Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

HIW Hospital Inspection Report (Unannounced)

First Floor Ward, Velindre Cancer Centre, Velindre University NHS Trust

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an inspection of the inpatient ward at Velindre Cancer Centre on 12 and 13 July 2022. The Trust was provided with a 24 hour notice period owing to the nature of the ward with the intention of ensuring our teams have time to communicate with staff to allow time for COVID safe arrangements to be put in place for the inspection.

The following hospital ward was reviewed during this inspection:

- First Floor Ward - 30 beds providing a breadth of inpatient oncology care and treatment

Our team for the inspection comprised of 2 HIW Inspectors, 2 clinical peer reviewers and 1 patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, we found that patients were provided with a positive experience. We observed kind and respectful interactions between staff and patients, and there were effective processes in place to capture, respond to and learn from patient feedback.

This is what we recommend the service can improve:

- Strengthen the dementia provision on the ward

This is what the service did well:

- Kind and respectful staff interactions
- Effective patient feedback processes

Safe and Effective Care

Overall summary:
Overall, we found that the ward and wider Trust was committed to maintaining patient safety, which was evident through its audit and governance processes. Some of the improvements that we identified, such as falls prevention, had already been recognised by the Trust and we saw evidence that work is underway in these areas.

This is what we recommend the service can improve:

- Continued focus on falls prevention
- Aspects of medicines management
- Individualised care planning and aspects of record keeping

This is what the service did well:

- Aspects of infection prevention and control (IPC)
- Aspects of blood management
- Aspects of audit activity

Quality of Management and Leadership

Overall summary:
We found good management and leadership on the ward with staff commenting positively on the support that they receive from the ward manager.

This is what we recommend the service can improve:

- Aspects of staff feedback could be reflected upon

This is what the service did well:

- Positive ward management and leadership was identified

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used HIW questionnaires to obtain views and feedback from patients. A total of 3 were completed, as patient contact was limited during this inspection due to the COVID-19 status of the ward. Patient comments included the following:

> *"Patient feels ward is very friendly. Good choice of food"*
> *"Nice and peaceful for recovery. Patients encouraged to go outside"*
> *"A hospital like no other"*

We also reviewed internal patient feedback logs to help us form a view on the overall patient experience.

Staying Healthy

Health Protection and Improvement
There was a range of information leaflets available in the patient information centre located near to the ward for patients and relatives to read and take away. These leaflets were informative, treatment specific and provided patients with an overview of their procedure.

There were a number of posters and reminders related to COVID-19 safety. This included reminders to wear masks and the promotion of good hand hygiene.

Dignified care

Dignified care
We observed kind and respectful interactions between all staff and patients at all times. Patients who completed a HIW questionnaire told us that they had been treated with dignity and respect by the staff at the hospital and that they felt listened to.

The ward environment overall provided patients with an appropriate level of privacy and dignity. Patients benefited from a number of individual cubicles or had access to curtains if they were located in a bay.

All but one staff member who completed a HIW questionnaire agreed that patient privacy and dignity is maintained on the ward.

Communicating effectively

We observed staff talking to patients in a respectful, professional and appropriate tone at all times during the inspection. This extended to clinical and non-clinical staff.

We found that bilingual (Welsh and English) signage was displayed throughout the ward and wider hospital. We were told that whilst there was a limited number of Welsh speaking staff on the ward, staff who could speak Welsh wore a 'Cymraeg' logo on their uniform to encourage use of the language. One patient indicated that they were a first language Welsh speaker but told us that they were only 'sometimes' offered the opportunity to speak Welsh and that no Welsh language information was offered to them. Senior management informed us that there were plans in place to improve the Active Offer[1] and we saw evidence in support of this.

We noted that a digital interpreter service was available on the ward and that patient information provided by the charity Macmillan was available to be requested in other languages or in braille for the visually impaired.

Patient information

There was a range of information leaflets available in the patient information centre located near to the ward for patients and relatives to read and take away. These leaflets were informative, treatment specific and provided patients with an overview of their procedure. There were also a number of posters and reminders related to COVID-19 safety.

We noted that patient status at a glance boards were in use on the ward which contained an appropriate level of information related to each patient. These boards were kept in secure areas of the ward in order to protect patient confidentiality.

Timely care

Timely Access

Overall, we found evidence that patients were provided with timely care during their time on the ward. Patient needs were promptly assessed upon admission and we observed staff assisting patients in a timely manner when requested.

