Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Moelwyn Ward, Ysbyty Gwynedd
Activity date: **28 August 2020**

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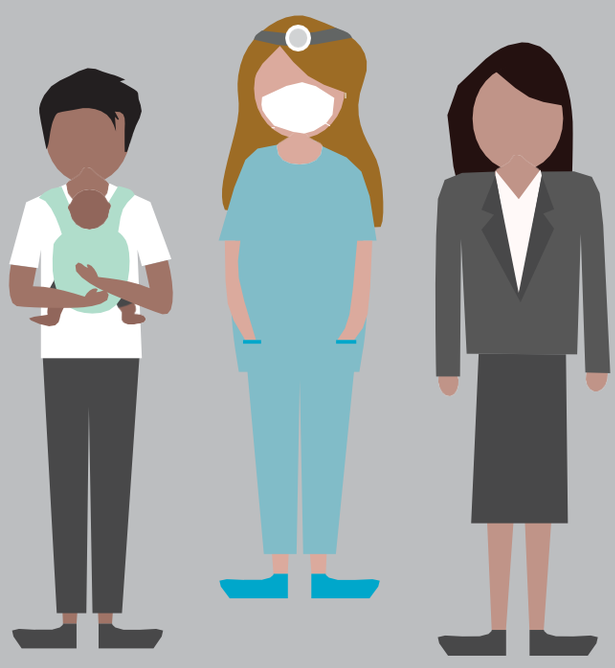

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Moelwyn Ward, Ysbyty Gwynedd as part of its programme of assurance work.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control (IPC); and governance. More information on our approach to inspections can be found here.

We spoke to the ward manager on 28 August 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

Moelwyn Ward was a Respiratory Ward with high level acuity of patients. Some of the patients would be on Non Invasive Ventilation (NIV)[1] or night time continuous positive airway pressure

[1] Non-invasive ventilation (NIV) is the use of breathing support administered through a face mask, nasal mask, or a helmet. Air, usually with added oxygen, is given through the mask under positive pressure; generally the amount of pressure is alternated depending on whether someone is breathing in or out. It is

(CPAP)[2]. Following the COVID-19 pandemic, the ward now has an aerosol generating procedure (AGP) bay for NIV or CPAP, requiring additional PPE, including fitted masks and visors.

We were told that the changes made to the environment included a ward trolley on the entrance to the ward with the relevant PPE. There was clear signage of PPE and the level of PPE requirements were displayed. Additionally, patients were swabbed for COVID-19 prior to being transferred onto the ward from the acute medical unit (a unit that provides rapid assessment, investigation, diagnosis, and treatment for adult patients). If they were negative, they would be admitted onto the ward. Cleaning schedules were more frequent with antibacterial hand wipes available for patients throughout the ward. A larger room was used with reduced numbers of staff for shift handovers. There were also posters on display, with information of maximum numbers of people in rooms and maintaining social distance. Chairs had been taken out of meeting and staff rooms, masks were worn throughout the hospital and there were additional stations for hand cleansing.

The ward self-assessment provided, stated that patient assessments were completed on admission to the ward, risk assessments completed within six hours and weekly thereafter unless there was a change in condition.

We saw evidence of a very recent health and safety self-assessment with low scores in some areas, including security, working from heights and hazard identification and risk assessment. We were told that the ward were in the process of arranging an action plan with the Health and Safety Representative.

Evidence was provided that showed there had been a number cases of COVID-19 identified on the ward during May 2020. We were told that as a result, all patients were moved out of the ward, including the non-COVID-19 patients. The ward was deep cleaned and new privacy curtains installed. An investigation revealed the cause, which was a patient who had previously swabbed as COVID-19 negative. It was also stated that a number of patients had been asymptomatic, that is a carrier for a disease or infection but not experiencing any symptoms, of COVID-19 and a number of previously non COVID-19 patients were swabbed as COVID-19 positive, prior to intended discharge.

