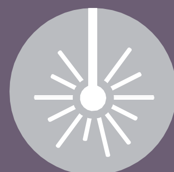
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Claerwen Ward, Llandrindod Wells Memorial Hospital, Powys Teaching Health Board

Inspection date: 17 and 18 January 2023

Publication date: 20 April 2023



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Digital ISBN 978-1-80535-835-0

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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.

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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 unannounced inspection at Llandrindod Wells War Memorial Hospital, Powys Teaching Health Board on 17 and 18 January 2023. We inspected Claerwen Ward, which provides rehabilitation of the elderly and palliative care services. At the time of the inspection the ward was operating at a maximum capacity of 21 beds.

Our team for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and one 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:
We saw evidence that staff provided respectful and dignified care. Patients were encouraged to be active and were given equipment to help them walk and move. We saw occupational therapists and assistants working well with patients throughout the inspection. We saw evidence of some initiatives that had been introduced to help care for patients living with dementia. The patients we spoke with during the inspection provided positive feedback about the care they had received while on the ward.

This is what we recommend the service can improve:

- Welsh speaking staff could be made more easily identifiable to patients, for example by wearing a 'iaith gwaith' badge
- Further work could be done to fully utilise all the initiatives available on the ward to provide dementia care in line with best practice guidelines
- A regular formal process of collecting patient and family and carer feedback should be implemented.

This is what the service did well:

- Staff attended to the needs of patients in a discreet and professional manner. This was particularly evident in relation to the care provided to patients requiring palliative care
- A defibrillator deactivation magnet was available to help provide better dignity for patients with implantable cardioverter defibrillators requiring end of life care.

Delivery of Safe and Effective Care

Overall summary:
We found that staff were committed to providing patients with safe and effective care. Suitable equipment was available and being used to help prevent patients developing pressure sores and to prevent patient falls. We were assured that the management and storage of medicines was being undertaken in a safe and effective manner. A pharmacy technician provided good support to staff on the ward. We found that the standards set out in the All Wales Hospital Nutrition Care pathway were generally being met.

Immediate assurances:

Throughout the inspection we had concerns over the arrangements in place to safely manage a patient emergency:

- We could not be assured whether the emergency equipment items were in date as no daily or weekly checks were being undertaken and recorded
- One staff member we spoke with did not know how to use the defibrillator
- Some staff members we spoke with did not know how to open the resuscitation trolley.

Details of the concerns for patient safety and the immediate improvements that were required are provided in Appendix A.

This is what we recommend the service can improve:

- Staff must be reminded about their responsibilities in relation to effective hand hygiene and audits must be effective at highlighting poor compliance
- Deprivation of Liberty Safeguards assessments must take place when required and recorded appropriately within the patient records to ensure patients are not illegally deprived of their liberty
- The individual needs of each patient must be documented, particularly around specifying what assistance is required during mealtimes
- The security of patient records must be improved; we saw multiple instances where patient records had been left unattended.

This is what the service did well:

- Yellow warning stickers were being used to warn staff of patients with similar names to avoid medication errors
- Incidents of pressure and tissue damage and falls were low, and falls prevention was being managed particularly well.

Quality of Management and Leadership

Overall summary:
The staff we spoke with told us that senior managers were visible and engaged with staff on a regular basis, and told us they felt able to report concerns. The ward was operating at a high acuity with many patients requiring enhanced patient support. Staff members that we spoke with during the inspection felt that it was often a challenge to spend enough time with patients and ensure care was being provided safely to these patients. There was a feeling that staff wellbeing was potentially at risk if patient acuity remained high. The health board must involve and communicate with staff when evaluating the evidence as part of the next staffing establishment review. We have recommended a large number of

improvements following the inspection which indicates there is work to be done to ensure senior managers have better oversight of the day-to-day running of the ward.