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[1] An 'Active Offer' simply means providing a service in Welsh without someone having to ask for it.

There was clear evidence of transfer of care and discharge planning, which was documented in the patient records that we reviewed. This included assessment by other professionals within multidisciplinary team to facilitate a safe and effective discharge.

Individual care

People's rights

We found that the multidisciplinary team enabled patients' individual needs and rights to be considered as part of the approach to their care. Access to clinical counselling, spiritual and third sector services work closely with the ward to support patients.

There were no patients under Deprivation of Liberty Safeguards (DoLS) at the time of the inspection. However, the ward manager was aware of the procedure and was able to describe the process that would be followed. We found compliance with DoLS training to be at a high level amongst ward staff.

We reviewed dementia initiatives and awareness on the ward and found that schemes such as the Butterfly scheme were no longer in use. We also found that dementia training was not mandatory for ward staff at the time of the inspection, although we were informed that new dementia and associated training will imminently become mandatory for staff.

The Trust must ensure that there is close focus on the dementia provision given the noted increase in DoLS patients and falls associated with confusion.

Visiting was restricted at the time of the inspection, except for reasons of compassionate grounds. Wi-fi was available on the ward to enable patients to use their phones and tablets as required. We were informed that patients who were at end of life would be allowed to receive visitors and a family room was available on the ward.

Listening and learning from feedback

We found that patients were provided the opportunity to provide feedback on their care, treatment and overall experience. Posters with QR codes were displayed throughout the ward and staff told us that they encouraged patients to provide feedback. We found that the system was effective in providing leadership and ward management with detailed results, enabling learning to be shared clearly and widely.

We found that Putting Things Right information was available on the ward and throughout the wider hospital.

We reviewed a sample of three complaints outcomes and found that these had followed an appropriate review and follow-up process. Where identified, actions had been implemented by the ward manager in a timely manner, which included communication to the wider ward team.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We found that measures were in place to manage risk and to promote the health and safety of patients, staff and visitors. The ward was accessible for those with a disability or mobility difficulties, and we observed the ward to be secure with buzzer access to prevent unauthorised access.

The internal ward environment was visibly clean and reasonably well organised, although some staff told us that space was limited in some parts of the ward. We noted that access to the cleaner's room was wedged fully open during the inspection. The Trust must ensure that this door remains locked when not in use to prevent access to hazardous substances.

We reviewed the emergency resuscitation trolley and found that staff checks had been completed on a consistent basis. All items observed were complete and in-date.

Preventing pressure and tissue damage
In all ten patient records that we reviewed, we found that patients had been assessed for pressure ulcer risk upon admission and there was evidence of an appropriate skin assessment, which were completed to a good standard. However, we noted that, whilst the nursing assessments were comprehensive, individualised care plans were not reflected within the patient notes.

We noted that there was evidence of on-going monitoring of pressure areas and evidence of repositioning patients in all but one record. Access to a tissue viability specialist was available if required.

We found robust arrangements for the reporting and monitoring of pressure and tissue damage. This included review at a Scrutiny Panel, which included a breadth of staff at various levels of seniority and the production of a monthly report to aid effective learning at a ward level.

Falls prevention
In all ten patient records that we reviewed, we found that patients had been assessed for risk of falls. However, where we identified patients who were a falls risk, we did not find an up-to-date and individualised care plan for two out of the three at risk patients. We did however find evidence that post falls observation

charts were completed and multidisciplinary team input was provided in a full and timely manner in one record where a fall had occurred.

We noted that falls on the ward had persistently been given a red or amber rating in the Trust's performance indicators at a corporate level. This is due to the rightful low tolerance that the Trust places on fall incidents. It was to note that the Trust had completed a recent comprehensive audit of falls and that plans were in place to review the falls procedure and to implement a patient supervision policy. The ward manager also explained how learning is fed back to ward staff and provided examples of changes that had been made in response.

The Trust must maintain a close focus on falls prevention on the ward and monitor the timely implementation and effectiveness of the above measures. The Trust may also wish to consider implementing intentional (safe) rounding on the ward as an additional proactive measure to aid the delivery of safe and effective care.

Infection prevention and control (IPC)
Overall, we found the ward environment to be visibly clean in all areas. The environment appeared to be well maintained, which helps to promote effective cleaning. Cleaning schedules were available and were completed on a consistent basis.

