Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Bonney Cohort Ward, Wrexham Maelor Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Bonney Cohort Ward, Wrexham Maelor Hospital 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 and the matron on 3 September 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:

We were told that Bonney Cohort Ward had four bays and four side rooms. Bonney Ward was commissioned for the pandemic and was the result of two teams coming together to create one new team working within a cohort environment. The ward admitted suspected COVID-19

patients into side rooms whilst pending results of the rapid swabs. Patients who swabbed negative with no clinical evidence of COVID-19 would be stepped down to non-COVID-19 wards. Those patients who tested positive would be cared for within a main bay. We were further told the team on the ward adhered to strict IPC guidelines whilst caring for patients who were suspected or had tested positive within the ward. As a result staff would be assigned to either suspect or positive patients and would not interact with both.

Evidence was provided that a Quarterly Ward Environment Risk Assessment had been completed and an action plan put in place. We were told that environmental audits such as a kitchen audit and fire safety audits were completed monthly and that regular checks of equipment were carried out by staff including slings and hoists. Additionally, medical equipment that was broken or damaged was sent to be repaired in a timely manner.

The self-assessment provided, stated that the ward manager ensured rotation of staff frequently so that they worked alongside senior members of the team. Additionally, the practice development nurse worked closely with all members of the team, ensuring that staff were up to date with training and had the skills required.

We were told that there had been an increase in staffing to cover the separation between COVID-19 and suspected COVID-19 patients. Staff also said that there had been a substantial increase in the cleaning regime by healthcare support workers and domestic staff.

Staff said that a number of changes had been made to reduce infection, these included, PPE being changed more frequently than previously and training for donning and doffing of PPE. Additionally, no paperwork was taken into rooms, everything stayed outside the patient area including charts and notes. Medication, which was normally kept in the patient side locker, was also secured outside the patient area, again to minimise cross infection. Staff also ensured what was taken into the various bays and cubicles was limited to only necessary items and equipment, to reduce cross infection. As a result, taking observations had been challenging, the staff used laminated sheets when with the patient and transposed this information onto the patient notes when away from the patient.

We saw evidence of the COVID-19 daily audits that were completed by the ward manager. This included the ward managers' visual and verbal evidence of the environment, patient care and IPC measures that were taken on the ward. In addition there was a weekly ward manager's audit as well as a monthly matron's audit. We also saw evidence of the action plan to put any matters right.

A number of changes had been implemented in light of the pandemic to ensure that IPC standards were maintained. We were told these included safety briefings at the start of each shift which highlighted the infectious status of each patient (and their risk of falling) and there was clear signage on all doors, to highlight the COVID-19 areas. Additionally, equipment was not transferred between positive COVID-19 bays and suspected COVID-19 patients. There was enhanced cleaning twice a day from domestic services and there was good housekeeping with all unnecessary equipment removed from the patient environment and cleaned. Minimal

items were kept within the patient environment, to again reduce the possibility of cross infection.

The system of red and green areas throughout the hospital was described that meant that staff across the hospital could not work in both areas. Staff movement between ward on shifts was monitored daily to prevent contamination. All staff conducted COVID-19 risk self-assessments and recorded this on their employee staff record.

Management stated that there had not been any issues with the supply of PPE to the ward. Staff wore the required level of PPE when entering patient areas and PPE was changed before moving to the next patient. Staff wore facemasks at all times when on the ward. 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.

We were told there was a process to manage staff who were showing the symptoms of COVID-19. They would be swabbed and sent home, staff would then self isolate and contacted HR when they were ready to return to work. Staff were also contacted to see how they were managing through the illness and if there was any support they required. Additionally we were told that antibody testing was now available for staff at the hospital.

We were also provided with evidence of the COVID-19 Workplace Protection Assessment Tool 2020. The purpose of this tool was to help managers assess how well social distancing and hygiene measures were managed in their workplace. This was designed to protect staff and patients against COVID-19, highlight areas for improvement, and to help managers decide how they could manage their work area, or where issues might require escalation or input. Additionally, we saw evidence of an all staff question and answer document, produced for staff on personnel matters relating to the pandemic.

No improvement areas 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 saw evidence of the low number of patient falls that had occurred on the ward. The ward manager said all patient falls were reviewed to ascertain any avoidable reasons and trends. We were told that all patients had an enhanced risk assessment in place. This was used to decide the best place to place the patient's bed on the ward, whether in the observation bay or on one to one nursing. The falls pathway looked at the level of care required and the

number of times the patient would be checked. Staff also made sure that during intentional rounding[1], which occurred at least daily, and if necessary three times a day for certain patients, the needs of the patient were identified, such as continence needs and to identify all trip hazards.

We saw evidence that a Generic Ward Risk Assessment had been completed contained an agreed list of the main hazards or activities that could be present on the ward. The ward manager, needed to check that if these hazards or activities were present on their ward and ensured that the agreed control measures were in place.