This is what we recommend the service can improve:

- A better system of enabling staff to monitor training compliance should be implemented
- Staff compliance with Intermediate Life Support should be taken into account when creating rosters to ensure staff working each shift have the appropriate skills in the event of an emergency
- Senior managers must ensure staff are kept informed of any improvements identified from audits, incidents or national patient safety notices.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we distributed HIW questionnaires to patients to obtain their views on the services provided. A total of two questionnaires were completed. We also spoke with patients on the ward when appropriate to do so.

Patients provided positive feedback about their experiences. Both patients who completed a questionnaire rated the service they had received as very good. All patients we spoke with were very complimentary about the care provided and about their interactions with staff.

Patients were asked in the questionnaires how the setting could improve the service it provides. The only comment we received was:

> *"More staff in the morning when bed making."*

Staying Healthy

Health Protection and Improvement
We saw information displayed throughout the ward about how patients could improve their health and wellbeing as well as details of local support services and groups. Patients we spoke with told us that staff have also provided them with information on how to look after themselves and their health.

The ward promoted protected mealtimes. This ensured that patients were not disturbed during breakfast, lunch and tea time. We observed patients receiving their meals at lunch time and saw staff assisting patients in a calm, unhurried and dignified way, allowing patients sufficient time to chew and swallow their food. Both patients who completed a questionnaire agreed that staff helped them to eat or drink when they needed assistance.

Dignified care

Dignified care
Both patients who completed a questionnaire said that they had been treated with dignity and respect by the staff at the hospital. The patients we spoke with also confirmed that staff had treated them with kindness.

We saw good interactions between staff and patients, with staff attending to patients' needs in a discreet and professional manner. This was particularly evident in relation to the care provided to patients requiring palliative care. Patients were able to wear their own clothes and bed bound patients appeared clean and well cared for.

Patients told us that they were offered either a daily wash or a shower. Both patients who completed a questionnaire agreed that staff gave them a choice about which method they wished to use when they needed the toilet, and provided assistance in a sensitive way. We observed staff closing curtains when administering care to patients to help protect their privacy and dignity.

The bathroom facilities on the ward were communal. During the inspection we found the bathrooms to be clean at all times. The furnishings and fittings though appeared tired and were in need of modernisation. Curtains were available in the communal washing area, but we did not feel this fully protected the privacy and dignity of patients using the facilities. Further information on the improvements required to the environment of the ward can be found in the 'Managing risk and promoting health and safety' section of this report.

It was positive to see that a defibrillator deactivation magnet was available to help provide better dignity for patients with implantable cardioverter defibrillators requiring end of life care.

Communicating effectively

Both patients who completed a questionnaire agreed that staff have talked to the about their medical conditions and helped them to understand them. Patients also agreed that staff have listened to them.

It was positive that the language requirement of patients was assessed on admission. We saw that some patient information was available to patients in Welsh and English. We were told that only a small number of nursing staff could speak Welsh. During our time on the ward, we could not easily distinguish whether any of the nurses spoke Welsh. **The health board should ensure Welsh speaking staff are easily identifiable to indicate to patients that they speak Welsh, for example by wearing a 'iaith gwaith' badge.** We were informed that translation services would be sought should patients wish to speak Welsh and no Welsh speaking staff were available.

We saw evidence of some initiatives that had been introduced to help care for patients living with dementia. For example, large clocks had been installed on the walls, and red trays and beakers were used to help staff identify which patients

needed extra attention when eating and drinking. However, we found other schemes were available but weren't being used. For example, although the ward had butterfly stickers, they were not being displayed to make staff aware which patients were living with dementia. In addition, we noted that although 'This is me' forms were available in patient records, they were not being completed by staff. **The health board must ensure they fully utilise all the initiatives available on the ward to provide dementia care in line with the guidelines described in the Dementia Friendly Hospital Charter for Wales**.

