Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Quality Check Summary

## Ward 1, Ysbyty Cwm Cynon

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# Findings Record

## Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ward 1, Ysbyty Cwm Cynon as part of its programme of assurance work. Throughout the pandemic, Ward 1 was designated as the COVID-19 ward for the Ysbyty Cwm Cynon site. However, at the time of the quality check taking place, the ward had returned to providing care to older adults.

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 Site Senior Nurse and the Ward Manager on 19 May 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 there was a booking system in place to manage visiting, which staff told us had helped to maintain social distancing. This booking system included asking visitors a number of COVID-19 related questions to ensure that they were not displaying symptoms. Staff told us that access to video calls through phones and tablets had also helped patients to maintain contact throughout the pandemic.

We were told that a weekly surgery style drop-in had been successfully trialled. This provided patients and relatives with a regular, allocated time to speak to a doctor and the ward manager regarding their care and treatment. Staff told us that they were hopeful this would be rolled out on a permanent basis.

We found that patient dignity was maintained in a number of ways. Staff confirmed that screens and curtains were available on the ward. Protected mealtimes were in place, which aims to minimise the disruption to meal times from visitors. However, we were told that relatives are welcome to support patients who would benefit from additional help.

There was a positive initiative being trialled on the ward called the promoting independence programme. This involves ward staff and occupational therapists (OTs) capturing individual patient needs in areas, such as toilet use, seating, washing and dressing. The staff that we spoke with were highly complementary of the input provided by the OTs in supporting patients.

We were also told by staff that an enhanced supervision framework was in place and we saw examples of this. This tool is designed to alert nursing staff of patients who may require additional support based on their presentation, such as increased agitation or risk of falls. Staff added that this is used in conjunction with intentional rounding[1] to help meet patients' fundamental care needs.

For patients with memory difficulties, staff told us that 'This is Me' leaflets[2] are used on the ward. These aim to record a range of personal details to support staff to better understand

[1] Intentional rounding is a set of checks carried out by nurses at set frequencies to ensure that safe and dignified care is being provided
[2] A tool provided for use by Alzheimer's Society

the needs and preferences of the patient.

The setting had undertaken a number of audits, including falls and tissue damage audits. We reviewed a sample of these and found that positive scores had been achieved. The ward manager told us that incidents are reviewed daily and that moderate and high risk falls are reviewed at a scrutiny panel. This is attended by ward staff and the health board's patient safety team, which helps to monitor and aid learning from incidents.

**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:**

Staff described how staff are kept up to date the latest IPC guidelines. This included communication through weekly huddles, by email and by maintaining a folder of printed policies and procedures.

We were told that staff had received training in how to don and doff PPE and that correct usage of PPE was monitored by audits and spot checks by the senior nurse. The ward manager added that IPC training needs are discussed through monthly individual staff meetings.

Staff confirmed that new patients are admitted into a cubicle and are tested for COVID-19 at appropriate intervals. This helps to minimise the potential transmission of COVID-19 to other staff and patients on the ward.

We were told that weekly ward level audits are undertaken by the ward management. We saw examples of two completed audits, including hand hygiene and PPE usage. Both of these were scored positively. Staff also noted that there was an IPC nurse linked to the ward and that regular advice and support had been provided throughout the pandemic.

It was confirmed to us that there had been no COVID-19 outbreaks on the ward in the last three months. There had been one non-COVID-19 related infection, which we found had required no further investigation by the IPC team.

**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:**

The senior nurse at the hospital site demonstrated a clear knowledge of the ward. Both staff that we spoke with were enthusiastic about a number of initiatives that were being, or that were about to be, trialled. Both staff added that ward staff had responded admirably well to the challenges posed by the pandemic.

Staff told us that there had been staffing shortages during the pandemic, however, we were told that this had since improved. We found that there were agreed staffing levels across the service and that the ward manager undertakes a daily review of the roster to ensure that the staffing numbers and skill mix is appropriate. The ward manager described a clear process that would be followed should additional staff be required.

It was confirmed to us that all staff had completed a COVID-19 workforce risk assessment. This helped to ensure that staff could attend work safely. Staff described ways in which support was provided to ward staff during the pandemic. This included regular phone check-ins with staff who were shielding and recommending use of the employee assistance programme for staff who required additional support.

We considered what arrangements were in place to ensure that do not attempt cardiopulmonary resuscitation (DNACPR) discussions were held in an appropriate and sensitive manner. Staff told us that there is a robust process that is well understood by the wider team and that patients and relatives are an important part of any discussions.

We found evidence of clear processes for reviewing the discharge of patients. Staff told us that the discharge liaison nurse attends weekly meetings and attends the ward on a daily basis. Staff added that discharge planning notes are accessible to all members of the multi-disciplinary team and that there is positive input from social services.

We were provided with a summary of incidents and found that these had been appropriately reported through the health board's incident reporting system. We discussed with staff one incident that was known to HIW. Staff were knowledgeable of the details of this incident and were able to describe what initial learning and corrective actions had been taken.

**The following areas for improvement were identified:**

We found low levels of compliance with mandatory training. Staff told us that this was due to pressures of the pandemic, as well as workforce disruptions and the suspension of face-to-face training. The ward manager recognised this as an issue and had begun to take steps to improve this, for example by identifying outstanding training needs through individual staff meetings. It was positive to hear that bespoke training, including dementia awareness, had been organised as an interim measure.

The health board must monitor the wards progress with mandatory training compliance and provide HIW with updates.

# 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: Ysbyty Cwm Cynon Ward: 1 Date of activity: 12 May 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 monitor the ward's progress with mandatory training compliance and provide HIW with updates. | Health and Care Standards 7.1 | 1. Ward Manager to review hierarchy on Electronic Staff Record (ESR) with a view to ensuring that the staff establishment information is correct. | Ward Manager | 2nd July 2021 |
| | | | 2. Ward Manager to review competencies with a view to ensuring that these are correct and reflect the requirements of the role/band. Where it is identified that the competencies are inappropriate the data will be cleansed and competencies removed. | Ward Manager | 9th July 2021 |
| | | | 3. Once the above exercise has been completed staff will be booked onto the required training. | | 16th July 2021 |
| | | | 4. In keeping with the wider Clinical Service Group (CSG) performance plan, the ward will be required to demonstrate a 5% or more increase in mandatory training compliance per month. This will be reported to the CSG Manager. Compliance with mandatory training will be discussed. | Ward Manager | Ongoing - monthly |
| | | | 5. Ongoing compliance will be discussed and monitored during monthly 1:1 meeting with Ward Manager to ensure that the data and compliance is accurate. | Ward Manager/Senior Nurse | Ongoing – monthly |
| | | | 6. Evidence to demonstrate that the above actions have been completed will be forwarded to HIW via Objective Connect by 12 August 2021. | Senior Nurse | 12th August 2021 |

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|---|---|---|---|---|---|
| | | | **Note:** There are potential barriers to achieving the 5% increase, these include:-<br><br>All Face to Face training was discontinued during the COVID pandemic to reduce the risk of transmission. Some mandatory training continued to be delivered online, however this was not possible with all mandatory training.<br><br>Against this background, some Face to Face training is in the process of being reinstated. These training days will still be subject to social distancing rules and limited numbers in the training venues which will affect the number of places available.<br><br>A review of compliance with online mandatory training revealed difficulties in accessing ESR during work hours and from home. In addition, the ESR system is sometimes inaccessible due to IT issues – this is an All Wales challenge. | | |

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: Claire L Powell

Date: 16th June 2021