Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Ward 3/4, Nevill Hall Hospital

Activity date: 29 September 2020

Publication date: 26 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 978-1-80082-380-8

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ward 3/4, Nevill Hall 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; and governance. More information on our approach to inspections can be found here.

We spoke to the Deputy Ward Sister on 29 September 2020 who provided us with information and evidence about their setting. The Senior Nurse Unscheduled Care and the Interim Divisional Nurse for Unscheduled Care Covering Medical Wards were also in attendance. 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 3/4 was a 28 bed stroke, rehabilitation and care of the elderly ward. The ward moved

in its entirety from Ward 1/2 as part of the Health Board Clinical Futures Programme, on 4 September 2020. Four of the beds in one of the bays had been adapted into a therapy room for exercise and assessment. There were eight side rooms used for patients who required barrier nursing and palliative care, as well as a treatment and multi-disciplinary room.

The deputy ward sister told us that there were daily meetings to discuss each patients care and discharge plans. A wide range of disciplines were based on the ward including speech and language therapists, for patients with speech and swallowing problems. Patient and clinical contact with families was mainly through personal electronic devices, where issues were discussed, including the planning of patients' safe discharge.

We were told that all staff wore appropriate PPE including aprons, gloves and masks. If staff were within two metres of patients, visors or goggles were also worn. There were also hand gel dispensers and PPE outside the patient bays and rooms and hand gel at the side of each patients' bed. There were posters relating to hand gel and COVID-19 signage on the ward. The bays were configured to ensure social distancing between patients.

A number of changes had been made to the ward to ensure infection prevention and control (IPC) was maintained, we were told that these included additional cleaning and wiping surfaces with clinical wipes. The ward was cleaned regularly during the day and the night. We saw evidence of hand hygiene audits and staff were also encouraged to point out any failures with hygiene or wearing PPE, to other staff. Currently, visiting was not allowed on the ward, except for palliative care and end of life patients. There were strict IPC controls for these visitors, including wearing PPE and also using track, trace and protect protocols.

We were told there was sufficient stock of PPE on the ward and that it was available from the central stores. There was signage on the ward and throughout the hospital on the appropriate PPE to wear. Staff had been fit tested for the FFP3[1] mask and staff had been trained on the correct donning and doffing of full PPE. This session had also been recorded and staff were able to view this on an end to end encryption messaging system.

Any patients who displayed symptoms of COVID-19 were moved to another ward for further investigations including swabbing. Patients returned to the ward if the results showed they were COVID-19 free. The medical hub would be informed of any suspected cases of COVID-19 and the infection control staff would then be involved. If staff were displaying symptoms, they would be sent home and arrangements made for appropriate testing. Staff could not return to work until they were free of symptoms, staff now also have access to anti-body testing[2]. Patients being discharged from the hospital were also tested prior to leaving the ward and negative results were required, in addition to the package of care, before discharge.

[1] FFP3 masks offer a high level of protection against dangerous particulates & radioactive contamination.
[2] Antibody tests are used to detect antibodies to the COVID-19 virus to see if it's likely that you have had the virus before.

The deputy ward sister said that staff had access to the wellbeing team and that all staff were approachable and made sure staff knew that they were there for each other. Staff also had access to the hospital psychologist, who held drop in sessions. There was regular contact with staff who had contracted COVID-19 and their families, ensuring they had all the relevant advice and relevant agencies to contact.

We were told that staff were still able to attend any training sessions, but the training available was limited due to COVID-19. All training requirements, in addition to objectives and personal development plans, were discussed at annual appraisals and staff were encouraged as part of their development, to attend training. An example of a recent session was training on Tracheostomy Care[3] and speech and language training, including the Yale[4] swallow protocol.

The following areas for improvement were identified:

We were provided with evidence relating to mandatory training, which showed the compliance with the majority of mandatory training was over 70%. However, the All Wales COVID-19 Workforce Risk Assessment compliance was under 30% and information governance under 50%. The All Wales COVID-19 Workforce Risk Assessment Tool aimed to identify vulnerable and at risk staff who needed to be redeployed from front line patient facing roles. The health board is required to provide assurance that the number of staff who have completed these important training modules are increased substantially and the measures they intend to put in place to ensure this level is maintained.