There were no instances of patients with pressure damage, based on evidence provided. We were told this was due to the staff being aware of the actions needed, including three hourly repositioning and if the patient was more vulnerable, this was changed to two hourly. Staff ensured patients' were repositioned, there were various audits and appropriate mattresses used and patients were risk assessed every day.

We were told that new staff received training on the ward from the outset, about how to treat patients, particularly ensuring their dignity. Staff ensured that patients were allowed to clean and wash themselves, behind closed doors, or with appropriate signage on the closed curtains.

Staff stated that conversations were held with patients on what mattered to them, conversations were also held with families. Although visitors were not allowed on the ward, patients were encouraged to maintain contact with their families through personal electronic devices. Families were also encouraged to bring in 'home comforts' for patients. Patients were encouraged to wash and dress themselves and to sit up in the bedside chair. There were also televisions and radios in the ward for the benefit of the patients. There was also a hospital chapel and a chaplain on call for patients spiritual needs.

No improvement areas were identified.

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 were told that the ward liaised with the infection prevention team on a regular basis and they frequently visited the ward to monitor practices. The ward were also supported by the Intensive Therapy Unit staff with the relevant training. Staff were updated on changes to PPE

[1] Intentional rounding is a structured approach where nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

required, as and when the requirements changed.

We saw evidence that over 84% of staff had completed the mandatory infection prevention e-learning. We were told that staff had been educated on the different levels of PPE and when and how it must be worn and what other precautions must be taken. Donning and doffing PPE training was given to all members of the team including bank and agency staff at the start of their shift. Permanent staff monitored compliance with PPE and challenged any instances of poor PPE practices observed.

We saw that up to date IPC policies were in place for the hospital and the ward in addition to the corporate policy and processes to ensure preparedness for future pandemic emergency, "Pandemic Influenza Plan" for the health board. The hospital also had an updated plan that set out the hospital response to the COVID-19 outbreak for the patients. We also noted the phased approach document used by the hospital to segregate the wards in red and green areas.

No improvement areas were identified.

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, to ensure that adequate staffing levels were maintained and to retain staff, these included:

- Health roster completed six weeks prior to the shift date
- Roster was completed and analysed to ensure that the skill mix was safe for each shift, it was fair and that all unused contractual hours had been utilised
- Bank shifts were sent out as soon as the roster was approved, then agency shifts were sent out later as time was given for bank shift workers to book shifts
- Daily 'housekeeping' was carried out on the roster, all nurses in charge had access to the roster to ensure is was kept up to date in the absence of the sister
- Liaising with staff to change shifts or offer overtime to cover sickness

- Safe care[2] was completed three times a day to included ward acuity. Shifts could be red flagged to highlight any concerns on the shift and responses added if the risk could be mitigated
- Staff shortfalls that could not be mitigated were escalated to the matron, bleep holder or night sister, to identify if staff could be redeployed from other areas to support the ward
- Job vacancies were advertised and recruitment completed in a timely manner to ensure that posts were filled in the shortest possible time
- Exit interviews were completed with staff members and options given to try and retain staff.

We were told that the ward manager supported the staff in a number of ways, these included being visible and spending time on the ward. In addition, the performance appraisal and development review (PADR) on the ward was just under 80%. The ward manager believed that completing the annual PADR and ensuring that staff objectives were met, led to staff satisfaction and retention. There were mentors on the ward, who supported a healthy learning environment for student nurses.

Staff were referred to occupational health in a timely manner for support, with the aim of preventing long term absences. There were monthly staff meetings, to keep all staff up to date. The ward manager was able to access the matron and head of nursing, who were both supportive and listened to any concerns.

The ward was staffed mainly by nurses from the isolation ward, we were told that these nurses were very familiar with the type of nursing required on this ward. The ward manager also stated that they had been supported by the matron as well as having support from other sisters and being able to speak to each other to provide mutual emotional support.

We were also told that human resources had been to the ward to support staff, in addition to support being available from the mental health team and consultants who provided psychological and social support. A wellbeing service had been set up, but we were told that staff found the best way was to debrief as a team, at the end of a shift to share emotions.

We were told that the team had received positive feedback throughout the pandemic from recovering patients and their relatives. More recently staff were interviewed by ITV Wales in a report that detailed a patient's journey within the hospital having tested positive for COVID-19. The nursing staff had also felt privileged to have read personal letters to their patients from loved ones, who have been unable to visit in person throughout this difficult time.

No improvement areas were identified.

[2] Safe care is a system used for a couple of years to enable acuity with numbers of staff, data is input per patient (based on patient acuity audit), Patients are categorise three times a day. This information gives a level of staffing required, shows if staffing low

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan 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.

The improvement plan, once agreed, will be published on HIW's website.

Improvement plan

Setting: Wrexham Maelor Hospital

Ward: Bonney Cohort Ward

Date of activity: 3 September 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.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No issues identified.				

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:

Date: