Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Oncology Ward 12, Singleton Hospital

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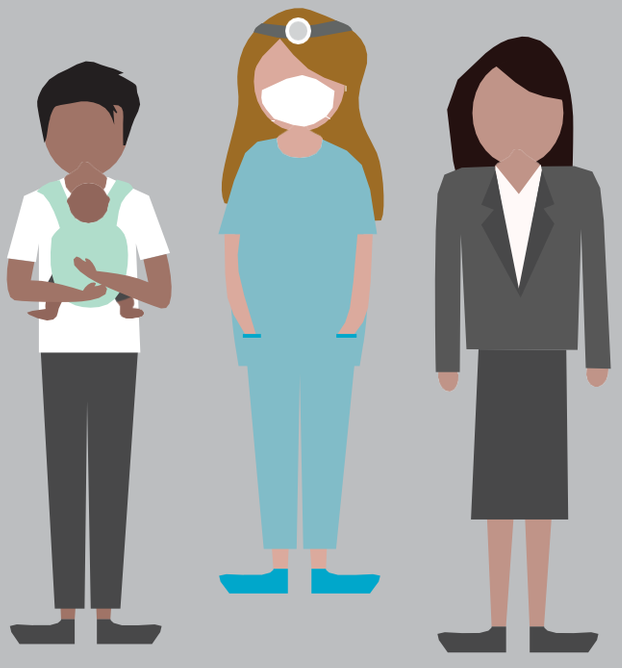

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Oncology Ward 12 in Singleton 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 senior matron, matron and ward manager on 3 November 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 informed that Ward 12 is a 30 bedded inpatient ward providing oncology and haematology services to patients. The ward is subject to the requirements of the Nurse Staffing Levels (Wales) Act 2016.

The ward has a team of experienced nurses, doctors and therapists who administer

treatments, manage side effects, control symptoms and offer support to patients who require a hospital stay. The ward reopened in January 2020 following extensive refurbishment, which took place after a fire in March 2019.

The health board provided us with copies of their Infection, Prevention and Control (IPC) policy and Pandemic framework and tactical plan. Additional evidence confirmed robust planning for emergency preparedness.

We were informed that patients attend the Assessment Unit prior to admission and are screened for COVID-19. Once there is no suspicion of the virus, patients can be safely admitted to the ward. We were informed there were no patients with COVID-19 on ward 12 at the time of the quality check. The ward manager and matron felt this was reflective of an effective pathway.

We were told that oncology have a pre-treatment pathway in place for those patients attending chemotherapy and radiotherapy. Arrangements are in place that require patients to be tested by the COVID-19 Coordinator and local COVID-19 testing team prior to presenting on the ward.

The process described to us of screening and testing patients for the Covid-19 virus, demonstrates the ward has taken measures to manage patient admissions as safely as they can.

We were informed there is an official pathway is in place for the safe screening of in-patients with suspected COVID-19. If patients have suspected COVID-19 the ward liaises with the IPC team and site management. Patients are transferred to a side room or ward 16.

There is a clear process for dealing with staff who have suspected COVID-19 which management were able to explain to us, demonstrating that they are confident in applying the process they have in place to minimise any risks of COVID -19 transmission which might come from staff. The process includes following Health Board policies and has taken account of National Guidance.

We were informed that the ward has access to PPE. Training is provided by champions on the ward who have been trained to show staff how to safely don and doff PPE and provide advice and support to help maintain safe standards. Staff are required to wear visors for all patient contact. These aim to add extra protection, prevent cross contamination and transmission of COVID-19 and other viruses. The visors are used on a sessional basis, can be wiped clean during the session and are then disposed of.

The ward manager informed us that they have allocated two side rooms equipped with toilets and showers to isolate patients with suspected or confirmed COVID-19. In the event these rooms are not available, patients can be transferred to ward 16 in Singleton Hospital which is currently being used as a cohort COVID-19 ward. This cohort ward provides an area in which care can be provided to patients presenting with the same infection. This ward enables effective management of patients with suspected and confirmed Covid-19 thereby attempting to isolate patients in a defined area and reduce transmission of the virus.

We were informed that routine visiting is not permitted at present and the ward day room is closed. These measures help prevent cross contamination and transmission of the virus. The ward manager was keen to inform us that the ward provides patients with iPads to enable them to communicate directly with family and friends. Patients are also able use mobile phones.

