Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Ward D6W, Royal Gwent Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ward D6W, Royal Gwent Hospital as part of its programme of assurance work. The ward was previously a paediatric ward and is now a designated COVID-19 testing ward. Patient accommodation consists 13 single rooms including with 2 single ensuite rooms.

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, both the senior nurse and deputy ward manager were also in attendance, on 13 April 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 ward was used to isolate patients until it was confirmed whether the patients had COVID-19, or not. The patients were then moved to a COVID-19 positive ward or amber (non COVID-19) ward depending on the result of the swab. We were told that positive patients were promptly transferred from the ward. There was occasionally a delay in transferring negative patients because of demand and capacity pressures for beds across the various pathways in the hospital. This was then escalated to the Hub, where beds were managed, for their action. The current manager had been in place since February 2021.

The changes made to the environment due to COVID-19 were described. These included cleaning the ward three times a day and additionally, regular cleaners had been allocated to the ward. Ward assistants were introduced on the ward, to assist in maintenance. They supported the management of the cleaning schedules and other non-clinical issues, such as maintaining the stock of personal protective equipment (PPE).

We were told that the health and safety department completed regular checks of the ward and the break room to ensure compliance with social distancing. Additionally, a COVID-19 specific risk assessment of the ward was completed to ensure compliance with social distancing and to ensure staff, patients and relatives were protected. The patient specific risk assessments were described. These included falls risk assessments, bed rail assessments, Waterlow[1] (daily), nutrition risk screening tool (known as WASSP[2]) and mouth care risk assessments.

The staff we interviewed said that the doors to each cubicle were kept shut in compliance with infection control measures and to maintain patients' dignity. However, if a patient had cognitive impairment and was at a high risk of a fall, enhanced care was considered that also ensured their stated dignity was maintained. Previously the ward was designated for paediatrics with two single en-suite rooms. These were now designated for dependant patients who required equipment and aids, as other toilets on the ward were currently not suitable for use with mobility aids.

[1] The Waterlow Scorecard is an assessment of the seven risk factors known to contribute towards the development of pressure ulcers.

[2] Weight, Appetite, Ability to eat, Stress factor, Pressure ulcer/wound (WAASP tool).

We were told that all staff were screened daily for COVID-19 symptoms and temperatures were recorded at the start of every shift. All staff had lateral flow kits[3] and were tested twice weekly. The majority of staff had been vaccinated.

The ward had measures in place to ensure consideration of a patient's individual circumstances, to balance the necessary measures for COVID-19 with supporting the patient, for example end of life care and visiting. In line with Welsh Government guidelines, the ward was currently operating restricted visiting to reduce the risk of the spread of COVID-19 between patients and their relatives. Visitors were only allowed for patients who suffered dementia or who were considered to be end of life. Visitors were tested prior to visiting the ward and were issued with PPE. They were then briefed on what they could and could not do on the ward.

We were told that the results of the latest ward environmental audit and the resulting action plan was discussed with staff at the ward meeting. In addition other items would be discussed at this meeting such as explaining to staff about the importance of wearing PPE, general passage of information and other important messages.

No improvements were identified.

Infection prevention and control (IPC)

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:

The changes that had been implemented in light of COVID-19 to ensure IPC standards were maintained, were described. Any visitors, including visiting staff, had to sign onto the ward to assist with track and trace and they were also temperature checked. We were told that disinfectant wipes were used to clean the equipment. The rooms were triply cleaned with a chlorine disinfectant product and also ultra violet lights were used when the rooms were deep cleaned between patients. Gloves and aprons were kept outside the cubicles for staff use, in addition to alcohol gel. There were several areas where masks could be collected throughout the ward, which the ward assistants replenished. There were three PPE stations on the ward, at the entry, mid-point and the end of the ward.

We saw evidence that the ward manager followed the health board processes to ensure

[3] "Lateral Flow" or "Rapid" Test Kits to carry out quick tests that indicate whether COVID-19 antigens are present. You can get a result within 15 minutes without having to send the kit off to a lab.

regular audits in conjunction with IPC via the one patient, one day[4] ward audit. We were told that daily cleaning schedules were completed for all clinical and non-clinical areas. These were then audited by the nurse in charge at the end of the week to establish the ward's compliance. Any action required was made know to staff and the results were uploaded monthly to the health and care standards measurement system used.

We were told that the infection control nurse specialist had increased their audits to weekly, in response to the pandemic with senior nurse surveillance daily. This included reviews of hand hygiene compliance, cleaning schedule compliance, inspection of the equipment for mattresses and commodes and monitoring infection rate cases.