Patient information

Claerwen Ward was clearly signposted from outside and within the hospital. There was a board behind the nursing station that displayed the names of the staff on duty by day and night. However, there was limited information on display for patients and carers to help them during their time on the ward. For example, we could not see any information displayed in relation to mealtimes, language services, or how patients could make a complaint or raise a concern through the Putting Things Right process. We raised this with the ward manager who informed us that new folders were in the process of being created which will contain useful information for patients and carers to help them understand their care and provide an overview of the ward. **The health board must ensure these are produced in a timely manner.**

Timely care

Timely Access

Both patients who completed a questionnaire agreed that they had access to a call bell and that when they used it, staff came to them. The patients we spoke with did not raise any concerns about having to wait a long time when asking for help.

Individual care

Planning care to promote independence

Patients were encouraged to be active and were given equipment to help them walk and move. The ward had access to occupational therapists (OTs) and occupational therapy assistants and we witnessed these working well with patients throughout the inspection.

We saw staff spending time with patients and supporting them to be independent. We noted that one patient on the ward during the inspection had registered as visually impaired, and staff had put positive arrangements in place to ensure the patient could eat meals without assistance.

Some patients on the ward had a 'do not attempt cardiopulmonary resuscitation (DNACPR)' form in place. We saw evidence that showed discussions and decision making around DNACPRs had been undertaken and documented appropriately.

It was clear that discussions about patient discharges were happening between appropriate agencies and services. We saw evidence of packages of care that had been arranged for patients. Some patients we spoke with also confirmed that packages of care had been put in place. However, we could not always find clear evidence of this documented in the patient records. In addition, we noted that the discharge form on the Welsh Nursing Care Record (WCNR) digital system had not been completed for a patient that was discharged during the inspection. **The health board must ensure decisions around all aspects of discharge planning are fully documented in patient records and on WNCR.**

People's rights

Both patients who completed a questionnaire said they felt they could access the right healthcare at the right time regardless of any protected characteristics. We were told that patients can access advocacy services when required.

Visits to the ward by family and friends were bookable via one hour slots between the hours of 1pm and 6:30pm. Some patients reported that this was not always convenient for family or friends due to work commitments. However, the ward manager told us that the visiting hours can be flexible if necessary and that staff would make sure any requests are accommodated wherever possible.

Listening and learning from feedback

Throughout the ward we saw numerous thank you cards being displayed from past patients. While it is good practice to share positive feedback with staff, we noted that no structure was in place to capture the views of patients or their family and carers. **The health board must implement a regular formal process of collecting patient and family and carer feedback to help identify any necessary improvements and enable the hospital to demonstrate listening and learning from patient feedback.**

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We saw that the entrance to the ward was kept secure at all times during the inspection. However, visitors to the ward had to knock the door because there was no buzzer or call bell to the nursing station. This meant that some visitors were kept waiting outside until a staff member was able to let them in. We were also told by patients near the door that the regular knocking can be a disturbance. **The health board must review the access arrangements on to the ward to ensure patients are not disturbed.**

The ward environment was generally accessible for people with mobility difficulties. We did note there was a lack of space in the communal bathrooms by the wash basin areas, and that there was only one walk in shower available.

The corridors were generally clean and clear from clutter. It was clear that the ward environment was looking tired and in need of attention. We were informed that some estates work was in the process of being undertaken, which included replacing metal bins with plastic bins and the installation of lockable information boards for the corridor walls. We were also told that the ward would be shortly undergoing a refurbishment, which we welcomed as a positive move to modernise the environment for patients. However, we noted a number of issues related to the environment that needed to be fixed in the meantime. This included:

- Paint had peeled away in places on the corridor walls, particularly outside bays 2 to 7
- The communal bathroom facilities and furnishings were well worn and in need of modernisation, including providing patients with more accessible options to shower and with more privacy
- Tape was being used on the flooring to cover gaps between floor panels which presented as a trip hazard to vulnerable patients
- The roof in the female staff changing room had a visible leak and was in need of repair
- No changing facilities were available for male staff.

The health board must ensure the environment remains suitable for patients until the refurbishment, which would include, but not limited to, rectifying the issues listed above.

During the tour of the ward, we noted that some areas were not being kept tidy. We raised this with staff and it was positive to note that these areas had been tidied by the end of the inspection.