All shared equipment was clean, with stickers indicating this, and equipment was covered where appropriate. Disposable curtains had recently been replaced and sharps boxes were in use and secure.

The ward had a number of COVID-19 cases affecting patients on the ward at the time of the inspection. We found that patients were isolated as far as possible and we observed staff wearing, changing and disposing of appropriate personal protective equipment (PPE). We also observed good hand hygiene measures being adhered to by staff on the ward.

We spoke with IPC staff who described suitable arrangements for the response to and monitoring of any outbreaks on the ward. This included convening outbreak meetings, increased audit activity, microbiologist input and a post incident review to capture any learning. An example of learning included the need to re-introduce rapid COVID-19 testing on the ward.

In the patient records that we reviewed, we found that there was a general infection risk assessment and evidence of COVID-19 risk assessments. The Trust confirmed that COVID-19 tests are performed on admission for every patient.

It was positive to note that there were notably low infection rates in a number of areas, including catheter related infections. Aseptic Non Touch Technique (ANTT) compliance on the ward was also maintained to a high standard and we were informed that the Trust is preparing to apply for gold accreditation to reflect the positive practice.

Nutrition and hydration
We found that patients were provided with meals in a timely manner and staff were available to assist if required. Patients had access to water, which we observed to be within arms reach.

Nutritional needs were clearly recorded on Patient Status at a Glance Boards and we observed specific needs (e.g. coeliac) was marked on the patient cubicle door as an additional reminder for staff.

Staff informed us that there were positive links with dieticians who formed part of the multidisciplinary team and we found that there were generally timely specialist referrals when required.

In two records, we found that patients had been regularly weighed, had a mouth care and nutritional assessment completed, and nursing notes and paper care plans were completed to a good standard. However, the Trust must ensure that nursing documentation fully reflects patients nutrition and hydration needs to ensure that all nursing and healthcare support staff are able to meet patient needs in a timely and effective manner.

Medicines management
We found that medication was consistently signed and dated when prescribed and administered and all medication was legible. However, we found that patient names / ID's were not consistently recorded on all pages in the majority of the records that we reviewed.

The ward has access to a pharmacy cover and there were appropriate arrangements in place for accessing medicines out of hours. We found that intravenous fluids were prescribed and recorded appropriately, and the administration of all medication was recorded in a consistent and contemporaneous manner.

We noted that patients do not administer their own medication, although we were informed that this was under review at a corporate level. We observed that patient lockers were secured when not in use.

We found that the medication rooms were secured from the outside, although we noted that individual medication fridges were not locked. We saw evidence of fridge

temperature checks being completed on a consistent basis and controlled drugs checks were being completed at the appropriate intervals.

We were unable to observe a medication round during the course of this inspection.

Safeguarding children and safeguarding adults at risk
We found evidence in all patient records that questions related to safeguarding and mental capacity were discussed with patients and were appropriately recorded.

There was clear Trust policies and procedures in place for staff to follow in the event of a safeguarding concern and there was a safeguarding lead within the service for professional advice.

We reviewed staff training records in relation to safeguarding and found high level of completion amongst staff groups on the ward. There were no open safeguarding cases or concerns on the ward at the time of the inspection.

Blood management
The service manages and stores its own blood products. We found that there were staff trained to check, monitor and order the blood products, and that there was a suitable process in place to monitor the safe and appropriate use of blood products.

We noted that staff had received training for blood transfusions and that there were appropriate checks in place to ensure that patient identification and blood component checks are established at all stages of the transfusion process.

Medical devices, equipment and diagnostic systems
We found that the ward had the right equipment and medical devices to meet the needs of patients. There were appropriate processes in place for the checking of equipment on the ward, but we noted that two of the ECG machines on the ward required an annual maintenance service.

The Trust must ensure that medical devices and equipment is reviewed within the appropriate timeframes.

Effective care

Safe and clinically effective care
There was evidence of sound multidisciplinary team working between the nursing and medical teams on the ward.

We found evidence that patients with suspected sepsis are identified and treated within the appropriate timeframes using relevant national screening tools. Monthly

audits demonstrated generally good levels of compliance in identifying and treatment of sepsis cases. We noted that sepsis training is provided in house and was well attended by nursing staff.