Upon admission to the ward, consultants provide face to face consultations with patients. In order to maintain social distancing, virtual meetings are available to patient's families as

and when necessary.

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 informed the Macmillan Therapy Team is a team of occupational therapists, physiotherapists and rehabilitation technicians who provide specialist holistic therapeutic rehabilitation and support for anyone admitted to ward 12 in Singleton Hospital.

We were informed that following a successful trial in Morriston Hospital, Ward 12 has recently had perspex screens installed in patient bays. The screens divide bed areas within bays and provide additional infection prevention and control. Curtains remain around each bed to maintain patient dignity and protect patient confidentiality. The ward manager confirmed that nurses always seek to obtain consent from patients to enable them to provide support and personal care.

The ward manager informed us they had recently had a new intercom system installed at the entrance to the ward to enable them to monitor and manage people accessing the ward. This enables strict management of those people permitted on the ward during the pandemic.

We were informed that patients are able to access a chaplain service for their religious needs.

We were informed that the ward aims to discharge a patient as soon as they are medically fit and it is safe to do so. During the first wave of the pandemic the ward used a rapid discharge service with patients receiving care packages, counselling and wellbeing services. The ward manager told us there were no current problems or delays with discharge from ward 12 at the present time.

The senior matron informed us the hospital uses the Signal patient tracking system which is a live data base and records all patient movements. This system is available on SharePoint and provides audit facilities.

The following areas for improvement were identified:

We reviewed documentation relating to the assessment and monitoring of patient pressure ulcers. Management and assessment of pressure ulcers aims to identify patients at risk of developing pressure ulcers, provide appropriate care and adopt preventative strategies. A ward audit dated 21 August 2020 identified poor compliance with the completion of assessments, care plans and skin bundles[1]. We were told that this had been recognised by the nurse in charge of the ward at the time of the audit and in response some face to face training was provided. Additional audit evidence dated 22 October 2020 identified completion of risk assessments upon patient admission and daily assessments had improved, however compliance with the completion of pressure ulcer prevention care plans and

[1] Skin bundles provide staff with a checklist to assist with the implementation of pressure ulcer prevention strategies.

individualisation of these care plans was found to be only 40% compliant. The health board must provide HIW with evidence that confirms staff have been adequately trained to assess and monitor patient pressure ulcers and that the completion of assessments and care plans has improved and is subject to regular audit and management review.

We reviewed an analysis of patient falls for the period 29.1.20 to 23.2.20. The ward reported five falls in this period. Management considered that inadequate staffing levels may have been a contributory factor. Further evidence considered inadequate staffing levels may have been a contributory factor to only two of the falls originally identified. There have been a further 26 falls since the 23 February 2020 however no further analysis has been undertaken to identify any themes or trends. HIW requires assurances that the health board assesses and analyses the reasons for patient falls and every effort is made to take action to prevent further falls and reduce patient harm.

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 an up to date Infection Control and a Covid-19 IPC policy.

We were provided with evidence which demonstrated that audits were being conducted on the hand hygiene of staff and compliance with the requirement for staff to be bare below the elbow. The concept of bare below the elbow aims to improve the effectiveness of hand hygiene helping to reduce the transmission of infection. A recent audit indicated staff were 100% compliant with these requirements.

We saw evidence of a cleaning audit dated 10 October 2020. This cleaning audit used a tool that measures standards of cleanliness on the ward against national cleaning specifications. The results indicated the ward was 99.44% compliant. We saw evidence of cleaning schedules that indicated cleaning was being completed in all areas of the ward on a daily basis.

We saw evidence of an IPC audit dated October 2020. The results identified the ward environment was clean and in a good state of repair. The audit identified staff were compliant with hand hygiene requirements and there were adequate facilities to store and dispose of PPE. A review of patient equipment identified items were clean and labelled, sharp items were being disposed of safely in contaminated waste facilities, linen was being stored and handled appropriately and signage was in place to provide guidance on social distancing.

