Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Usk Ward 3/2, Nevill Hall Hospital

Activity date: 21 April 2021

Publication date: 26 May 2021

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 978-1-80195-456-3

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Usk Ward 3/2 as part of its programme of assurance work. Usk Ward 3/2 is a 28 bedded ward providing care for elderly patients. It opened in November 2020, as part of the health board's Clinical Futures Programme and was initially responsible for accommodating patients suspected of having COVID-19.

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 one of the Band six nurses on Wednesday 21 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, up until February 2021, the ward was used to care for patients who were suspected of having COVID-19, and that only minimal changes were needed to the environment. There are eight single occupancy cubicles which can be used to isolate patients should the need arise.

We were told that all staff have responsibility and accountability for maintaining a safe environment and that regular audits and risk assessments are undertaken to ensure patient, staff and visitors' safety. These include, but are not limited to the following examples; manual handling, slips trips and falls, violence and aggression, sharps injuries, latex allergy and provision of medical cover out of hours.

We were told that fire risk assessments are updated yearly and that the Health and Safety officer undertakes an annual fire safety inspection. Staff members are also designated as ward Fire Marshals who would co-ordinate the response in the event of a fire.

We were told that measures are in place to ensure that patients' individual needs and wishes are taken into account when planning care, whilst at the same time balancing the necessary precautions in place due to COVID-19. The ward manager confirmed that there were processes in place to manage Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions, with medical staff ensuring that the wishes of the patient and relevant family members are sought and recorded.

We were told that, in line with Welsh Government guidelines, the ward is currently operating restricted visiting to reduce the risk of the spread of COVID-19. However, staff recognise the impact of this on both patients and families, and make every effort to balance the risks with consideration of the individual circumstances of patients and families, in particular where the patient's condition is deteriorating and they are not expected to recover. Consequently, some visiting is allowed, under certain circumstances, limited to nominated family members and with appropriate risk assessments in place. Visitors are required to adhere to the, test and trace process.

We were told that the health board has a values and behaviours framework which all nursing staff are expected to adhere to, ensuring that patients' and, where appropriate, their

families' wishes and preferences are listened to and accommodated where possible. Dignity and Essential Care Inspection audits are also being conducted to support this process.

We were told that individual patient risk assessments are undertaken on admission. These are then updated on a weekly basis, as a minimum, or if there is any change in the patient's condition. These include falls risk assessments, bed rail risk assessments, pressure area risk assessment, malnutrition screening and mouth care risk assessments. We were provided with a copy of a completed falls audit for March and April. This shows that there are good governance and reporting systems in place to manage the risk of falls. We were also provided with completed audit data relating to the prevention of pressure and tissue damage. This also shows that there are robust governance and reporting systems in place to reduce the risk of pressure and tissue damage.

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 told that there were no current, confirmed cases of COVID-19 within the staff or patient group.

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 were seen to be comprehensive and reflective of current COVID-19 national guidance. In addition to this, there is a COVID-19 specific risk assessment in place to ensure that all aspects of the ward are compliant with social distancing to protect staff, patients and relatives.

We were told that the ward manager follows the health board's processes to ensure regular infection prevention and control audits take place. We were also told that a One Patient One Day ward audit takes place. This audit focuses on an individual patient each day, looking at the patient's general appearance, cleanliness and safety of the environment, availability of PPE, staff presentation and appearance, review of patient's care notes and key assessment documentation and a summary of the patient's views on the quality of the care provided. We were provided with copies of competed audits for February, March and April 2021, which showed very good compliance with standards.

We saw from the documents submitted, and from discussions with the ward manager and

Band six nurse, that any patient diagnosed with an infectious disease would be managed appropriately.

We were told that the infection control nurse specialist audits the ward every three months. This includes review of hand hygiene compliance, cleaning schedule compliance, inspection of equipment e.g. mattresses and commodes, monitoring infection rates, Methicillin-Resistant Staphylococcus Aureus (MRSA) screening compliance and staff training specific to infection control. We were provided with a copy of the completed hand hygiene audits for February, March and April 2021, which showed good compliance with standards. We were also provided with a copy of a completed COVID-19 specific infection control audit completed in April 2021. The audit clearly highlighted where areas for improvement were identified and what action was taken to address these issues. This shows that there are robust governance, reporting and escalation processes in place to address any non-compliance with standards.

We were told that all incidents of healthcare acquired Infection are reviewed through an infection control root cause analysis[1] process. Any learning and actions are then fed back to all ward staff. Any new risks identified relating to infection prevention and control would be escalated to the senior nursing team, to ensure review, action and recording on the Risk Register.

We were told that the outcome of audits are posted on the ward, in the form of Safety Crosses[2], for patients, visitors and staff to see, and that there are two, nominated members of staff who are infection prevention links nurse and healthcare support workers.

We were told that cleaning routines have been optimised with daily cleaning schedules completed for all clinical and non-clinical areas, which are then audited by the nurse in charge at the end of the week to establish compliance. We were provided with copies of cleaning audits for March and April 2021, which showed high compliance rates.

The ward manager 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.

[1] Root Cause Analysis is a technique that helps people answer the question of why the problem occurred in the first place. It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can determine what happened, why it happened and figure out what to do to reduce the likelihood that it will happen again.

[2] A safety cross is a visual data collection tool that is used to identify areas for improvement. A safety cross is a calendar in the shape of a cross that records the occurrences of a particular issue.

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 provided with copies of the Health Board's Operational Plan and COVID-19 Response Policy. These were seen to be comprehensive and show that the health board has strong governance measures in place to manage and review the varying pressures on the service.