While we were informed that visual checks were being regularly made on the environment by staff, this was not evidenced. We were provided with a health and safety folder, but noted that relevant information was either missing, or was out of date. For example:

- Only one Control of Substances Hazardous to Health (COSHH) risk assessment was contained in the folder
- The health and safety policy was not the most recent version
- Risk assessments appeared to be at least two years out of date.

Senior staff assured us that a new health and safety risk assessment was due to be undertaken and that documented ward walk arounds were to be re-introduced shortly to monitor the safety of the environment. **The health board must provide evidence of progress and the actions taken since the inspection in relation to these issues.** We did note appropriate documentation was available in respect of fire safety throughout the ward.

Preventing pressure and tissue damage

We saw evidence that patients were being assessed for whether they were at risk of developing pressure and tissue damage on admission. Patients also received appropriate skin assessments. Senior managers had good oversight of incidents of pressure and tissue damage through monthly scrutiny meetings to review incidents and identify any lessons learned. However, during our review of patient records, we identified the following issues:

- We saw two instances where care plans had not been developed for patients as required by their skin assessment score
- We could not see evidence of frequent repositioning throughout the day and night for three out of the five patient records
- In all five patient records we saw instances where patients had not been monitored as often as required by their care plans. For example, one patient was required to be checked every eight hours, but we saw that checks had not occurred for 11 hours and 12 hours on two separate occasions within a three day period.

Although instances of pressure and tissue damage acquired on the ward appeared to be low, **the health board must rectify the issues identified above to help prevent instances of pressure and tissue damage in patients going forward.**

Falls prevention
We were assured that suitable processes were in place to help prevent falls from patients throughout the ward. Falls prevention equipment and mats were being used. The number of incidents of patient falls was relatively low, which was positive considering the layout of the ward made it difficult to always monitor patient movements. Senior managers again had good oversight of incidents, with scrutiny meetings taking place every two weeks to review incidents and identify any lessons learned. Improvements were required in some areas:

- Fall care plans had not been developed for two of the four patients that required them
- One patient had not received their falls risk assessment in a timely manner; the patient was assessed the day after their admission
- The reducing falls policy was last reviewed in 2019 and needed updating.

The health board must action the improvements listed above. However, in general, we felt that falls prevention was being managed well.

Infection prevention and control
During our inspection the floors and surfaces of the ward appeared clean. We saw cleaning schedules displayed on the wall which were being maintained appropriately. Both patients that completed a questionnaire, and all patients we spoke with, felt that the ward environment was kept clean throughout their stay.

We saw that Personal Protective Equipment was available and excess stock was being stored appropriately. However, during the inspection we observed clean PPE (e.g. face masks) for staff and visitors placed on top of a clinical waste bin at the entrance to the ward. We raised this with senior staff who immediately moved the PPE and set up a new station for clean PPE.

We saw hand washing facilities and hand sanitiser dispensers available throughout the ward. Hand hygiene audits were being regularly undertaken, and we noted that compliance with the December 2022 hand hygiene audit was 100%. However, we visually observed very poor compliance with best practice hand hygiene techniques from staff during our inspection. For example, we observed a doctor shake hands with a patient and then move on to the next patient without decontaminating his hands in between. We also witnessed staff moving from one patient bay to another without washing their hands after patient contact. **The health board must remind staff about their responsibilities in relation to effective hand hygiene and ensure audits are effective at highlighting poor compliance.**

We reviewed the minutes of previous staff team meetings and saw that there had been multiple reminders provided to staff about adhering to the uniform policy. However, despite these reminders, throughout the inspection we saw instances of staff contravening the uniform policy. For example, some staff members were not bare below the elbow, and some staff members were wearing clothing over their uniform. **The health board must take action to ensure staff adhere to the uniform policy at all times.**

Equipment generally appeared to be well maintained, apart from one air pressure cushion which was torn. We raised this with staff who immediately arranged for the cushion to be replaced. While the equipment appeared to be clean, we saw that stickers were not being used to indicate to staff that reusable medical equipment was clean and safe to use. We did not raise this with staff at the time, but we did note that on the second day of the inspection the stickers had started to be used.