The following areas for improvement were identified:

We were provided with a copy of the matron's monthly environmental check for ward 12 dated October 2020. The findings from this check raised concerns pertaining to the potential transmission of the Covid-19 virus, cleanliness of equipment, potential trip hazards and the safety of patients. The check indicated the ward was 89% compliant with required standards but noted there were a number of concerns raised in respect of the requirement for staff to maintain social distancing around the nurses station, excessive equipment stored in corridors, ligature points identified on the ward and evidence that the resuscitation trolley was not being checked on a daily basis. Further evidence was provided to HIW and a review of the

care indicators report covering the period January to October 2020 also indicated there had been gaps in the checking of resuscitation equipment. The issues identified raise concerns pertaining to the potential transmission of the virus, cleanliness of equipment and potential trip hazards and the safety of patients respectively.

HIW require assurance that action has been taken which demonstrates that resuscitation equipment is effectively maintained so that it is safe to use.

In addition HIW require assurance that the required standards are met and action is taken to ensure social distancing within staff groups, a review of excessive equipment on corridors and ligature points identified on the wards are risk assessed in order to ensure a safe health care environment.

The IPC audit for October 2020 conducted by the IPC department identified one issue that identified a nurse had not removed PPE after leaving a patient room. HIW require assurance of what action the ward took at the time to ensure learning from this finding and to ensure that practices have improved.

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 informed that ward 12 is a 30 bedded ward subject to the requirements of the Nurse Staffing Levels (Wales) Act 2016. In line with the Act and patient acuity the health board agreed ten additional registered nurses were required. The ward currently has two registered nurse vacancies. A number of students who are due to graduate in March 2021 have expressed an interest in joining the ward.

The ward manager informed us that ward 12 has been nominated and will be receiving an award for outstanding contribution to learning and development on the 25 November 2020.

We were informed that the staffing roster is planned six weeks in advance on the live system "Allocate". The ward uses bank and agency staff to support safe staffing levels. There is a daily hospital risk meeting and safety huddle that reviews and ensures safe staffing levels across the hospital. We were informed there have not been any recent adverse incidents related to staffing levels.

We were informed a practice development nurse is responsible for staff training and staff are allocated time to complete mandatory and other training. We were informed that the IPC department provides ward level training. We were provided with evidence that showed us staff were compliant with mandatory training in areas including IPC, resuscitation, health, safety and welfare, safeguarding, equality, diversity and equal rights. Mandatory training is deemed essential by the health board to ensure the delivery of safe and effective care.

We were told that a tissue viability nurse provides specialist advice and supports the review of pressure ulcers through the use of medical photography by comparing photographs of pressure areas present upon admission to those present on discharge. This is done virtually to ensure social distancing.

We were told that staff have access to a Wellbeing policy, wellbeing Unit and the occupational health department.

The following areas for improvement were identified:

We were informed the health board requires mandatory training to attain a minimum compliance of 85% however, we reviewed mandatory training records that identified staff training compliance for fire safety was 80%, information governance was 76% and moving and handling was 73%. In addition we were informed that staff training compliance for the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLs) was 45% and 9.38% respectively. The ward manager informed us training had been delayed as a result of the pandemic however, training dates had been booked in both November and December. HIW require assurance and evidence to confirm the level of mandatory and other training compliance is improved and meets health board requirements.

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: Singleton Hospital, Ward 12 Oncology

Date of activity: Plan submitted 8th January 2021

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 reviewed documentation relating to a ward audit dated 21 August 2020 that assessed and monitored patient pressure ulcers. The audit identified poor compliance with the completion of assessments, care plans and skin bundles. Additional audit evidence entitled audit skin bundle dated 22 October 2020 identified completion of risk assessments upon admission and daily assessments had improved however compliance with the	Standard 2.2 Preventing pressure and tissue damage	1.1 Tissue Viability and Purpose-T training to be delivered to all staff to ensure staff are appropriately trained to assess and monitor pressure areas. 1.2 Re-audit compliance risk assessments and care plans.	Ward Manager / Practice Development Nurse Ward Manager / TVN / Matron	Ensure 100% compliance of available staff by 31st January 2021 31st January 2021