We found evidence that pain relief was managed appropriately. There was evidence that pain was being measured, actioned and evaluated at regular intervals using an appropriate national assessment chart. All patients had an up-to-date pain score recorded and suitable pain relief was administered when necessary. Whilst assessments were completed to a good standard, we recommend that individualised care plans are used, particularly given the patient group being cared for.

We were assured that the discussions related to DNACPR[2] was undertaken appropriately and sensitively. We saw evidence the DNACPR forms were completed to a high standard and that discussions had been held with individual patients and their relatives where it was appropriate to do so.

We were informed that recently implemented treatment escalation plans were also in use on the ward to help guide future clinical interventions. However, we found no evidence in four patient records we reviewed of a treatment escalation plan or, if required, discussions related to DNACPR. One of these records involved a palliative care patient who was admitted very unwell. We recommend that the Trust ensures that where these discussions or forms of escalation are not considered necessary that details of the decision making are recorded within the patient notes to evidence an appropriate audit trail.

Quality improvement, research and innovation

There was evidence of a breadth of clinical audit activity which was mapped against performance indicators. We saw evidence that audit activity was closely monitored at a local and corporate level, and that clear learning outcomes were identified and disseminated to ward staff.

Information governance and communications technology

We found that patient records and identifiable patient data was kept securely to ensure that confidentiality was maintained. There was a combination of electronic and paper records in use at the service, with paper records stored in locked offices to prevent unauthorised access.

We found that the majority of staff on the ward had completed information governance training.

[2] Do not attempt cardiopulmonary resuscitation

Record keeping

The Trust had recently implemented the Welsh Nursing Care Record (WNCR) system, which we found to be a beneficial addition to the ward. The electronic nursing assessments that we reviewed were overall thorough and robust, however, it was unclear in several patient records what care plans were implemented following relevant assessments. The absence of these care plans and notes made it difficult for us to accurately provide an informed view on the care and treatment provided to those patients. Some records were also missing relevant charts, such as medication and NEWS[3].

We also noted that access to records, particularly the electronic system, is only accessible to certain staff groups. Aspects of patients records are also split across systems, including CANISC[4] and a paper file, which can give rise to a potential lack of MDT approach to unified care.

Overall, the patient document that was available was completed to a satisfactory standard. We saw positive examples, including a 'What matters to me'[5] form completed to a high standard, containing person-centred detail and written in the patient's own words. A treatment escalation plan and DNACPR form that we reviewed was also completed to a high standard, with the involvement of the patient and their relatives.

The Trust must consider how care plans are completed and reviewed to ensure that individualised patient care can be captured and demonstrated within patient notes. The Trust should consider how its patient record systems align to ensure that there is a unified and streamlined approach to the access and review of patient notes by all staff groups

[3] National Early Warning Score (NEWS)

[4] Cancer patient record management system

[5] This aims to encourage and support more meaningful conversations between people who provide health care and the people, families and carers who receive care.

Quality of Management and Leadership

Governance, Leadership and Accountability

We found good management and leadership on the ward with staff commenting positively on the support that they receive from the ward manager. However, a number of staff commented that communication and decision making involving senior management could be strengthened.

We found that there were clear governance processes in place to ensure that the Trust placed a strong focus on quality and safety, and we saw evidence that there was a generally effective flow of information from board to ward.

Workforce

We found kind and respectful staff and we observed positive interactions between staff and staff and patients.

We found that there were sufficient numbers and skill mix of staffing during the inspection. We noted that staff absences due to sickness had caused some difficulties in recent months, but we noted that the ward occupancy was reduced to help ensure that patient needs continue to be met. Senior staff told us that the requirement for inpatient care had reduced significantly during the pandemic due to a reconfiguration of outpatient care and treatment.

During the inspection, we distributed HIW questionnaires to staff to seek their views on the service. We received 14 completed questionnaires. Some of the highlights include:

All but one staff member who expressed a view recommend their organisation as a good place to work and would be happy with the standard of care provided by their organisation for themselves, their friends or their family.

All but one staff member agreed that their training, learning and development helped them to do their job more effectively and all staff told us that they had completed an appraisal within the last 12 months. We asked staff whether there was any other training they would find useful, they told us:

'Venepuncture and cannulation'
'Airways'

Only half of staff agreed that they have enough time to give patients the care they need, with half of staff disagreeing that there are enough staff for them to do their job properly. Staff comments included:

'Assess staffing for each shift for the ward need'
'Use agency to help with staff shortages'

Despite this, all staff indicated that they were satisfied with the quality of care they give to patients and all agreed patients and their relatives are involved in decisions about their care. All but one staff member agreed that patient privacy and dignity is maintained at all times.