We spoke with housekeeping staff who were aware of their roles and responsibilities in relation to effective infection prevention and control measures. However, we noted that on one occasion the cleaning cupboard had been left unlocked. **The cleaning cupboard must be locked at all times when not in use to prevent unauthorised access to hazardous cleaning materials.**

Nutrition and hydration
We were assured that the standards set out in the All Wales Hospital Nutrition Care pathway were generally being met. We saw that nutritional risk assessments had been completed within 24 hours of admission in the patient records we reviewed. A system was in place to identify patients who needed assistance to eat. Patients had access to softer options and alternative textures if required. We saw that where necessary, food and fluid intake was being monitored and recorded.

However, it appeared from our review of patient records that care plans in relation to the nutrition and hydration needs of patients were generic. **The health board must ensure that the individual needs of each patient are documented, particularly around specifying what assistance was required.**

We noted that patients always had access to water throughout the inspection. The patients we spoke with told us that they were happy with the quality and choice of food on offer. However, we were made aware that on occasions patients have to wait until staff have delivered food to all patients before they are able to return and assist patients who may need help. **The health board must ensure that enough staff are available to help patients eat once food has been served to ensure the food remains hot and edible.**

Medicines management

Overall, we were assured that the management and storage of medicines was being undertaken in a safe and effective manner. We saw that patients were wearing identification bands and observed staff checking names and date of birth with each patient before administering medication. We saw good practice in the use of yellow warning stickers that were being used to warn staff of patients with similar names.

Medicines were stored securely in the clinic room and fridge. Lockable medicine cupboards were also available on the wall by each bed to allow quick access to patient medication.

Fridge and room temperatures were being checked. However, we did note some gaps in the recording of the room temperatures. **The health board must ensure the room temperature is consistently logged in the clinic room.** We also noted that the checking sheets did not contain any guidance on what the accepted temperature range should be, or what to do if the temperate recorded fell outside the range. **We recommend the health board adds this guidance to the checking sheets to help ensure staff can quickly identify any temperatures that fall outside of the recommended range and can escalate accordingly.**

A pharmacy technician visited the ward three times a week and provided good support to staff on the ward. This included undertaking regular stock checks and arranging the medication for patients to take home once discharged. We saw that controlled drugs were being recorded and signed for correctly.

We viewed a sample of the All Wales Drug Charts (the chart) and noted that they had been mainly completed correctly. However, we saw some instances where there was incorrect instructions recorded regarding the prescribed dose which could have led to confusion or a medication error. We asked staff to amend the documentation during the inspection to provide better clarity to staff. **The health board must ensure that the charts are written clearly and contain the correct prescribed dose for staff to administer.**

We checked the stock of medical equipment on the ward and found that only two safer sharp needles were available for staff to use. **The health board must increase the availability of needles with safety mechanisms to better protect staff from the risk of needle stick injuries and the risk of exposure to blood borne viruses.**

Safeguarding children and safeguarding adults at risk

All of the patients we spoke with said that they felt safe while on the ward. Staff we spoke with were able to describe the relevant safeguarding issues and how to raise concerns.

There were numerous patients on the ward that required constant enhanced care and were subject to one-to-one observations. We saw evidence that mental capacity assessments were being undertaken on admission. However, we found one instance where a doctor had determined that a patient lacked capacity, but there was no evidence within the patient records that a deprivation of liberty safeguards (DOLS) assessment had been undertaken. **The health board must ensure that DOLS assessments take place as required and recorded appropriately within the patient records to ensure patients are not illegally deprived of their liberty.**

Blood management

Llandrindod Wells War Memorial Hospital is a community hospital and staff do not administer blood components to patients. We were told that any patients requiring a blood transfusion would be transferred to an acute hospital to receive the treatment.