	completion of pressure ulcer prevention care plans and individualisation of these care plans was found to be only 40% compliant. The health board must provide HIW with evidence that confirms staff have been adequately trained to assess and monitor patient pressure ulcers and that the completion of assessments and care plans has improved and is subject to regular audit and management review				
2	We reviewed an analysis of patient falls for the period 29.1.20 to 23.2.20. The ward had reported five falls, three of which were considered to be a result of inadequate staffing levels. Further evidence indicated only two of the falls were attributable to inadequate staffing levels. There have been a further 26 falls since the 23 February 2020 however no further analysis has been undertaken. HIW requires assurances that the	Standard 2.3 Falls Prevention	2.1 A thematic review of the remaining no, and low harm falls will be undertaken to identify any shared learning and actions required. 2.2 Continue to review and present any frequent and above moderate harm falls that occur at Singleton Hospital Fall Scrutiny Panel for shared learning. 2.3 Further training will be provided on health board falls policy and documentation.	Matron / Senior Matron Ward manager / Matron Practice Development Nurse / Ward Manager	31st January 2021 Monthly Ongoing Ensure 85% compliance of available staff by 31st

	health board assesses and analyses the reasons for patient falls and every effort is made to prevent and reduce harm.				January 2021 and 100% by the 10th February 2021
3	We were provided with a copy of the matron's monthly environmental check for ward 12 dated October 2020. This indicated the ward was 89% compliant with required standards but noted there were a number of concerns raised in respect of the requirement for staff to maintain social distancing around the nurses station, excessive equipment stored in corridors, ligature points identified on the ward and evidence that the resuscitation trolley was not being checked on a daily basis. The issues identified raise concerns pertaining to the potential transmission of the virus, cleanliness of equipment and potential trip hazards and the safety of patients respectively. HIW require assurance that action has been taken which demonstrates that resuscitation equipment is effectively maintained so that it is safe to use.	Standard 2.1 Managing Risk and Promoting Health and Safety Standard 2.4 Infection, prevention and control (IPC) and decontamination	3.1 Continue to audit, monitor and record resuscitation trolley checking compliance. 3.2 Introduce daily nurse-in-charge assurance checklist for completion of Ward daily safety checks. 3.3 The COVID-19 Safety Measures monitoring audit tool will be completed twice weekly and compliance reviewed weekly by the Senior Matron. 3.4 Conduct Ward audit and risk assessment of storage of equipment and ligature points.	Ward Manager / Matron Ward Manager / Matron Ward Manager / Matron Matron / Senior Matron/ Health and Safety Officer	Monthly January 31st 2021 Weekly 31st January 2021

	In addition HIW require assurance that the required standards are met and action is taken to ensure social distancing within staff groups, a review of excessive equipment on corridors and ligature points identified on the wards are risk assessed in order to ensure a safe health care environment.				
4	The IPC audit for October 2020 conducted by IPC department identified one issue that identified a nurse had not removed PPE after leaving a patient room. HIW require assurance of what action the ward took at the time to ensure learning from this finding and to ensure that practices have improved.	Standard 2.4 Infection, prevention and control (IPC) and decontamination	4.1 Non-compliance was addressed with the individual at the time of the audit. A re-audit was completed by the IPC team following this and no concerns were observed. Learning from compliance audits are shared at the Hospital COVID-19 Outbreak Control meetings. 4.2 Donning and Doffing of PPE training has been prioritised on the ward and a PPE champion was allocated from the ward team to improve awareness and	Practice Development Nurse / Ward Manager / IPC team Ward Manager / Practice Development Nurse / PPE Ward Champion	Ongoing Ongoing

			training compliance. 4.3 The COVID-19 Safety Measures monitoring audit tool will be completed twice weekly and compliance reviewed weekly by the Senior Matron.	 Ward Manager / Matron / Senior Matron	 Weekly Ongoing
5	We were informed the health board requires mandatory training to attain a minimum compliance of 85% however we reviewed mandatory training records that identified staff training compliance for fire safety was 80%, information governance was 76% and moving and handling was 73%. In addition we were informed that staff training compliance for the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLs) was 45% and 9.38% respectively. The ward manager informed us training dates had been booked in both November and December. HIW require assurance and evidence to confirm the level of mandatory and other training compliance is improved and meets health board requirements.	Standard 7.1 Workforce	5.1 Action plan developed for improved training compliance. 5.2 Continue to audit, monitor and record all training compliance at monthly intervals to ensure there is continuous progress.	Practice Development Nurse/ Ward Manager Practice Development Nurse/ Ward Manager	Ensure compliance >85% of available staff by 31st January 2021 Monthly Ongoing

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: Lesley Jenkins, Group Nurse Director, NPT & Singleton Service Group

Date: 8th January 2021