We were told that a number of staff also contracted COVID-19 over this period. The after incident reviews did not highlight a cause for the staff infections, other than the number of COVID-19 patients that had contracted the disease on the ward. The correct PPE was used on the ward according to guidelines at the time.

The staff member interviewed said that the infection prevention specialist nurse regularly visited the ward to support staff. Additionally, we were told that a standard operating procedure was completed for COVID-19 patients to step down from the high dependency unit

termed "non-invasive" because it is delivered with a mask that is tightly fitted to the face or around the head, but without a need for tracheal intubation (a tube through the mouth into the windpipe).

[2] Continuous positive airway pressure is a form of positive airway pressure ventilation in which a constant level of pressure above atmospheric pressure is continuously applied to the upper airway. The application of positive pressure may be intended to prevent upper airway collapse, as occurs in obstructive sleep apnea, or to reduce the work of breathing in conditions such as acute decompensated heart failure.

to Moelwyn ward. All staff were assessed for their level of risk. Skype for business was installed on ward computers, to encourage video contact meetings for staff, rather than face to face. Furthermore, we were told that a COVID-19 file had been set up on the ward to keep staff updated.

We were told there was a process to manage staff who were showing the symptoms of COVID-19. Initially they were sent home and contacted by the staffing hub to arrange a swab. Staff would then self isolate and went through the hub when they were ready to return to work. Additionally, staff would be referred to occupational health where required. The hub also rang staff to see how they were managing through the illness and if there was any support they required.

No areas for improvement were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were provided with evidence of the number of patient falls in July, which also showed the time of the falls, which coincided with staff handovers and during the silent hours. We were told that an additional member of staff now works the night shift to try to prevent the recurrence of falls in the future and there are now split handovers throughout the day.

We were told that patient dignity was maintained in a number of ways, including the use of screens and closed doors in the cubicles. There was a toilet and sink within the cubicles and patients in the bays had access to ward toilets. Additional wipes were available to patients at mealtimes and there was a separate room available to discuss conditions with doctors individually. Patients were encouraged to use the toilet when required, as opposed to using a commode, and the ward had access to a hoist and a bariatric chair, if needed.

We were told that patients' needs were met through a variety of methods. These included asking the patients what mattered to them and what their needs were through a system called "nurse rounding". This involved a nominated nurse being tasked daily with asking patients if there was anything they needed and to try to address these needs. Additionally, patients had access to social workers, occupational therapists, physiotherapists and carers. The staff organised bingo and dominoes with the patients in addition to supplying magazines and books. The ward were trying to secure a television for the patients and had been donated two tablets, which were used by patients to contact their families, as there were no visitors allowed on the ward. There was access to a hospital chapel and a chaplain on call. Patients also had access to a physio gym, as the patients were often more in need of physio than

nursing, at the end of the ward.

The following areas for improvement were identified:

We were provided with evidence of both an environmental risk assessment dated August 2020 and a COVID-19 environment risk assessment dated March 2020. Whilst the environmental risk assessment had a relevant action plan that was in the process of being actioned, there was not an action plan for the COVID-19 assessment. We were told of a number of actions that had been completed, but these were not documented.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We saw evidence of a number of infection control policies and COVID-19 specific policies, both at a health board and hospital level including the "Secondary Care Arrangements for the Coordination and Management of COVID-19 – Pandemic, Ysbyty Gwynedd". This plan complemented the "Betsi Cadwaladr University Health Board (BCULB) Pandemic Flu Plan, Site Specific Hospital Major Incident Plans", and specific pandemic flu arrangements at an operational level. It described how the health board would work in order to effectively coordinate its secondary care response to a pandemic COVID-19 outbreak.

We were told that staff had been fit tested, a series of steps used to determine the suitability of a respirator mask for a specific user, for the relevant masks. Further testing was taking place, as an alternative mask supplier had been sourced. Staff had also attended training for PPE scenarios. Additionally, there were PPE stations in the hospital and ward. The ward were able to restock from the central stores, without any issues of supply.

