Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Ward B, Morriston Hospital

Activity date: 9 September 2020

Publication date: 7 October 2020

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-304-4

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ward B, Morriston 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 on 9 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:

Ward B was a 26 bed, trauma and orthopaedic ward. The majority of the patients on the ward were elderly and many suffered with Dementia. We were told that the environment was assessed to ensure risks were kept to a minimum, such as keeping corridors free from clutter

to reduce the risk of falls. Fire exits remained clear and a clear fire plan was displayed, the call bells and lighting were in good working order.

The ward was a mixed sex ward, with four bays and 3 single cubicles. We were told that patients included pre-operative neck of femur (also known as a broken hip). The cubicles were used for patients with suspected and confirmed infections.

There were PPE donning and doffing areas outside the various rooms and areas marked as barrier nursing, a method to regulate and minimize the number and severity of compromises being made in isolation care. The ward was fortunate in being able to isolate areas, such as only one door in and out and staff changing into PPE outside the patient areas.

Staff we interviewed stated that PPE was available outside each section of the ward for all staff to use and all members of the multi-disciplinary team were actively encouraged to be bare below the elbows. "I am clean" tape was applied to items after cleaning such as commodes and hoists so the patients would feel assured that they were receiving clean equipment. Mattresses were also checked for strike-through of fluids and permeability. Updated documents such as a priority list for cubicle utilisation, cleaning guidance and inoculation policy were all displayed in the ward area for quick easy reference. All Infection control policies were available on the intranet with quick reference guidance. Individual hand wipes were distributed to patients prior to meals.

During the COVID-19 pandemic routine visiting to the hospital was suspended, guidance in relation to reintroducing visiting was issued in July and we were told that the ward were currently piloting allowing visitors for the patients. Patients had two hour slots and were allowed one relative in a bay, with staggered visits, which were allocated proportionately. If patients were very unwell and confused this arrangement would be flexed, to allow them more visits.

This pilot had been on the ward for four weeks, we were told that this helped with patient moods, particularly with those who had been on the ward for a considerable time. Patients also had the use of hospital personal electronic devices, to enable them to contact and see their relatives. The number of clinical staff visiting the ward was also reduced, to limit the opportunity for cross infection.

We saw evidence of up to date infection control policies, including COVID-19 infection control policies, such as the COVID-19 Patient Testing and Management Pathway and the Adult Patient Pathway for Patients Recovering from COVID-19.

Evidence was supplied that showed that eight patients had contracted COVID-19 whilst on the ward. We were satisfied that the Health Board were reviewing COVID-19 cases to identify learning and that they had a plan to adopt the all Wales methodology once approved by the Nosocomial[1] Group.

[1] originating in a hospital

A system called SIGNAL was used to inform on patients with suspected or confirmed COVID-19. This was an electronic patient safety at a glance board, connected to the whole hospital, Any patient that developed COVID-19 was entered on DATIX, the organisation wide system used by all staff to report both incidents and risks.

Staff stated that the ward had a system in place to phone the relevant store to obtain PPE as required, on a daily basis, and that there had not been any issues with PPE supply.

We were told that additional well-being sessions had been arranged in the hospital gym, to support the well-being of staff during the pandemic. When staff displayed symptoms of COVID-19, they were sent home to self-isolate for 14 days. They were required to contact occupational health to organise a COVID-19 test. Once staff were symptom free, they were free to return to work. The ward manager would also contact the member of staff to offer support.

No improvements 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 told that patients who were deemed to be at a high risk of falls were nursed in bays close to the nursing station. Twiddle mitts, knitted mittens or hand warmers with beads, buttons and objects sewn onto them, were used to occupy patients suffering with dementia, and also as a falls preventative measure.

We were told that confused patients were assessed to establish if they were lacking capacity and Deprivation of Liberty Safeguard (DoLS) applications were applied for, as necessary. DoLS ensured patients who could not consent to their care arrangements in the hospital were protected, if those arrangements deprived them of their liberty. We were also told the ward used increased observational tools for those patients that required one to one nursing, due to behavioural issues. The patient safety at a glance board also had the facility to highlight if a patient was a falls risk, had dementia, or had mobility issues.

Staff told us that all patients were treated as an individual and part of the assessment process involved ensuring that patient individual needs were identified, in addition to their safety. The ward encouraged and included patients in care and planning of care, and believed that communication was important. Curtains were used where necessary, around the patient bed

area, with do not enter signs used. Whilst there were no designated male and female toilets, the ward attempted to keep the toilet nearest the male bay or female bay to be designated male or female as appropriate.