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 when patients were admitted to the ward, the staff completed various assessments including, falls risk and waterlow[5]. If the patient was at a high risk of falling the staff completed a care plan risk assessment which was updated weekly. If the patient did subsequently fall, the plan would be further updated. Where the patient lacked capacity, a

[3] Tracheostomy (trach) care is done to keep your trach tube clean. This helps prevent a clogged tube and decreases your risk for infection.
[4] The Yale Swallow Protocol (YSP) consists of a brief cognitive screen, a brief oral motor exam, and a 3oz water challenge (subjects instructed to drink 3oz of water without stopping).
[5] Waterlow is a pressure area risk assessment. The primary aim of this tool is to assist in assessing risk of a patient / client developing a pressure ulcer.

capacity assessment and a Deprivation of Liberty Safeguards (DoLS) was completed. Enhanced care requirements were then documented and the senior nurse informed in order to request additional nursing staff, to maintain patient safety.

We were provided with evidence on the Health Care Standards Audit Results - Preventing Pressure and Tissue Damage for the last 12 months. This showed 100% compliance with the assessment of the patients' skin condition and had been discussed with the patient, and 100% compliance where there was evidence that the patient required assistance. There was evidence of up to date care plans implemented, evaluated and reviewed within the agreed timescale. The care indicators showed for the current year that there had not been any healthcare acquired pressure ulcers. Additionally, for the same period there had been between 70 and 100% compliance with nutrition scores completed and appropriate action taken within 24hrs of admission.

Evidence of the ward health and safety risk assessment was provided. This assessment included the identification of the hazard and activity, the control measures to reduce the risk and the additional control measures required to manage the risk. The completion of these documents was of particular note as it was completed within three weeks of moving the ward.

We were told that the measures to protect privacy and dignity included the use of a do not disturb sign and patient curtain dignity pegs, when personal care was being undertaken. The health board had a values and behaviours framework which was evidenced in the care given by all nursing staff. Patient centred care was at the forefront of this framework, ensuring patients and families' wishes and preferences were listened to and accommodated where possible.

We were told that patient dignity was also maintained by providing dignity shorts and families were encouraged to bring in the patients' own clothes. Patients were taken to the toilet, as opposed to bedside care, there were also engaged signs on the doors. This included using a steady standing aid[6], so patients were secured. There were male and female toilets and a shower on both sides of the ward, one for female and one male.

Patients' needs were fully met within the environment, we were told, through playing games and Reminiscence Interactive Therapy Activities (RITA)[7]. There were televisions and radios on the ward and families were encouraged to use a video telephony product to contact patients. Prior to the current COVID-19 restrictions, families were encouraged to take their family member out onto the grounds. A chaplain would also visit the ward on request to minister to the patients' spiritual needs.

No improvements were identified.

[6] The standing aid promotes dignity and independence as the standing aid provides transport to the toilet and washbasin, and can support other activities of daily living.
[7] RITA is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities as part of their hospital recovery.

Infection prevention and control

During the quality check, we considered how well the service managed and controlled 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 provided with evidence of the relevant policies operating at the health board, these included the Health Board Infection Prevention Policy and Standard Operating Procedure (SOP) for Working Safely during Coronavirus. We also saw evidence that daily cleaning schedules were completed for all clinical and non-clinical areas. These were checked and signed by the two deputy sisters and audited by the nurse in charge at the end of the week. This was done to establish the ward compliance, any action required and uploaded monthly to the Health and Care Standards dashboard at the health board.

The evidence provided, showed that there had not been any healthcare acquired infections since January 2020. It there had been any, these would be reviewed through an Infection Control Root Cause Analysis process with the ward manager and senior nurse. Any learning and actions would then be fed back to all ward staff.

We saw evidence of the hand hygiene audits that showed a high compliance with the requirements such as staff were bare below the elbow and gloves were removed as appropriate. Additionally, we saw evidence of the audit called, one patient, one day unscheduled care, which checked patients, staff and equipment appearance, as well as a review of nursing records, with positive results. We were told by the deputy ward sister that staff awareness of infection control had increased recently and believed that the ward had a good cleanliness record.

The self-assessment provided, stated that the infection control nurse (ICN) specialist, audited the ward every three months with senior nurse surveillance between these quarterly audits. The ICN audit, included a review of hand hygiene compliance, cleaning schedule compliance, inspection of equipment e.g. mattresses and commodes, monitoring infection rate cases (e.g. MRSA, CDT), MRSA screening compliance, staff training specific to infection control. The evidence provided showed that these audits had been carried out up to July 2020, with the majority of areas showing as green (at least 95% compliance). We were told an audit was not carried out in August due to the move of the ward, at the beginning of September. We also saw the action plan that listed the actions being carried out on amber areas (86 to 94%) to show further improvement.

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).