The staff member interviewed stated that staff normally wore, on a day to day basis on the ward, face masks, aprons and gloves. Level 2 visors were worn in the AGP area along with Filtering Face Piece (FFP3) masks, for the highest level of protection. There were double doors to the AGP bay corridor, the area was cordoned off and the doors in the cubicles were closed. There were several PPE disposal bins on the corridor, along with a sink and alcohol gel, to use when the staff left the AGP area. All staff could wear visors should they wish, regardless of the area in which they worked.

We were told that several training sessions were put in place, both before March 2020 and since, to ensure IPC standards were maintained.

The following areas for improvement were identified:

We were shown evidence of some good IPC audit scores on hand hygiene and bare below the elbow. However, we also saw consistently low scores throughout July, relating to the peripheral cannula (to add fluids or medication to the bloodstream, or to remove blood for

diagnostic testing) care bundle being completed for 100% of patients with a cannula. We were told that this was being monitored more often and the staff were fully aware of the issue. Additionally investigations were ongoing to see what was making it difficult and why it was not done. The ward were monitoring the insertion and risk score. We were told that once the IPC training on Clostridioides difficile (a bacterium that is found in people's intestines) also known as Cdiff, had been completed, the training team would be asked to try to look at this from a different angle.

We were provided with two documents that were overdue for review; one called "Isolation - Procedures for Patients With Infection", review was due in December 2019; and the "Outbreak Reporting and Control Procedure including Major Outbreaks", review was due in January 2019.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.
We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

We were told that a number of actions were taken if staff numbers were reduced and to ensure that adequate staffing levels were maintained, these included:

- The ward manager, along with the matron / head of nursing held a bi-annual staffing review with the director of nursing, to review the ward-staffing template
- The ward manager was responsible for assessing the holistic nursing care needs of the patients and for categorising these under the "Welsh Levels of Care" descriptors daily. (The Welsh Levels of Care consists of 5 levels of acuity ranging from; Level 1 where the patient's condition is stable and predictable, requiring routine nursing care; to Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis.)
- Rosters were updated where shortfalls were identified, uncovered shifts were offered within the ward, then sent to the nursing bank for cover
- Daily huddle, where the Hospital Team would seek assurance that the ward areas were safe to start
- Matron of the day was made aware of the shortfalls of staffing early to intervene and support to mitigate any risks
- During the COVID-19 pandemic, temporary contracts were offered to health care assistants to support staffing levels
- Student nurses were redeployed to the ward, by the university

- Specialist nurses were redeployed to the ward, during the pandemic, to support the skill mix and staffing levels.

We were told that the ward was currently short of permanent staff to meet safe staffing levels. This was due to the introduction of the AGP bay, which requires more staff to manage this area. The ward manager stated that this was reported on a daily basis and the shortfall was met from bank and agency staff. The staff shortages of qualified staff were due to be resolved in September 2020, when a number of student nurses qualified. However, there would still be a need to employ bank and agency staff to cover the AGP bay. The ward were in the process of advertising for a temporary vacancy to cover the shortfall over the next six months.

We saw evidence that showed that mandatory training compliance was generally good, with a plan in place to increase the subjects with lower compliance rates. We were told that staff were encouraged to attend any additional training in the hospital. Specific reference was made to the end of life care training that had taken place on the ward. This training was also given to new staff, by the palliative care nurses. Both the ward manager and deputy attended the Six Steps to Care course, an end of life course, that we were told would benefit staff in the future. Additionally, specialist nurses and the acute intervention team provided a bespoke training package for staff which included; how to care for a patient with a chest drain; how to use NIV machines; managing the deteriorating patient; cardio-pulmonary resuscitation during COVID-19; tracheostomy care (an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help the patient breathe); and Nasogastric(NG) competencies (a medical process involving the insertion of a plastic tube through the nose, past the throat, and down into the stomach).