All staff who expressed an opinion agreed that their manager can be relied upon to help with a difficult task and all but two agreed that their line manager asks for their opinion before making decisions that affect their work.

However, the majority disagreed that communication between senior management is effective and disagreed that senior management try to involve staff in important decisions. Despite this, all agreed that senior managers are committed to patient care.

All staff who expressed an opinion agreed their organisation encourages them to report errors, near misses or incidents and that they know how to do this. All but one agreed their organisation takes action to ensure that they do not happen again. Despite this, the majority of staff disagreed that they are given feedback about changes made in response.

The majority of staff agreed that there are appropriate IPC procedures in place. However, only half of staff who expressed an opinion agreed that their organisation has implemented the necessary environmental changes in response to COVID-19. One comment included:

'Separate area for COVID patients'

The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required..

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans 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 inspection.

As a result of the findings from this inspection 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.

Appendix A - Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified			

Appendix B - Immediate improvement plan

Service:

Date of inspection:

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues were identified				

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.

Service representative:

Name (print):

Appendix C - Improvement plan

Service: First Floor Ward, Velindre Cancer Centre

Date of inspection: 13-13 July 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The Trust must ensure that there is a close focus on the dementia provision on the ward. This may include implementing a patient identification system on the ward and a review of the current non-mandatory approach to training	Standard 4.1	The Enhanced Supervision Policy to be fully implemented. The policy will identify the requirements of patients with confusion or cognitive impairment e.g. closer supervision, open visiting.	M Walters, Operational Senior Nurse R Hathaway, First Floor Ward Manager	30th October 2022
		Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to assess effectiveness.	R Hathaway, First Floor Ward Manager	From 3 months post implementation – January 2023.
		First Floor ward to implement "This is me" booklet for patients with dementia and cognitive impairment	M Walters, Operational Senior Nurse R Hathaway, First Floor Ward Manager	30th November 2022
		The implementation of "This is Me" booklet will be audited quarterly for the first year to assess effectiveness.	R Hathaway, First Floor Ward Manager	3 months post implementation – February 2023.

		A dementia awareness/ update session to be provided to all staff within a ward meeting	R Hathaway, First Floor Ward Manager	30th November 2022
		All staff to receive formal dementia training via the arrangement with Cardiff and Vale Heath Board	R Hathaway, First Floor Ward Manager	31st March 2023
		Ward to develop as part of patient status at a glance board, above beds & handover process a visual mechanism for all patients with cognitive impairment that's a visual reminder to all personnel.	R Hathaway, First Floor Ward Manager	30th November 2022
The Trust must ensure that the cleaning room on the ward is locked when not in use.	2.1	The operational services team to ensure the cleaning room remains locked at all times unless personnel are in the room	S Shepherd-Murphy, Operational Services Manager	Completed
The Trust must continue to carefully monitor falls incidents on the ward to ensure that the anticipated improvements are realised in a timely and effective manner.	2.3	Trust monthly falls scrutiny panels to continue	V Cooper Head of Nursing VCC	Completed
		All actions from the recent corporate nursing falls audit to be fully implemented	M Walters, Operational Senior Nurse R Hathaway, First Floor Ward Manager	30th November 2022

The Trust may wish to consider implementing intentional (safe) rounding as an additional proactive measure.		The ward Manager and Operational Senior to formally consider implementing intentional rounding.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	October 2022
		Enhanced Supervision Policy to be fully implemented which identifies the level of supervision a patient requires dependent on risk of falls, confusion, risk of patient becoming lost/ wandering.	M Walters, Operational Senior Nurse S Owen, Quality and Safety Manager	October 2022
		Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to assess effectiveness.	R Hathaway, Ward Manager	3 months post implementation – January 2023.
		The ward manager to implement the "Big 4" as a communication tool. Each day 4 important messages are relayed to staff at the midday safety huddle, including learning and improvements identified from scrutiny panels. The same big 4 themes are repeated for a week at each huddle to ensure maximum number of staff are informed.	R Hathaway, Ward Manager	Completed