The chaplaincy service continued throughout the pandemic and the chaplain visited as required. The ward had televisions that could be used by patients, and relatives were encourage to bring in home comforts and mementoes for the patients. Patients, if they were able, could use the limited grounds in the hospital for exercise.

The following areas for improvement were identified:

We were told that the ward had recently had the use of a newly appointed clinical educator, who facilitated teaching sessions on various subjects and would be investigating the reasons for patient falls. We were told that any lessons learned from falls were informed to staff at the shift handover, as no staff meetings were held currently due to the need to maintain social distance. We were told that other electronic means of passing information was used. However, whilst we saw evidence of the Ward B - Inpatient Falls "deep dive", which was completed for all patients over 65, we were not provided with any evidence of the action that was taken as a result of the scores under 50%, including:

- Falls risk assessment within 4 hours of admission
- Evidence that actions deemed required from risk assessment score have been undertaken
- Written evidence of updating of risk assessment following first transfer between wards
- Falls care plan individualised and updated
- Assessment of presence of delirium and or confusion of the patient
- Continence/Incontinence Assessment Undertaken
- Patient Assessment of their fear of falls.

Additionally, we saw evidence of a Ward Fundamentals of Care Safety Audit that had been undertaken on 14 July 2020. This audit was of five patients and their documentation was reviewed, including skin bundles, hydration and nutrition. The audit showed that nutritional assessments had not been completed on three patients. Again, there were no written records of any action taken as a result of this.

The health board is required to ensure there is a documented action plan in place to ensure that these issues are corrected and do not re-occur.

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 good hand hygiene and bare below the elbow audit scores. We were told that there were systems in place to ensure IPC measures were effective and up to date. These included the regular audits by the ward manager, the matron's monthly audit and an independent IPC audit.

Evidence provided showed the action that had been taken as a result of the IPC assurance visit undertaken on the ward by the IPC Team at the beginning of September 2020.

We were told that skin bundles were completed on the ward for every patient, using a pressure ulcer risk assessment tool called PURPOSE T. This system encouraged clinical judgement rather than the scoring system used by the previous system called Waterlow, also a pressure area risk assessment tool. If a patient was considered as a high risk, there were turning charts used on the ward.

The self-assessment provided, stated that if an infection occurred on the ward such as Clostridium difficile[2], also known as Cdif or a bacteraemia[3], then a multidisciplinary meeting was arranged to discuss and establish any learning points with action plans initiated. We were told that the Cdiff multi-disciplinary meetings held relating to the outbreaks on the ward, did not show evidence of cross infection.

No improvements 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).

[2] bacteria that can infect the bowel and cause diarrhoea
[3] the presence of bacteria in the blood

The following positive evidence was received:

From speaking to the ward manager and through the self-assessment provided, we noted that staff rotas were planned six weeks in advance and were reviewed in line with the roster policy. To fill the ward vacancies, substantive staff were distributed equally and efforts made to fill the gaps by moving staff, utilising excess hours or working overtime. In addition, patient acuity was assessed daily and decisions on ward staff required made accordingly.

Staffing issues were highlighted to the matron for consideration of deploying additional nurses via the nurse bank or outside agencies to maintain a safe environment for patients. We were told that the staff shortages had been covered by nurse practitioners, nurses from the fracture clinic and with the assistance of student nurses, through the pandemic. There had not been any instances of staffing below the requirements of the Nurse Staffing Levels (Wales) Act 2016.

We were provided with evidence of the percentage completion rates of mandatory training (listed by individual subject) and noted that the majority of training had been completed by over 70% of staff. Staff were given time to complete the relevant training, in addition to ad-hoc training opportunities on the ward, such as from the IPC nurses. In addition, the ward staff included trainers on hand hygiene and the Filtering Face Piece (FFP3) masks, for the highest level of protection, who would also provide training on these subjects.

The evidence for the performance appraisal and development review (PADR) supplied for qualified band five staff was 66% compliance. We were told that the figures had now improved and that all staff needing a PADR had been given dates of when the reviews would take place. We were told these reviews would be completed before the end of September 2020.

We were also provided with evidence of a number of policies and procedures at both a health board and hospital level including, internal transfers, surge and emergency preparedness resilience.