We were told that the ward manager supported the staff by being visible and spending time on the ward, additionally the deputy ward manager worked on the ward and also supported staff. During the current COVID-19 pandemic, a staff well-being and support service was being provided by the hospital psychologists, on a drop in basis. Staff also had access to the occupational health support network. The ward manager was able to access the matron and head of nursing, who were supportive and listened to any concerns.

The performance appraisal and development review (PADR) is the ongoing continuous cycle providing all staff with clear agreed work objectives, feedback on how they were doing in their job and a personal development plan for the year ahead with new/ongoing work objectives. The PADR level on the ward, based on evidence provided, was just under 37%. However, we were told that this figure had now risen to over 57%. The figure was effected by the number of temporary staff who had worked on the ward, in addition to the student nurses, who are having their PADR equivalent from the University. We were told that the ward manager had a plan in place to further increase this percentage in the short term.

No areas for improvement were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed below:

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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.
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check

As a result of the findings from this quality check, 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.

Improvement plan

Setting: Ysbyty Gwynedd

Ward: Moelwyn Ward

Date of activity: 28 August 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.
Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	A COVID environment risk assessment was completed in March 2020. Whilst we were told of actions that had been completed, a documented action plan for the COVID assessment had not been completed. The health board is to ensure that a documented action plan is put in place.	2.1 - Managing Risk and Promoting Health and Safety	Action plan to be added to the environmental risk assessment and to be updated with all the actions that have been undertaken + evidence where applicable. Monthly compliance will be reported to the site Health & Safety meeting with exception reporting to the Secondary Care Quality & Safety Group.	Ward Manager Elinor Thomas and Head of Nursing Tina Macphail-Owen	30th October 2020

2	There were consistently low scores throughout July on care bundles relating to the peripheral cannula care bundle being completed for 100% of patients with a cannula. There was not an action plan in place to address this issue. The health board is to ensure that a documented action plan is put in place.	2.4 - Infection Prevention and Control (IPC) and Decontamination	These are monitored by the clinical services and supported by Aseptic Non-Touch Technique (ANTT) training and support from the Infection Prevention Control Team (IPCT). However, the proactive work in removing all unnecessary devices, and introduction of the new VIP document for managing peripheral devices needs including in the action plan and IPCT will support the action plan with these elements. Improvement plan for the ward to include staff being reminded twice daily at safety brief to complete VIP document and remove any unnecessary devices. Introduce the piloted revised care bundle (VIP).Daily spot checks by ward manager for two weeks, and then weekly until sustained. This should be reported to Director of Nursing through exception reporting to the site Quality & Safety Group, along with any non-compliance of the IPCT. IPC Quality visits will also be implemented to support until practice improves. Minimum compliance of 85% plus to be recorded on ward accreditation and matron walkabouts consistently.	Infection Prevention Team. Amanda Miskell, Associate Director of Nursing Ward Manager Elinor Thomas	30th October 2020 30th October 2020

			Ensure all staff are up to date with Infection Prevention mandatory training. (Target compliance of 85%) with, compliance reported to the departments Quality & Safety meeting with exception reporting to the site Quality & Safety Group.		
3	The health board documents called; “Isolation - Procedures for Patients With Infection”; and the “Outbreak Reporting and Control Procedure including Major Outbreaks” were both overdue for review, reviews due December 2019 and January 2019, respectively. The health board is to ensure these documents are reviewed, amended and re-issued as necessary.	2.4 - Infection Prevention and Control (IPC) and Decontamination	These policies are currently under review and will be approved via the Infection Prevention Sub Group governance route which includes approval by the Consultant in Communicable Disease Control (CCDC) and Microbiologist. The policies remain fit for purpose and are in line with national guidance and IPC policies.	Infection Prevention Team. Amanda Miskell, Associate Director of Nursing	13 October 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.

Name: Tina Macphail-Owen, Head of Nursing, Medicine

Amanda Miskell, Associate Director of Nursing, Infection Prevention

Date: 16 September 2020