of which can be found in Appendix A.

Record keeping

We considered a sample of patient records within both wards. Overall, we found patient records were of a good standard, easy to navigate and informative. Patient records were further supported by formal history notes, prescription charts, drug charts, fluid and observation chart and nursing evaluation. We saw evidence of daily consultant review with key identifiers which included signatures, printed names and general medical council (GMC) numbers. All entries were dated and the time of entry included. We saw that all sets of notes we reviewed had nutritional, tissue viability and mobility risk assessments in place.

We spoke to a manager who showed us examples of PEWS document audits that had been undertaken on the wards.

[3] 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.

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 help improve services and strengthen governance arrangements. There was also a robust system in place for managing clinical incidents.

Ward staff on both wards were cohesive and had a good relationship with ward managers which demonstrated good team working.

An established system was in place for the completion of staff personal appraisal development reviews.

Compliance with mandatory level 2 fire safety was low due to a requirement for specific training, relevant to the footprint of the wards.

Governance, leadership and accountability

We spoke to the paediatric senior nurse quality assurance manager who advised us they have responsibilty for paediatric services for three sites within the health board area. We were told they are the senior nurse for children's services and are the health board's link to emergency departments (ED) and high dependency units (HDU). They also told us they are the health board lead for the introduction of the paediatric nurse staffing act.

They told us the Childrens Service Group had in place a number of regular meetings to improve services and strengthen governance arrangements. Such meetings include monthly quality assurance meetings where items such as fundamentals of care, health care standards audits and compliance with paediatric care indicators are discussed. We were told that on alternate months datix meetings are held where reported incidents, investigations and their findings are discussed in a multidisciplinary format. We reviewed the minutes of

the meetings that had been produced and saw that information and learning was shared across paediatric services across the health board to support changes to practice and learning. Themes and trends were also identified with the view of highlighting any areas of practice, which were in need of addressing across the heath board.

In addition, we were told that monthly consultants meeting take place followed by a paediatric forum. Monthly childrens services meetings, where subjects discussed include performance, sickness and staff absence, complaints, vacancies and patient experience are also held. Other meetings included a quarterly clinical governance and audit multi-disciplinary day where lessons learned from datix are fedback to the directorate. We were also told that quarterly paediatric and emergency liaison forums are held.

We saw feedback on the staff room notice board from ‘druggles’ which are a forum where medication errors are discussed every fortnight. We were told that the pharmacist leads the meeting and nurses and doctors are encouraged to go. We were told that both datix and non datix errors are openly discussed and all errors are anonymised to protect staff identification. Positive feedback is also provided to staff. The inspection team considered the ‘druggles’ to be an open and positive way of sharing and learning from medication errors.

We were told by managers that feedback from meetings is provided to staff during regular team briefs and at monthly ward meetings and any urgent feedback is provided to staff by e-mail. We were also told that staff who are involved in incidents may be requires to attend study days, are encouraged and supported by managers to write a reflective log and have an opportunity to feedback based on their own experience at team meetings if they wish.

Senior managers told us that staff are encouraged to report incidents on datix. We were told that there had been an improvement in incident reporting within the past year as a list of reportable incidents had been developed and staff had fully engaged in the process, including the reporting of minor incidents.

We spoke to staff who described the process for reporting incidents, errors or near misses on datix and said they felt encouraged and supported to report all incidents. Around a quarter of staff who completed questionnaires said they had seen errors, near misses or incidents in the last month that could have hurt staff and around a quarter said they had seen errors, near misses or incidents that could have hurt patients. All staff who had seen an error said they had reported it. One staff member commented:

> *"The last incident reported was an infection control issue which was dealt with immediately and steps were put in place to ensure that this would not happen again."*

Most respondents agreed staff who are involved in an error, near miss or incident are treated fairly and confidentially, and all agreed that their organisation encourages them to report incidents. Around a quarter of respondents agreed that the organisation would blame or punish people who are involved in errors near misses or incidents. A majority of respondents agreed they were informed about errors, near misses and incidents that happen in the organisation and were given feedback about changes made in response.

We saw that a clear and robust process was in place for reviewing, investigating and managing clinical incidents. We were told that this is overseen by the health board's overall Head of Governance. In the event of an unexpected death, we were told that they are investigated by staff who are trained in root cause analysis.