Discussions with the ward manager and Band six nurse highlighted a good understanding of their responsibilities and the health board's escalation and reporting processes. The ward manager told us that they are well supported by the senior nurses and have access to advice and guidance when required.

We were told that the ward manager ensures that the staffing levels meet the agreed establishment. This is managed via the electronic health roster, which is overseen and signed off by a senior nurse, up to three months in advance. The ward manager and senior nurse review each roster 48 hours in advance, to identify any deficits and manage/escalate in line with the health board's Nurse Staffing Escalation Policy, a copy of which was provided as part of the self-assessment.

We were told that agency staff are sometimes used to cover staffing shortfalls. We were also told that every effort is made to ensure that the same agency staff are secured to provide cover. This provides a level of continuity in the care provided and ensures that the agency staff are familiar with the ward layout and working practices.

We were told that registered nurse vacancies are advertised externally once a month. At the time of the call, we were told that there are currently 8.48 whole time equivalent Band five nursing staff vacancies. However, five of these posts have been filled and the ward manager was awaiting confirmation of start dates.

We were told that the Welsh Levels of Care[3] audit tool is used to highlight and record any shortfalls in staffing linked to patient dependency levels. We were also told that staff are

[3] The Welsh Levels of Care consists of 5 levels of acuity ranging from; level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis, down to level 1 where the patient's condition is stable and predictable, requiring routine nursing care.

asked to report any adverse incidents related to staffing levels on Datix[4].

We were told by the ward manager that systems had been introduced to provide additional support to staff during the COVID-19 pandemic. This includes access to the health board's occupational health service, Health and Wellbeing team, Palliative Care team, counselling and psychology support. In addition, we were told that staff have access to the family room on the ward, and Chaplaincy room, should they need time away from the clinical area.

We were told that staff are supported on a day to day basis by the ward manager and more experienced nurses on the ward. In addition to the more informal day to day support, we were told that Performance Appraisal and Development Reviews (PADR) are conducted on a regular basis. We were provided with documented evidence of PADR completion rates which shows very good compliance.

The following areas for improvement were identified:

We were provided with a copy of the health board's Procedure for NHS Staff to Raise Concerns, and found that this was due for review on 2 February 2021. We were also provided with a copy of the health board's Deteriorating Patient Policy, and found that this was due for review on 2 June 2020. We were also provided with a copy of the health board's Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust Protocol, and found that this was due for review in November 2020. We appreciate that the health board has had to prioritise its response to the COVID-19 pandemic over other aspects of the service, and although we received assurances from the ward manager that all policies will be reviewed in due course, the health board must provide HIW with details of how it intends to ensure that policies, procedures and protocols are reviewed and, where necessary, amended to ensure that they are up to date and take account of current guidance, standards and regulations.

We were told that staff mandatory and statutory training compliance is recorded, and that staff development is enhanced and opportunities created in relation to professional development, leadership and clinical skills. However, information presented as part of the self-assessment shows mandatory training completion rates to be low in some subjects, i.e. Fire Safety - 70%, Health and Safety - 70%, Manual handling - 60%, Violence and Aggression – 66.67%, COVID-19 Compliance 50%. The ward manager explained that completion rates were low in these subjects due to staff having issues accessing the on-line training modules.

The health board must ensure that all staff complete training in all mandatory subjects as a matter of priority.

[4] Datix is the reporting system for recording clinical incidents or 'near misses'. It allows for the sharing of the details of incidents; enabling weaknesses in the system to be identified, customs and practices to be changed and staff to be retrained where necessary. Datix allows incidents to be reported in real-time reducing delays experienced with paper systems.

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: Usk 3/2

Date of activity: 21 April 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	The health board must provide HIW with details of how it intends to ensure that policies, procedures and protocols are reviewed and, where necessary, amended to ensure that they are up to date and take account of current guidance, standards and regulations.	2.1 Managing Risk and Promoting Health and safety 2.7 Safeguarding Children and Safeguarding Adults at Risk 3.1 Safe and Clinically Effective care 5.1 Timely Care 6.3 Listening and	• Identification of policies needing review – prioritisation is based on polices that impact patient and staff safety and experience. • Engaged author/senior manager – to commence the review process for policies “owned”. • Communication plan – plan being developed to inform staff and departments including utilising the Health Board’s intranet and direct departmental engagement. • Strengthening of communication with departments to ensure policies are and remain a key focus	Head of Corporate Services – Risk and Assurance	In progress August 2021

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
		Learning from Feedback	• Policy Register – Exploration of an information management system to proactively assist future management. In respect of the 3 lapsed policies identified, 1. **Procedure for NHS Staff to Raise Concerns** – an All Wales policy adopted by the Health Board; Human Resources notified should they wish to raise this at a national level. 2. **Deteriorating Patient Policy** – currently under review and is scheduled for ratification at next Clinical Standards and Policy Group in July. 3. **Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust Protocol** - currently being reviewed by the Gwent safeguarding Board. The Regional Protocol is in the process of being updated and the Head of Safeguarding Chairs the task and finish group that is responsible for this work. The content is largely complete but there is also a National update underway so we are awaiting an update as to timeframes for this National piece		

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
			of work. If there is likely to be any delay the Regional Guidance will be published ahead of the National update.		

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
2	The health board must ensure that all staff complete training in all mandatory subjects.	7.1 Workforce	• Monthly focus to increase compliance. • Increased compliance >85% within 3 months.	Senior Nurse/Ward sister	August 2021 **Update - 11/05/21** Current ward compliance is 74.7%

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: Penny Gordon, Head of Nursing

Date: 7/5/21