We saw evidence of the infection control root cause analysis (RCA)[5] process of all incidents of healthcare acquired infection (HCAI). These were reviewed by the ward manager and senior nurse. All learning and actions were fed back to all ward staff. We were told that any new risks identified relating to the risk of infection would be escalated to the senior nursing team, to ensure review, action and recording on the risk register. Visual and written notices were available for staff, patients and relatives (such as safety crosses[6]). There were two nominated members of staff who provided an infection prevention link, one nurse and one healthcare support worker. Clear signage was displayed in relation to COVID-19 measures.

We were told there was sufficient and suitable PPE on the ward. We were told that staff had not had to perform any aerosol generating procedures[7] but were aware of the PPE and precautions required. We were told that additional training modules had been added to the Electronic Staff Record (ESR) system used in relation to training and staff appraisals. In addition, the IPC nurses at the hospital were available to provided additional training and advice, specific to infection control.

No improvements were identified.

[4] Additionally, we saw evidence of the various audits 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. The document also reviewed compliance with all aspects of patients' documentation and assessments and the suitability of the environment and the well-being of the patient.

[5] Root cause analysis (RCA) is a systematic process for identifying "root causes" of problems or events and an approach for responding to them. RCA is based on the basic idea that effective management requires more than merely "putting out fires" for problems that develop, but finding a way to prevent them.

[6] Each safety cross represents one calendar month. Within each cross there are 31 boxes, as each box represents a single day. To the left of the cross is a key which lets you know that each colour represents an outcome of a single day in your ward or care home.

[7] An aerosol-generating procedure is a medical or health-care procedure that results in the production of airborne particles or respiratory droplets, which may be pathogenic.

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 ward manager ensured that the staffing levels met the agreed establishment via a health roster. The health roster was agreed by the senior nurse up to three months in advance. They reviewed the roster again 48 hours in advance to identify any deficits and managed or escalated this accordingly. There was a daily and weekly review of staffing levels between the ward manager and senior nurse with plans developed and communicated to the out-of-hours team. Staff were requested to swap shifts to cover, if necessary. The ward was also supported by block booking agency staff and vacant shifts were advertised to the health board resource bank and to agencies. We were provided with evidence of the nurse staffing escalation policy. Both wards were presently staffed up to the establishment, from the previous elective orthopaedic ward and were supported with additional staff from the resource bank.

We were told of the methods used by the ward to ensure staff had access to relevant training. Some classroom training had stopped due to the pandemic, but had re-started again recently. There was also a manual handling cascade trainer on the ward, who would train staff. We were told that the majority of staff training was carried out online, most of which could be set up and accessed at home. The ward manager described how staff were valued and were given protected time to maintain their competencies and attend training to provide evidenced-based care. Staff compliance varied between 63 percent compliance for manual handling and 90 percent for equality. We were told that a number of members of staff were new starters and were working their way through the mandatory training.

The ward manager spoke of the support and supervision given to ward staff. Staff were put on the rota to ensure there was a competent nurse on duty with a less competent nurse. The ward manager had supernumerary status and would attend in the ward as required, to speak to staff and to assist where necessary. New staff were given a ‘buddy’ to mentor and provide clinical supervisions.

The 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 evidence provided in the self-assessment stated that there was 70 percent compliance with the PADR. During the quality check we were told that compliance was now at 85 percent.

Management spoke of the psychologists assigned to different wards to provide support to staff during the pandemic. The psychologists made themselves available to staff as required. We were told of the online staff well-being information available on the health board intranet. This included a new resource to maintain staff mental health in addition to occupational health and counselling services available at the health board.

We were provided with a copy of the corporate policy to ensure preparedness for future pandemic emergencies. This plan set out how the health board would deal with the pandemic challenges. The self-assessment provided, stated that planning during a pandemic was complex, services were required to be flexible and the response must be agile to the changing course of COVID-19.

The arrangements in place to ensure a Do Not Attempt Cardio Pulmonary Resuscitation[8] (DNACPR) discussion and decision making had been undertaken appropriately and sensitively were discussed. We were told that the doctors discussed escalation notes with patients on admission to treatment. This included what escalation of care was required if the patients was transferred to another hospital. In addition, there was a treatment of care plan for COVID-19 patients. These included details about relatives and if there was a deterioration to have discussions sooner, rather than later. If patients did not have the capacity, the next of kin would be contacted.

We were told that the ward adopted an equality and rights based approach. Everyone was treated equally and the health board had a set of values and beliefs, including dignity and respect that staff complied with. There was a PADR booklet that included the health board values as well as the nursing and midwifery council standards. Staff also had to complete equality and diversity training.

No improvements were identified.

[8] https://www.nhs.uk/conditions/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions/

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.