The inspection team noted that a monthly paediatric newsletter which had been introduced was an excellent communication tool in conveying information to paediatric staff across all the paediatric services in the health board. The newsletter included feedback from identified themes from incidents, highlighting areas of good practice, training information, study days, conferences available for staff to attend and other team related news. Information relating to learning from incidents was also displayed on the notice board within the staff room.

We saw there was a good level of oversight of clinical activities and patient outcomes. The service was using a paediatric dashboard which had recently been developed and implemented. The dashboard is an electronic tool to monitor the clinical performance and governance of their services.

We considered the audit activity being carried out on the ward, to ensure that essential activities were being undertaken. We were 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.

Staff and resources

Workforce

During the course of the inspection, we found that all staff and managers take great pride in the service they provide to the patients and their families/carers. We observed strong local management through to senior nurse level. The

demeanour of all staff was professional and welcoming and they fully engaged with and embraced the inspection process. During the course of the inspection all concerns raised with managers regarding patient safety were immediately addressed. Details of the improvements are provided in Appendix A.

We saw that both ward managers were clearly visible on the wards. We observed staff approach them for advice and support and both responded positively taking on board any queries and providing assistance when required. Staff we spoke to said they felt supported by managers on the wards and that senior managers are also approachable. All staff who completed questionnaires said the organisation always or usually encourages teamwork. Staff we spoke to said that it was difficult to secure a job within Cilgerran ward or PACU as staff who are already employed there do not want to leave.

Managers spoke highly of their teams and said that, despite the poor working environment, staff are always positive. Staff we spoke to said that they received mixed messages in relation to the future of the development of the environment and footprint of the wards and whether that will take place. They said that this had a negative impact on staff morale. Staff also expressed that the commencement of building work at the hospital had blocked light to some areas of the wards, including the staff room. We discussed this with senior managers and recommended they explore how communication with staff can be improved regarding any possible redevelopment of the wards to manage their expectations and for staff to feel better informed of the future of the wards.

All staff and managers we spoke to told us that the wards were well staffed. Both PACU and the HDU were staffed independently of Cilgerran ward. We saw that acuity is assessed using the all Wales acuity tool. Managers said that, in instances where additional staff are required, they have access to bank staff. We reviewed the staff rota and were satisfied that staffing levels and skill mix was appropriate.

Nursing staff and managers told us that play specialists are a vital part of the ward team and play an important and positive role in a child's experience in hospital. We observed the play nurses spending quality time with patients, encouraging play and actively engaging and listening to parents. A play nurse is available on the ward between 7am and 7.30pm, seven days a week. We were also told that the play nurses attend patients who need assistance in the ED and any therapy units, for example, radiology.

We also saw volunteer staff on the wards. We spoke to managers who told us volunteer staff undergo DBS[4] checks and the number of volunteers is limited to three or four to provide consistency. All volunteers undergo the corporate induction and have a walk around of the wards and introduced to staff before their commencement.

We spoke to the paediatric practice and professional development nurse (PPPDN) who had been in post for under a year. They were enthusiastic and knowledgeable in their role and the training requirements of staff. They are based at Glangwili hospital but have responsibility for the training needs of the acute paediatric nursing team across the health board, in addition to training specific to each site, for example, fire training. 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 reviewed an induction and knowledge and skill development pathway pack which are provided to newly qualified and paediatric high dependency unit staff nurses with more development for other staff members. This includes a portfolio of competencies and development opportunities available.

We found that there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training such as health and safety and safeguarding is predominately carried out on-line, and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

We were told that regular practice development days take place. A Band 6 paediatric training day had taken place which included incident reporting, team building, leadership and discussions on how to improve the service. This had resulted in improved communication with staff within the other hospital paediatric units.

We saw that compliance with mandatory level 2 fire safety was low. We were told that this was due to a requirement for specific training, relevant to the footprint of

[4] A Disclosure and Barring Service (DBS) check is a record of a person's criminal convictions and cautions for those applying to work with children or vulnerable adults.

the wards. We were told that the health board's fire department were unable to provide the training and therefore staff had been completing the generic mandatory training. The practice development nurse told us the fire department had now agreed to provide specific training but had not committed to dates.

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. All staff we spoke to said they receive annual appraisals. We saw the compliance rate for the completion of appraisals was high.

