Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

First Floor Ward, Velindre Cancer Centre

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the First Floor Ward at Velindre Cancer Centre as part of its programme of assurance work. Velindre Cancer Centre (VCC) is part of the Velindre University NHS Trust and provides non-surgical specialist cancer services for the population of South East Wales.

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 are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the ward manager and a Band 6 nurse on Wednesday 03 March 2021, 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?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. 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, the maximum number of patients accommodated on the ward has been reduced from 32 to 22. This is in order to comply with social distancing guidance ensuring that patients are always over two metres apart

The ward has eight, single occupancy cubicles, some with en-suite facilities. We were told that the cubicles are currently, mainly used to accommodate those patients whose admission is not pre planned. This is to ensure that all patients are appropriately isolated and screened for COVID-19 at the point of admission in order to reduce the risk of cross infection. Patients are not permitted onto the bays of the ward until they have tested negative for COVID-19, or are symptom free. A maximum of two patients are accommodated within each of the bays at any one time, and where there has been confirmed cases of COVID-19 on the ward, only one patient has been accommodated within the bay. This is in order to ensure adequate social distancing to reduce the risk of cross infection.

We were told that additional handwashing facilities have been installed to further reduce the risk of infection and transmission. Plastic easy clean curtains have also been provided and alcohol hand-gel is available by each bed and in other key areas of the ward.

We were provided with documented evidence to show that the most recent environmental audit of the ward was undertaken on 05 February 2021. This showed an overall compliance against the Trust's standards of 97.86%.

We were provided with documented evidence to show that the risk of falls was being assessed and reported on a monthly basis to the Falls Scrutiny Panel. We were also provided with documented evidence to show that incidents of pressure or tissue damage was also being monitored and reported on. This shows that the organisation is making every effort to ensure the health and safety of patients through robust and comprehensive audits and risk assessments.

No improvements were identified.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were provided with copies of the policies and procedures in place for the prevention and control of infection, which included specific COVID-19 policies and guidance. These are comprehensive and reflective of current COVID-19 National guidance.

We were told that infection prevention and control (IPC) and COVID-19 specific training has been provided to all staff.

We were provided with documented evidence to show that regular IPC audits are undertaken, which include regular air quality sampling, together with daily environmental cleaning audits and hand hygiene audit. We were provided with copies of the Executive Management Report on Quarter three IPC Surveillance and Performance, IPC report detailing surveillance trends for January 2021, and the Trust's Annual IPC Report 2019/2020. These show that the organisation is making every effort to ensure that the risk of infection is appropriately managed through robust and comprehensive audits and assessments. The audit results are formally reviewed each month by the Trust's IPC Committee, and at the Social Distancing and PPE Cell meetings which take place every two weeks.

We were told that the Trust has a team of three designated IPC nurses, and a Respiratory Protection Advisor, all of whom have a regular presence on the ward. A designated Microbiologist/Infection Control Doctor is also available to provide support to the ward staff as necessary. In addition, a Consultant Oncologist has designated responsibility the Cancer Centre's Infection Control Medical Lead. This means that there is a multidisciplinary team who oversee the management of infection prevention and control on the ward. We were also told that, over the past six months, the Public Health Wales Lead Nurse Consultant for IPC has visited the Cancer Centre to undertake assessments. This arrangement was said to have been instigated by the Cancer Centre's senior nursing team in order to ensure that all IPC measures have been optimised during the pandemic.

We were told that all planned admissions patients are screened for COVID-19 prior to being admitted on to the ward. All visitors are screening for COVID-19 at each of the Cancer Centre's entrances. We were told that the National guidance for visitors to care settings is been adhered to. However, in exceptional circumstances, some relatives may be permitted to visit their loved ones. Where visiting is permitted, use is made of the Family Room, located off the ward in order to minimise the risk of infection. Electronic tablets are also available for patients to keep in touch with family and friends during this time of restricted visiting.

The ward manger told us that there were sufficient stocks of PPE for staff, patients and visitors, which are regularly audited to ensure adequate levels are maintained.

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:

We were told that the Cancer Centre and Trust Executive Nurse Director has oversight of the staffing levels and ensures that there are appropriately trained staff, in sufficient numbers to provide care for the patients.

We were told that the Trust has been using formal frameworks to ensure continuously safe and sufficient staffing levels at all times. We were told that an internal audit, conducted at the end of 2020, provided assurance that the ward was compliant with the Nurse Staffing Levels Act (Wales) 2016. Data in relation to patients' dependency levels, patient flow and staffing levels is collected daily and entered onto the Health and Care Standards Monitoring System (HCMS). In addition, the Trust participates in the bi-annual benchmarked acuity review process. The outcome from this is used twice yearly to review nurse staffing numbers in conjunction with reviewing core ward quality indicators including such as number of falls, pressure ulcers, health care acquired infections, patient experience and complaints. This is discussed in twice yearly establishment reviews meetings chaired by the Executive Director of Nursing.

We were also told that the ward staffing roster is checked daily in order to ensure that there

are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care, in order to meet the needs and numbers of patients at that time. The ward manager works 100% of her time in a supervisory capacity to ensure the safe and effective day-to-day management of the ward, including the monitoring of safe staffing levels.

The ward manager told us that, as the ward is operating at lower occupancy, there is no need to advertise vacant posts at present, and that there is very little reliance on agency or bank staff. The ward manager ensures that there is an appropriate skill mix of staff on the ward at all times, with a Band six nurse on each shift. The ward nursing staff are supported by hospital senior nurses and doctors. Daily Consultant review of newly admitted patients has been introduced over the past year to further ensure that patient care is being optimised. A daily Board round takes place which includes the multidisciplinary team members, Infection Prevention and Control lead, Therapy staff and Pharmacy and a multidisciplinary review of all newly admitted patients also takes place weekly. This ensures that patients' care is managed smoothly and efficiently, and that the care provided is holistic.

Documentation provided shows that staff Performance, Appraisal and Development Reviews (PADR), are undertaken on a regular basis. We were provided with training statistics which show generally high compliance rate for mandatory training. The ward manager told us that fire safety training completion rates have increased to 82% and that completion rates will increase further over coming weeks. An independent training facilitator has been sourced for Intermediate Life Support (ILS) training with four sessions booked over the next two weeks. This will mean that the majority of staff will then have completed the course. Five staff members have been trained to cascade Basic Life Support (BLS) with Band 3 staff member delegated responsible for chasing up staff who need to complete the training. The ward manager told us that that his will ensure that that majority of staff will have completed BLS training within the next two weeks.

The ward manager told us that measures have been set in place to provide staff with additional support during the pandemic. These include staff having the use of the visitors' room to have time away from the clinical area. The Therapy unit has also been made available to staff together with psychology support and complementary therapies. Band 6 nurses have been delegated responsibility for setting up support groups for staff. The ward manager also told us that team members are also very good at providing mutual support for each other. Notice boards have been set up to display positive comments about the service and an employee of the month scheme introduced to further boost staff morale.

The ward manager stated that she is well supported by the head of nursing and deputy head of nursing who are visible on the ward.

No improvements were identified.

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: Velindre Cancer Centre

Ward: First Floor Ward

Date of activity: 03 March 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
	No Improvements Needed				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name:

Date: