Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Ward 10, Withybush General Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote follow-up quality check of Ward 10, Withybush Hospital on 24 September 2020. The purpose of this was to check progress on the recommendations in the improvement plan that was developed following the original inspection on 20-21 November 2018.

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.

We spoke to two senior nurse managers and a ward sister as part of the follow-up video call, who provided us with information and evidence about their setting.

Summary

Ward 10 within Withybush General Hospital provides General Medicine, Oncology, Haematology & Palliative Care. The ward currently has facilities to care for 16 patients across all specialities.

The ward reopened in April 2020 following an extensive refurbishment. The environment now provides five en-suite patient bedrooms, two smaller four bedded bays anda three bedded bay. Facilities for patients and relatives have also improved, including a day room and overnight bed space for relatives.

Overall we found evidence that the service provided a positive experience, and safe and effective care to patients. We found that the service had implemented and sustained the majority of the improvements found within the original inspection improvement plan.

Patient Experience

During our inspection November 2018, we identified patient experience issues relating to signage, aspects of patient care and dignity, and how patients were helped to understand their rights in terms of raising concerns about their care.

During the follow-up quality check, it was positive to see that the health board had implemented and sustained all of the improvements listed in their improvement plan following the last inspection.

Improvements required following the last inspection

Areas for improvement we identified during the last inspection included the following:

- Patients are reminded of and encouraged to use the designated toilet/ shower rooms that they should be using
- Signage at the hospital is reviewed to ensure it is easy to navigate for all patients and visitors and the announcement in the lift is repaired / corrected
- Staff must ensure that they make every attempt to maintain patient privacy and confidentiality when communicating their care amongst team members
- Communications are made with ward staff to establish why they are not always able to meet all the demands on their time at work, and the impact this has on care
- Patients and their families / carers understand their rights in terms of raising concerns about their care.

What actions the service said they would take

The service committed to take the following actions in their improvement plan dated 21 January 2019:

- Clear, dementia friendly signage to be placed on each patient toilet / shower room
- Signage to be reviewed and lift to be repaired
- Develop a briefing on the information governance code, including advice on confidentiality and information risks, highlighting the security of patient identifiable information
- Ward Sisters and Nurse in Charge to check staff well-being at the end of each shift.
- All incident reports relating to staffing shortfalls to be scrutinised through the monthly Health and Care Monitoring Standards meetings
- All areas to have 'Putting Things Right' leaflets and posters displayed for patient, carer and family information.

What we found on follow-up

During the review of the evidence and follow-up call we noted the following:

- We found that appropriate signage had been installed on the ward clearly indicating male and female bath and shower facilities

- We found that clear signage had been installed at the entrance to ward and we were told that the lift announcements had now been fixed
- We found that information governance posters were on display in the staff areas on the ward, such as next to computers. We were told that this was done to remind staff of their responsibility to keep patient data secure
- We found that the ward had placed a 'Getting Home Checklist' on the door of the staff room to remind staff to reflect on their day before leaving the ward.
- We reviewed a small number of incidents relating to staffing shortfalls and found that these were escalated and reported appropriately
- We found that, prior to the pandemic, Family Liaison Clinics had been established to further support patient communication with ward teams and relatives. Ward management were complimentary about the way this had worked and were keen to see this service restart in the near future
- We saw that 'Putting Things Right'[1] leaflets were on display, as well as a 'You said, we did' board to demonstrate how the ward has responded to patient feedback.

Delivery of Safe and Effective Care

Since the last inspection, it was positive to note that the health board had taken action to improve processes and procedures in support of safe and effective care, and that staff were committed to providing this. We found improvements had been made in all areas previous identified as requiring improvement.

However, we identified one area for improvement in order for the health board to fully promote the delivery of safe and effective patient care.

The immediate assurances required during the last inspection

Areas for immediate improvement identified at last inspection included the following:

- Ensuring resuscitation equipment / medication is always available and safe to use in the event of a patient emergency

[1] Putting Things Right in the NHS Wales mechanism for submitting concerns and complaints about NHS care

- Ensuring that the fire escape route, the ward plan for evacuation to the bed lift and the means of alerting others once in this area is reviewed to ensure the safety of all staff, patients and visitors at all times

- Reviewing the use of the bed evacuation lift by staff from other departments as a thoroughfare through ward 10 corridor to other areas within the hospital

- Ensuring that medication is stored safely and at the correct temperature.

What actions the service said they would take

The service committed to take the following actions in their improvement plan dated 21 January 2019:

- Implementation of daily / weekly resuscitation equipment checks, including a weekly and monthly spot check audit programme overseen by Senior Nurse Managers

- Review of fire evacuation plan by Fire Officer and local fire service and swipe card to enable access to evacuation lift

- Restriction of lift to authorised staff and restriction of use of the ward as a thoroughfare by other hospital staff

- Order of thermometers to be made and revisions to the fridge temperature log sheet, followed up with a spot check audit programme to ensure compliance.