Medical devices, equipment and diagnostic systems

There was appropriate and sufficient equipment in place on the ward to support the needs of the patients. This included hoists, walking frames and monitoring equipment. Staff were able to describe the arrangements for reporting faults with equipment. We saw that the majority of equipment had been serviced or checked within the last 12 months. However, we did not see servicing labels on the chair weighing scale or the patient transfer scale. We also found some out-of-date blood medical equipment (blood bottle, needles and cannulas) which needed to be replaced. **The health board must ensure the scales, and other similar equipment on the ward, are calibrated regularly to ensure they give accurate measurements. In addition, a system must be implemented to monitor when the servicing or replacement of equipment is due.**

Effective care

Safe and clinically effective care

The staff we spoke with knew how to access relevant clinical policies and procedures to help provide safe and effective care to patients.

Staff discussed the procedures that were in place to help identify and manage cases of sepsis. A sepsis screening tool was being used for all patients. Due to the number of patients requiring palliative care on the ward, the health board may wish to consider whether using a sepsis screening tool designed specifically for

palliative care patients may be more appropriate in some instances. We were told that a National Early Warning Score (NEWS) score of three or above requires immediate escalation for a potential sepsis diagnosis. However, we saw one instance of a NEWS score of four which had been noted by the doctor, but it was not clear from the documentation what escalation procedures, for example increased observations, had been determined. **The health board must ensure that decisions around escalation procedures in suspected cases of sepsis are clearly documented for staff to follow.**

We saw resuscitation equipment was available that was conveniently placed towards the centre of the ward. However, throughout the inspection we had concerns over the arrangements in place to safely manage a patient emergency:

- We could not be assured whether the emergency equipment items were in date as no daily or weekly checks were being undertaken and recorded
- One staff member we spoke with did not know how to use the defibrillator
- Some staff members we spoke with did not know how to open the resuscitation trolley.

We raised these issues with staff and it was positive that immediate actions were taken to address our concerns. Further information on the actions taken by the health board are referred to in Appendix A of this report.

We saw that a Patient Status at a Glance (PSAG) Board was located in the staff room which helped to protect the privacy and confidentiality of patient information. The information contained on the board was also included as part of daily staff handover notes. However, we noted a disparity between the information on the board and in the handover notes, and staff confirmed that the board was not up-do-date. We were informed that plans were in place to use an electronic PSAG board, but that issues with the internet were delaying this from happening. In the meantime, the disparity between the board and the handover notes presented a potential risk of staff making decisions using incorrect information. **The health board must improve the process of recording and displaying contemporaneous information about patients to staff so that it can be understood and used effectively by all relevant disciplines.**

Quality improvement, research and innovation
During our tour we saw that a 'How we are doing' board was displayed in the corridor that provided safety performance metrics for the ward such as the monthly number of falls and pressure sores. However, we noted that the board was out of date, and displayed the data for September 2022. **The health board must ensure that the 'How we are doing' board is kept up to date to provide real time information and raise awareness of any improvements needed.**

Record keeping
During the inspection we reviewed five patient records. We found evidence of good and clear documentation recorded of the day-to-day activities of patients. Patient care was planned in a way that promoted independence. Nursing documentation was being recorded via a mix of paper and electronically. We saw the digital nursing records were being used effectively. Some improvements were needed in the maintenance of the paper nursing records:

- We saw that care plans were not always being fully completed during the initial patient assessment and were not always being updated on a weekly basis thereafter
- Three out of the five care plans were not individualised to specific patient needs
- We saw one instance of a nutritional risk assessment, and two instances of pain risk assessments, that had not been undertaken when required
- In all five patient records we saw that SSKIN care bundles were not always being completed as required. For example, one patient was required to have 4 hourly checks, but we saw multiple occasions with gaps between checks of at least 5 hours.

The health board must ensure all nursing documentation is maintained in accordance with clinical standards guidance to ensure patients receive safe and effective care.