The following positive evidence was received:

From reviewing the self-assessment provided, we noted that the deputy ward sister ensured that the staffing levels met the agreed establishment. This was managed via a health roster that was signed off by the senior nurse up to three months in advance. Each roster was then reviewed by the deputy ward sister and senior nurse up to 48 hours in advance to identify any deficits and this was then managed and escalated accordingly. Additionally, there was a daily review of staffing levels between the deputy ward sister and senior nurse with comprehensive plans developed and communicated to the out of hours team.

We were told that staff were requested to swap shifts to cover or were requested to move from other areas when able. Vacant shifts were then advertised to the health board resources bank and to nursing agencies. The deputy ward sister told us that a number of bank and agency staff work on the ward, and attempts had been made to block book these staff to ensure shifts were covered. Additionally, staff stated that there were strong relationships between staff in the hospital and staff knew one another. COVID-19 had increased this support for each other across the medicine directorate. Whilst it was sometimes difficult to cover shifts where there were enhanced care patients on the ward, there had not been any shifts left uncovered. This had included re-introducing enhanced care protocols for health care support workers to cover these shifts.

The deputy ward sister told us that the majority of staff training was carried out online, which could be set up and accessed at home, except for Information Governance. Staff were encouraged to do the training online and the senior nurse, who also had access to the training data, sent out regular reminders. Performance appraisal and development reviews (PADR) were undertaken to ensure that staff development was enhanced and opportunities created in relation to professional development, leadership and clinical skills. The appraisal compliance was at 100%, except for a member of staff on maternity leave.

The staff we spoke with were very complimentary about the management support and supervision that they had access to, in addition to being very positive about the staff on the ward. This included positive feedback from bank and agency staff who had worked on the ward, despite the high acuity, and in senior management taking the time to thank staff for their work. The deputy ward sister also told us that they believed that sickness was low because morale was high.

The following areas for improvement were identified:

The information supplied showed that the ward were short of just under eight qualified members of staff. Registered nurse vacancies were advertised externally by the senior nurse once a month. They were also advertised as a joint advert with other divisions on a monthly basis. There had also been a comprehensive overseas nurse recruitment programme. Whilst this had now reduced the shortage to just under four and a half members of staff, this staff shortage made it difficult to cover the shifts as described above, with permanent members of staff. We recommend that further efforts are made to reduce the shortage.

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: Nevill Hall Hospital

Ward: Ward 3/4

Date of activity: 29 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.

Ref No.	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The mandatory training evidence supplied showed a low compliance with the: All Wales COVID-19 Workforce Risk Assessment at under 30%: and information governance under 50%. The health board is required to provide assurance that the number of staff who have completed these important training modules are increased substantially and the measures they intend to put in place to ensure this level is maintained.	Standard 7.1 – Workforce	Since the ward has settled into its new environment, a review of the mandatory training compliance on 13.10.20 has shown a significant improvement; Covid-19 online training is now at 73%. (Supporting evidence supplied.) Further support will be offered to staff who have yet to complete Covid-19 training by facilitating training time at work and a managerial focus.	Senior Nurse USC	14th Jan 2021
			Information Governance training has reached 100%. (Supporting evidence supplied.)		
			Staff compliance will be assessed monthly between by Ward Manager and Senior Nurse to assess compliance and secure improvement as required.		
2	The information supplied showed that the ward were short of just under eight qualified members of	Standard 7.1 – Workforce	The organisational RN deficits are included in the Corporate Risk Register and the Covid Risk Register.	Senior Nurse USC	Mid-October 2020

Ref No.	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
	staff. We were told that this had now reduced to just under four and a half members of staff, this staff shortage made it difficult to cover the shifts with permanent members of staff. We recommend that the health board inform HIW of the further efforts being made to reduce the shortage.		There is an RN Workforce Tracker that is presented regularly to the Executive Team & a clear programme to attract, recruit and retain staff. Significant efforts have been made organisationally to ensure safe staffing to include a new model of care (The Core Care Team Model), the introduction of Band 4 Assistant Practitioners, Overseas Nurse Recruitment, Recruitment Wheels, together with constant recruitment to the Resource Bank & utilisation of Agencies. There is Current RN vacancies are 4.56 whole-time equivalent (WTE) the gaps for which are filled, in the interim, via bank, agency & over-time. An advert closing on 14.10.20, has attracted two applicants and a further RN has expressed an interest in an internal redeployment to Ward 3|4 as part of the Clinical Futures Programme. (Supporting evidence supplied.) A rolling advert is in place alongside Student Nurse Streamlining to attract Registered Nurses.		

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: Beverley Cadman

Date: 14th October 2020