What we found on follow-up

We were pleased to find that the health board had implemented and sustained all of the areas for improvement listed in their action plan following the last inspection.

- We saw that the resuscitation trolley had been replaced and that consistent daily and weekly checks had been carried out to confirm that contents were in date and sealed. A safety cross[2] was displayed on the ward to demonstrate compliance

- We were told that the ward evacuation plan has been reviewed by the Fire Safety Advisor and that a new fire risk assessment had been completed

- We found that arrangements had been put into place to aid the evacuation of patients, including evacuation exercises and updated protocols for staff to follow in the event of a fire. We saw that a swipe card had been securely installed next to the lift and that additional work was being undertaken to further strengthen fire safety arrangements for other escape route options

[2] Safety crosses records the number of occurrences of a particular event, and act as a visual display for staff and patients

- Staff confirmed that there is now no thoroughfare on the ward for use by other hospital staff
- We found that fridge temperature checks had been consistently undertaken and that any out of range temperatures had been appropriately reported to the estates department. We noted that ward spot checks are undertaken by the nurse in charge to ensure compliance.

The additional improvements required following the last inspection

Additional areas for improvement required following the last inspection included the following:

- The storage of equipment within the corridors and shower rooms is addressed appropriately
- The method used to store filled waste bags in the corridors until collection is reviewed to minimise the risk of tripping and cross infection
- Nursing staff regularly reposition patients and check the patients' skin for signs of pressure and tissue damage on the ward
- Assessments and documentation within the relevant pressure ulcer care documents are undertaken and completed robustly
- Nursing staff have re-assessed and updated risk assessments and care plans for patients at risk of falls, including any appropriate action taken to help prevent falls
- Staff knowledge and skills must be updated and competence assessed with further provision of training in falls management
- A range and number of cleanliness and infection prevention and control (IPC) improvements
- Nursing staff have completed nutritional risk assessments for patients and reassessed patients as appropriate
- Patient identifiable data and care records are kept securely at all times.

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

- Unused equipment to be removed and waste storage area and facilities to be reviewed through use of C4C[3] cleaning audits

[3] Credits for Cleaning system mandated within national standards of cleanliness

- Pressure area care training sessions to continue on a monthly basis until all nursing staff have attended. Including spot checks by ward management
- Bi-monthly documentation audit with themes discussed at monthly health and care standards scrutiny meeting
- Quality improvement programmes to be established which are expected to result in a sustained reduction of inpatient falls, including a training programme around falls risk assessment and management.
- Further training around falls prevention, e.g. lying and standing blood pressure recording, which is to be monitored at monthly health and care standards scrutiny meeting / ward governance group.
- Key actions in response to the cleanliness and IPC improvements:
    - All nursing staff to be booked to attend / undertake IPC training updates
    - Monthly cleaning schedules audit to be implemented
    - Weekly spot checks to be implemented by clinical site management to monitor compliance
    - Spot check audit of clinical hand wash sink by infection prevention team
    - Reinforce use of Clinell tape indicating the date of decontamination of equipment and staff signatures.
- Monthly nutritional screening and assessment compliance audit to be undertaken
- The Dietetic teams to undertake widespread refresh training regarding the use of the Nutrition risk assessment tool
- All areas have keys to lockable notes storage trolleys
- Head of Nursing to request that supervisors and managers ensure their staff are compliant with their mandatory Information Governance e-learning and provide evidence of this.

What we found on follow-up

We were pleased to find that the health board had implemented and sustained the majority of the improvements listed in their action plan following the last inspection, relating to the delivery of safe and effective care.

- We found that appropriate waste storage bins were stored in a designated area situated off the main ward environment. We reviewed a sample of cleaning audits and found these to be scored positively in all areas

- We were told that the ward had not had an incident of hospital acquired pressure damage for eight months and that any incidents would be reviewed at monthly scrutiny meetings, attended by the ward manager and senior nurse manager, with any learning shared with the wider team

- We found that a new pressure damage risk assessment tool had been implemented, which was supported by a recently updated All-Wales pressure ulcer care prevention and management care plan. We reviewed a sample audit which demonstrated excellent compliance in the completion of risk assessments for each patient.

- We were told that there had been a reduction in the number of patient falls on the ward, with all incidents reviewed at monthly scrutiny meetings in order to identify any themes. Safety crosses were also in use

- We were told that the ward has a link nurse[4] who undertakes lying and standing blood pressure audits, and that lying and standing blood pressure is now recorded on shift handover sheets in an effort to reduce patient falls. However, we noted evidence of audits which showed that patient blood pressures had not been consistently recorded at all times

- In response to the cleanliness and IPC improvements:

    - We found a high level of compliance in ward staff mandatory training for IPC

    - We found that cleaning checklists had been implemented for day and night shifts

    - We were told that hand hygiene audits are completed on a monthly basis and that adherence to bear below the elbow practices are overseen by ward management. We were told that instances of poor practice are reported to the relevant line manager

    - We saw examples of other monthly audits undertaken by the IPC link nurse, such as peripheral cannula audits, to further support patient safety.