Patient records were being stored in two trolleys in a room behind the nursing station. However, we noted that both trolleys were not secure. One trolley was unlocked, and while the other trolley was locked, the code to the electronic keypad was visible next to the keypad. We also observed the doctor leaving the trolleys in the main corridor while undertaking ward rounds. This meant patient records were unattended and easily accessible on multiple occasions. In addition, we noted on one occasion the handover sheet containing confidential patent information was left unattended on top of one of the trolleys. We raised this with senior managers who assured us that the doctor would be reminded of their responsibility to protect patient confidentiality and privacy. **The health board must provide further assurance on the processes put in place since the inspection to improve the security of patient records in the room behind the nursing station and during ward rounds.**

Quality of Management and Leadership

We asked staff at the hospital to complete an online HIW questionnaire to find out what working conditions were like and to obtain their views on the standard of care. Unfortunately, we did not receive enough responses to include in this report. However, throughout the inspection we spoke with several members of staff of a variety of roles and grades, and their views are included where relevant.

Governance, Leadership and Accountability
The staff we spoke with told us that senior managers were visible and engaged with staff on a regular basis, and told us they felt able to report concerns. Staff also told us that they have been able to receive clinical supervision and receive annual performance appraisal development reviews (PADRs). However, we saw that only 58% of staff had received their PADR as of December 2022. **The health board must ensure all staff receive their annual PADR in a timely manner.**

We saw that overall compliance with mandatory training for staff was 72%. The ward manager informed us about the plans in place to increase this rate in the near future. The Electronic Staff Record (ESR) system was being used to determine overall staff compliance. However, it did not appear to be easy for senior staff to identify the compliance of each member of staff, or compliance by training course. For example, it took senior staff some time to determine which staff members were compliant with Basic and Intermediate Life Support training. **The health board must implement a better system of monitoring training compliance which allows quicker identification of which staff members are in date, and who requires training to be completed.**

When looking at the training compliance for Basic and Intermediate Life Support, it was apparent that some staff members were out of date with their training. We raised this with the ward manager who immediately booked those staff members on to future courses. **The health board must ensure staff compliance with Intermediate Life Support is taken into account when creating rosters to ensure staff working each shift have the appropriate skills in the event of an emergency.**

We saw that a range of quality improvement audits were being undertaken to monitor compliance with best practice guidance. Regular scrutiny meetings were also being held to review and discuss recent incidents. However, we could not find evidence of actions resulting from audits or incident reviews being shared with staff. In addition, some members of staff we spoke with told us that they were not aware of any patient safety notices that had been shared with them. **The health**

board must ensure staff are kept informed of any improvements identified from audits, incidents or national patient safety notices.

Workforce

We reviewed staffing rosters and saw that the agreed staffing establishments for the ward were being met. We were told that there were currently 9.85 whole time equivalent registered nurse vacancies, and it was clear from our discussions with staff that there are often staffing deficits on the ward. While these deficits are typically filled by bank staff, or agency staff, staff we soke with felt this was challenging for them. For example:

- We asked staff whether they had enough time to provide care safely and answers were mixed. The ward was currently operating at a high acuity with many patients requiring enhanced patient support. Staff felt that it was often a challenge to spend enough time with patients and ensure care was being provided safely to these patients
- One staff member raised concerns to us that on some occasions they have been unable to meet the required frequency of intentional rounding due to staffing deficits
- More than one member of staff told us that they felt the staffing establishment of two healthcare support workers at night was insufficient due to the needs of the patients. This was echoed in the minutes of previous staff team meetings, where we noted that staff had said that staff morale was low, and that staff raised concerns about being unable to provide patient care, particularly at night.

Furthermore, during our review of the documentation provided to us during the inspection we saw two incidents of staff shortages potentially affecting patient care. In the first instance, a patient required enhanced care but could not receive it due to there only being one healthcare assistant available due to a shortage of staff. In the second instance, we saw an example where one shift operated with only one registered nurse instead of the required two registered nurses.