The Trust must ensure that, following completion of risk assessments, patients are followed up at the required intervals and that these checks are evidenced within patient notes. This includes evidencing a plan of care or referrals to specialist services (e.g. dieticians) where required.	3.5	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing assessment include a care plan e.g. skin bundle. The ward manager, senior operational nurse, ward clinical educator, and digital CNS are meeting to formulate and roll out an improvement plan for documentation.	Rhian Hathaway, Ward Manager Matthew Walters, Operational Senior Nurse	December 2022
		Documentation, including risk assessments and care plans will be audited on a quarterly basis to ensure compliance and high standard of documentation evident.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	December 2022
The Trust must ensure that: • Patient names / IDs are recorded on all pages	2.6	All staff (doctors, nurses, AHP's) reminded to include patient ID on all pages. Included in Big 4, emailed to all doctors, emailed to all AHP, put on nurses Whatsapp work group. This information to be included in future documentation audits.	R Hathaway, First Floor Ward Manager M Walter, Operational Senior Nurse	30th September 2022

• Medication fridges are locked when not in use		All staff (nurses and pharmacy) reminded of safe storage of medication. Emailed to all pharmacy staff, included in Big 4, put on nurses Whatsapp work group, and emailed to Medicines Safety Group chair. Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to ward Medicines Safety Group.	B Tranter, Chief Pharmacist K Baker, Head of Therapies Dr E Gallop-Evans, Clinical Director	30th September 2022
The Trust must ensure that medical devices / equipment on the ward are serviced at the required intervals.	2.9	Ward manager and medical physics to undertake a spot check of all medical devices on the ward to identify devices/ equipment that need immediate servicing	R Hathaway, First Floor Ward Manager J Raiyani, Medical Physicist	30th September 2022
		Ward manager and medical physics to ensure a robust system in place for regularly checking the service date for medical devices/ equipment	R Hathaway, First Floor Ward Manager J Raiyani, Medical Physicist	October 2022
		Trust to consider implementing a Medical Devices electronic tracking system that recalls devices requiring service	J Raiyani, Medical Physicist	30th March 2023
The Trust must ensure that where DNACPR discussions or forms of escalation are not considered necessary that details of the decision making are recorded within	3.5	The clinical director discusses regularly with all doctors about documenting decision making around DNACPR and escalation in the medical notes at morning handover. To discuss at SMSC (Senior Medical Staff Committee) on 7th	Dr E Gallop-Evans	30th September 2022

the patient notes to evidence an appropriate audit trail.		September 2022. Speedy Cascade to be circulated with immediate effect. Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to clinical team. Ward daily midday safety huddle to include question regarding treatment escalation plan to ensure in place for all patients.	Dr E Gallop-Evans R Hathaway, Ward Manager M Walters, Operational Senior Nurse	Complete
The Trust must consider how care plans are completed and reviewed to ensure that individualised patient care can be captured and demonstrated within patient notes	3.5	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing assessment include a care plan e.g. skin bundle. The ward manager, senior operational nurse, ward clinical educator, and digital CNS to formulate and roll out an improvement plan for documentation.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	December 2022
		Documentation, including risk assessments and care plans will be audited on a quarterly basis to ensure compliance and high standard of documentation evident.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	From September 2022
The Trust should consider how its patient record systems align (or otherwise) to ensure that there is a unified and streamlined approach to	3.5	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. The Velindre Cancer Centre (VCC) is implementing WPAS in	M Walters Senior Operational Nurse (lead for the FF ward WPAS implementation)	30th December 2022

the access and review of patient notes by all staff groups		November 2022 and full use of WCP as the clinical record as part of its Canisc replacement, this will improve the current situation where there are multiple sources of documentation in relation to a patients care at VCC.		
Given the improvements identified above, the Trust should increase its record keeping audit activity.	3.6	Following improvements being made to documentation overall, regular audits will be undertaken quarterly to monitor risk assessments, care plans, referrals, and patient identification.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	December 2022
The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required.	7.1	The team have reflected on the staff feedback, there are in place multiple ways of receiving staff feedback, in relation to the specific feedback in this report the senior nurses will include themes from the feedback in the ward and team meetings agendas and in the daily Big 4 communications.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	October 2022
		Explore the use of Civica for regular staff feedback, pulse surveys, implement and monitor feedback from themes.	R Hathaway, Ward Manager M Walters, Operational Senior Nurse	October 2022

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.

Service representative

Name (print): V Cooper

Job role: Head of Nursing, Quality, Patient Experience and Integrated Care

Date: 02/09/2022