- We found that a new All-Wales nutritional screening tool[5] had been implemented and that this was in use.

- We were told that a link nurse had been allocated to the ward to undertake nutrition audits and that staff training had been implemented as a result of the

[4] Link nurses act as a link between their own clinical area and usually specialist services

[5] All Wales Adult Nutritional Risk Screening Tool (WAASP)

audit findings in a small number of areas. We found that ward spot checks had been amended to record compliance in this area.

- We were told that all notes trolleys have keypads installed in order to keep patient data secure.
- We found that compliance with mandatory information governance training was generally high, but had been affected by a small number of staff on long term sickness leave.

The following areas for improvement were identified:

We were told that the number of patient falls on the ward has greatly improved since the last inspection, and that a number of interventions had supported the reduction of falls. This included patients being risk assessed for falls, with the option for ward staff to implement enhanced observations according to patient need. Also, a dementia friendly bay was available with distraction games and RITA[6] activities.

We were also told that other falls prevention initiatives had been successfully piloted on other wards, and that similar equipment had been recently purchased for ward 10, but was not yet in use.

We noted that the recording of lying and standing blood pressure checks were undertaken upon admission to the ward, with the support of a link nurse who undertakes regular ward audits.

However, we found that lying and standing blood pressure checks were not consistently being recorded and that there had been some incidences of patient falls. The health board should ensure that existing good practice is this area is sustained and that other initiatives are developed and implemented, where appropriate, to reduce the risk of patient falls.

Quality of Management and Leadership

It was positive to note that all ward management and staff had worked hard since the last inspection, with improvements made in all areas previously identified as requiring improvement.

Staff told us that the new ward environment had helped to improve the working environment for staff and patients, and we saw evidence to show that communication had improved through ward meetings and a staff messaging group.

[6] Reminiscence Interactive Therapy Activities (RITA) is a bedside software package aimed at reducing falls

The improvements required during the last inspection

Areas for improvement we identified at last inspection included the following:

- Issues identified with low morale and motivation and some staff behaviours and attitudes are explored and addressed where appropriate
- Persistent low scores within the monthly care audits are addressed to ensure an improvement is made where appropriate
- Ward staff are able to attend regular ward meetings
- Investigation is undertaken into errors, near misses or incidents in the last month that could have hurt staff or patients
- Investigation is undertaken in to the reasons why there is a perception by some staff, that the organisation would blame or punish the people who are involved in such incidents
- A robust plan for recruitment is in place to maintain compliance with the Nurse Staffing (Wales) Act 2016
- A robust process is in place to manage temporary staffing requirements to maintain compliance with the Nurse Staffing (Wales) Act 2016
- A robust process is in place to ensure all staff have the opportunity to have a formal Performance Appraisal Development Review (PADR).

What actions the service said they would take:

- Team away days arranged in November 2018 where all nursing staff attended and themes from away days to be identified and fed back to Head of Nursing for appropriate action
- Ward 10 Governance Group established in November 2018 which will include monitoring of monthly care audits, clinical incidents and concerns
- Ward Sisters to arrange ward meetings well in advance with items for discussion invited from the team. Notes to be made available for those unable to attend
- Incident reports to be reviewed by individual area sisters and senior nurse managers and areas for learning identified
- Active steps to be taken to support timely recruitment of Registered Nurses to ensure the required staffing levels are achieved in line with the Nurse Staffing (Wales) Act 2016

- Daily Acuity Measurements in place and acuity levels to be reviewed across the site and staff deployed accordingly as a means of risk assessment and management

- PADR plan to be in place in each area so staff have advance notice of the appraisal to ensure these take place.

What we found on follow-up

We were pleased to find that the health board had implemented and sustained all of the improvements listed in their action plan following the last inspection, relating to the quality of management and leadership.

- We found that regular comprehensive ward meetings took place and that minutes are available for staff to view. This provides ward staff with the opportunity to receive and provide feedback to ward management. A private messaging group has also been set-up to further improve communication between ward staff and management

- We were told that clinical incidents are now investigated in live time and that ward management ensures that these are managed in a timely manner, including a local review and sign-off by the senior nurse manager

- We found that there were a low number of nursing and no health care support worker vacancies on the ward at the time of the follow-up check, and staff told us that they felt staffing levels and the skill mix on the ward were now appropriately balanced

- We saw that a new staffing risk assessment tool based on patient acuity had been implemented for use by staff whenever there is an identified staffing shortfall. We were told that this is ordinarily completed by the nurse in charge, but that steps have been taken to ensure that all staff are familiar with the tool so that they are confident to use it in the absence of a senior nurse.

- We found that PADR plan uptake rate was high on the ward and that all outstanding plans had been scheduled to take place shortly after the follow-up check.

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.