The following areas for improvement were identified:

As stated above, we were provided with evidence relating to mandatory training, which showed the compliance with safeguarding (adults and children) level one mandatory training was over 85%. However, the role specific training for safeguarding children level two had only been completed by 32% of qualified staff and for adults the completion was only 43%.

We were told that the ward manager believed there was an issue with the electronic staff record, which recorded staff training undertaken. The health board is required to provide assurance that the number of staff who have completed this important training is increased substantially and the measures they intend to put in place to ensure this level is maintained.

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: Morriston Hospital

Ward Ward B

Date of activity: 9 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.

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	We saw evidence of the Ward B: Inpatient-Falls "deep dive" that was completed for all patients over 65. We were not provided with any evidence of the action that was taken as a result of the scores under 50%.	2.3 Falls Prevention	1. Practice development nurse to undertake further face to face training on new health board falls policy and documentation. Training to cover staff completing for all patients on admission, being updated appropriately and actions being taken as required. 2. Service improvement commencing with Consultant	Practice development nurse /Ward Manager/ Matron Ward Manager/	95% of staff trained by end of October 2020. Training records from Care metrics and local records will be provided as evidence.

			geriatrician/ fragility Nurse/physio improving prevention of falls in fractured neck of femur for inpatient as part of NOF pathway.	Matron	Progress report on project to be submitted as part of evidence
			3. Health board implementation of digital documentation planned, which will support improvement of falls documentation as assessment not able to be closed until these are.	Ward manager / Matron/ Senior Matron	December 2020
			4. Ongoing falls and fundamentals of care audits to be undertaken by both matrons for MSK and Peer review by another matron. (Evidence supplied – Falls evidence/ audits for Ward B).	Ward Manager/ Matron Matron/ Senior Matron	Re-start this process from September 2020 on a monthly basis for a period of 3 months. Findings of audits to be fed back to HoN on monthly basis and also discussed in SSS group governance meetings. Copies of audits will be provided as evidence.
			5. Review of all Datix incident for the last 6 months resulting in a fall with and without injury to be undertaken to identify any lessons to be learnt which can be shared with the wider team	Matron/ Senior Matron / Clinical governance lead	October 2020 Present at November MSK board meeting. Copy of meetings will be provided as evidence.

2.	We also saw evidence of a Ward Fundamentals of Care Safety Audit that had been undertaken on 14 Jul 2020. The audit showed that nutritional assessments had not been completed on three patients. There were no written records of any action taken as a result of this. The health board is to ensure that a documented action plan is put in place.	2.5 Nutrition and Hydration.	1. Fundamentals Care Audit and nutritional audit repeated to give baseline on current compliance. Most recent audit score 54 %. Immediate action taken by matron to discuss findings with Ward Manager. Practice development Nurse providing additional training. Score effected by not being able to weigh patients. Senior matron looking at alternative methods for non-weight bearing patients. (Evidence supplied – assurance audit 24 Sep 20 and Ward B 28 Sep 20). 2. Action plan developed for nutritional improvement on Ward B. (Evidence supplied – Action plan for nutritional improvement).	HoN/ Senior Matron and Ward Manager	Meeting planned for October with HoN/ Senior Matron and Ward Manager to discuss findings of most recent audits and nutritional action plan that has been developed. Monthly meetings with HoN to review progress of nutritional action plan until December 2020. Copy of audits will be provided as evidence. As above
3	From evidence provided on training completed, the role specific training for safeguarding children level two and adult level two was low for qualified staff. The health board is required to provide assurance that the	7.1 - Workforce	1. Current training levels are Level 1 = 100% Level 2= 45.1% Level 3 = 100% Training suspended during COVID but will now resume and be supported by the practice development nurse. On line training available	Ward Manager/ Practice development nurse/	To have 100% compliance by Dec 2020. Evidence from care metrics will be provided as evidence.

	number of staff who have completed this important training has increased substantially and the measures they intend to put in place to ensure this level is maintained.		2. All staff provided with updated list of essential e learning they are required to undertake. 3. Ward Manager to share HIW report and action plan with nursing team. 4. Matron to share findings and lessons learnt within speciality and wider matron group 5. Action plan and progress to be presented at, MSK board meeting and Morriston DU Quality and Safety group meeting.	Ward Manager Ward Manager Matron/ Senior Matron HoN	Completed 12/9/2020 October 2020. Email with report as attachment as evidence October 2020 November 2020. Copies of meeting minutes will be provided as evidence.

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: Julie Thomas. Interim Head of Nursing

Date: 29th September 2020