We discussed the provision of servcies and medical cover with the clinical director for paediatric and neonatal services and were assured there was appropriate medical cover on the wards. We were told that paediatric services at the hospital had been asked to increase their number of trainee doctors as a result of excellent feedback from previous trainees.

We spoke to senior managers who told us that a staff wellbeing service is available to all staff within the health board. We were told that staff can self refer to occupational health if required, or managers can refer staff for support, for example, following a critical care incident or for staff who work within the palliative care environment. Nearly all of the staff who completed questionnaires agreed they were aware of the occupational health support available and none disagreed. Most respondents also agreed that in challenging situations they are offered full support.

Improvement needed

The health board must ensure that:

- Required staff are provided with up-to-date level two fire safety training.

4. What next?

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

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

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, 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
We saw the door to the cleaning cupboard on Cilgerran ward was not securely locked. These issues could pose a risk of unauthorised access to hazardous substances to patients and visitors.	This meant there was a risk to patients and visitors of unauthorised access to hazardous substances.	We raised this concern with a ward manager during the inspection.	The ward manager dealt with this and the door to the cleaning cupboard remained locked for the duration of the inspection.
We saw two cleaning trollies which contained cleaning equipment and substances left unattended in the corridor of Cilgerran ward.	This meant there was a risk to patients and visitors of unauthorised access to hazardous substances.	We raised this concern with a ward manager during the inspection.	The domestic staff immediately returned to the cleaning trollies and they were not left unattended for the remainder of the inspection.
We saw that the locks on the door to a drugs cupboard was broken, however the drugs were securely locked within a locked room.	This meant there was a potential risk to unauthorised access and a risk to patient safety in the event the room had been unlocked.	We raised this concern with a ward manager during the inspection.	The cupboard locks were immediately replaced by a member of the estates team within hours of being informed during our inspection.

We also saw a storeroom where IV fluids were stored did not have a lock.	This meant there was a risk to unauthorised access and a risk to patient safety.	We raised this concern with a ward manager during the inspection.	A push button code lock was installed on the door.
We saw a trolley located in the corridor of Cilgerran ward which was unlocked and contained sensitive patient information. 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.	We raised this concern with a ward manager during the inspection.	The trolley was moved to within a secure locked room. We were assured the trolley would remain within the locked room until a new lockable trolley had been delivered.

Appendix B – Immediate improvement plan

Hospital: Glangwili General Hospital

Ward/department: Paediatric Ambulatory Care Unit and Cilgerran Ward

Date of inspection: 4–5 March 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
There were no immediate assurances identified during the course of this inspection.				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Glangwili General Hospital

Ward/department: Paediatric Ambulatory Care Unit and Cilgerran Ward

Date of inspection: 4-5 March 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 leaflets are available for a multiple of topics displayed or accessible via the intranet for children and their families/carers. These are based on a rolling programme which reflects any ongoing active national campaigns and events . The materials will be displayed in waiting areas and communal areas. Due to COVID situation these will be accessed by staff for individual children and families as requested	Senior Sister Cilgerran Ward/ Senior Sister PACU	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must: • Ensure that staff draw the curtains around patient beds at all times when administering care	4.1 Dignified Care	The Senior Nursing team will issue a reinforcement brief to the team on the importance of maintaining privacy and dignity at all times. This will be done via the electronic platform – Teams.	Senior Sister Cilgerran Ward	August 2020
• 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		The Paediatric Ambulatory Unit will purchase and implement Patient Dignity Curtain Pegs that will be an effective solution to ensure patient privacy and dignity when used on the bed surrounding curtains. These pegs are specifically designed to be robust and clearly visible.	Senior Sister Cilgerran Ward	October 2020
• Consider the layout of the wards and access to the outdoor garden area and toilets and showers in order to maintain patients' privacy.		Prior to COVID 19 There had been ongoing discussions on the environment of Cilgerran Ward with the estates team. Once the COVID pandemic has been resolved the layout of the ward and access to the outdoor gardens will be considered in the ongoing discussions with the estates and capital programme as this will need to be considering on the	Senior Nurse Manger for Quality Assurance/ Head of Nursing for Paediatrics and Neonates /	This will be reviewed post COVID on a quarterly basis and reported back to the Women and Children's

Improvement needed	Standard	Service action	Responsible officer	Timescale
		overarching refurbishment of Cilgerran Ward	Operations Manager	Quality and Safety meeting
The health board must ensure that: • All staff positively communicate and engage with patients at all times	3.2 Communicating effectively	The senior nursing team will ensure ongoing communication and engagement with staff on the importance of managing positive communication strategies for children undergoing procedures, the positive steps approach and how to apply theory to practice. This is delivered on a monthly basis to all existing and new staff. The Paediatric Practice and Professional Development Nurse will source communication E learning for teams on positive modelling to support children.	Senior Sister Cilgerran Ward Paediatric Practice and Professional Development Nurse	Completed. December 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Patients and their families/carers receive consistent and clear information about their treatment and care.		This element was specifically around medical management of care information to parents. This will be led by the clinical lead to ensure that information is provided in a clear way for families to understand and rational why management plan have to change due to patient condition	Paediatric Clinical Lead	August 2020
The health board must consider how the environment within PACU can be updated and tailored towards children.	6.1 Planning Care to promote independence	This will continue to be part of the ongoing discussion with estates and capital on Cilgerran Ward refurbishment programme. The Play manager will ensure once COVID period is over that the environmental will be reviewed to incorporate some painting and stickers that are tailored for children of all ages	Manager for Quality Assurance/ Head of Nursing for Paediatrics and Neonates/ /Operations Manager Play Manager	This will be reviewed post COVID on a quarterly basis and reported back to the Women and Children's Quality and Safety meeting

Improvement needed	Standard	Service action	Responsible officer	Timescale
		and play corner will be in place, this has been delivered and in storage .		
The health board must consider the location of the rainbow suite on the ward.	6.2 Peoples rights	Discussions will be considered with the Child and Mental Health service on the location and access to this unit based on the footprint of Cilgerran Ward, to include the need of the children and young people	Head of Nursing for Paediatrics and Neonates/|Head of Service CAMHS	January 2021
Delivery of safe and effective care				
The health board must ensure the following: • Consider the provision of additional storage space	2.4 Infection Prevention and Control (IPC) and Decontamination	This is programmed in line with phase 2 work with estates to re build the storage facilities for the unit	Service delivery Manager / Assistant Major Capital Development Manager	March 2021
• Ensure the bathroom tiles, seals and the uneven flooring within the wards are either fixed or replaced to ensure		Ongoing discussion with site estates and capital programme regarding the Environmental work of facilities. This is	Senior Nurse Manager for Quality	This will be reviewed post COVID on a bi-monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
that effective cleaning can be carried out		currently on the Risk register and monitored closely both within directorate and on site meetings	Assurance/ Head of Nursing for Paediatrics and Neonates/ /Operations Manager	basis and reported back to the Women and Children's Quality and Safety meeting.
• Consider the provision of an additional sluice		Ongoing discussions with estates on the refurbishment of the unit and this will be included in those discussions		
• Continue to identify, monitor and act on the risks caused by the poor environment		Ongoing discussion with estates and capital programme, monitored monthly on ward audits		
• All damaged pull out beds within both wards are replaced.		Charitable funds use to purchased pull out beds , these now in place	Senior Sister Cilgerran Ward	Completed
The health board must ensure that consideration is made to the provision of a dedicated drug storage and preparation room on PACU.	2.6 Medicines Management	Ongoing discussions with estates on the refurbishment of the unit and this is included in the longer term plans for the refurbishment of Cilgerran Ward	Senior Nurse Manager for Quality Assurance/ Head of Nursing for Paediatrics and Neonates/	This has been temporarily completed however will need to be reconsidered post COVID

Improvement needed	Standard	Service action	Responsible officer	Timescale
			/Operations Manager	and will be reported back bi-monthly to the Women and Children's quality and safety meeting
Quality of management and leadership				
The health board must ensure that required staff are provided with up-to-date level two fire safety training.	7.1 Workforce	Ongoing staff update training in accordance with mandatory eLearning fire training. Currently on hold for face to face training due to COVID, consideration for E learning or electronic platforms to deliver training	Paediatric Practice and Professional Development Nurse Fire Officer for face to face training	Completed August 2021

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): Paula Evans

Job role: Head of Nursing

Date: 15 July 2020