We were told that the last review of the staffing establishments for the ward was undertaken in September 2022, and that another review would be taking place shortly. We were left with a sense that staff are feeling tired and that staff wellbeing is at risk if things continued as they have been. **The health board must involve and communicate with staff when evaluating the evidence as part of the next staffing establishment review.**

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
During the tour of the ward, and from discussions we had with staff, we identified the following issues in relation to resuscitation arrangements: • Staff did not know whether emergency items were in date due to the trolley being open, but no documented daily checks being recorded • One staff member informed us that they	This meant we could not be assured that appropriate arrangements were in place to safely manage a patient emergency.	We immediately spoke with senior managers on the ward about our concerns.	Senior managers took the following immediate actions during the inspection: • The resuscitation trolley was checked and appropriately sealed to indicate to staff all items were safe to use • All staff members on shift were shown how to open the resuscitation trolley and arrangements were made to show staff on subsequent shifts • A checking sheet was created for staff to undertake documented checks of the emergency equipment and medication going forward.

did not know how to use the defibrillator • Some staff members did not know how to open the resuscitation trolley.			
During the inspection we observed clean PPE (e.g., face masks) for staff and visitors placed on top of a clinical waste bin at the entrance to the ward.	This meant we could not be assured that PPE being used by staff and visitors on the ward had not been contaminated by the dirty clinical waste bin.	We immediately spoke to the ward manager about our concerns.	We raised this with senior staff who immediately moved the PPE and set up a new station for clean PPE.

Appendix B - Immediate improvement plan

Service: Claerwen Ward

Date of inspection: 17 and 18 January 2023

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 on this inspection.				

Appendix C - Improvement plan

Service: Claerwen Ward

Date of inspection: 17 and 18 January 2023

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 health board should ensure Welsh speaking staff are easily identifiable to indicate to patients that they speak Welsh.	Communicating effectively	• Powys Teaching Health Board (PTHB) have processes for ensuring that Welsh speaking staff are provided with a uniform with a Iaith Gwaith badge embroidered. • Admission process identifies which language the patient prefers to use, we will achieve 100% compliance in this domain. • Where we don't have Welsh speakers available, we will include family members and	• Ward Manager • Community Services manager (CSM) • Head of Nursing (HoN)	Monthly review at 1:1 and during recruitment process. Welsh Nursing Clinical record (WNCR) Audit Monthly

		translation service to ensure that patients are spoken with in their preferred language. • Nursing teams will include Welsh language awareness training in their mandatory training with a target of 85% by August 2023 • RiTA Therapy unit upgrade will include Welsh content. • Bedside communication folders are being developed which will be bi-lingual and include pictures.		August 2023 Decision re funding Due June 2023 July 2023
The health board must ensure they fully utilise all the dementia care initiatives available on the ward.	Communicating effectively	• Dementia Care board present on ward • Butterfly scheme use has improved on patient status at a glance board (PSAG) • Butterfly scheme icons being sourced to go in patients bedspace.	• Ward Manager • CSM • Clinical Nurse Specialist (CSM) • Ward manager	Completed April 2023

		• Dementia CNS and Community services manager (CSM) to undertake visit to ward and review areas for improvement under the dementia charter. • Dementia CNS attended ward meeting (February 2023) to provide an update for staff • Staff to have completed Dementia training (E-Learning) and Paull Ridd training (E-Learning) to a level of 85% • Dementia link nurse working with Dementia program. • CAREFITVIPS due to roll out Pan Powys in 2023 as part of the dementia hospital charter. • RiTA therapy upgrade - bid submitted to panel for funding agreement.	• CNS/CSM • Ward manager/CNS • Ward manager/Band 6 with CSM oversight • HoN CSM	Date Booked 28th March 2023 Completed September 2023 to achieve 85% Completed Monthly meetings with Ward manager involvement June 2023

The health board must ensure the new patient information folders are produced and made available as soon as possible.	Patient information	• Bedside folders in development, led by Ward manager. • Bilingual, multi-disciplinary focus • Translation service to liaise and ensure accuracy. • Pan Powys sharing for Quality improvement project.	• Ward manager • CSM	July 2023
The health board must ensure decisions around all aspects of discharge planning are fully documented in patient records and on WNCR.	Planning care to promote independence	• PSAG board updated in real time for discharge planning. • Welsh Nursing Care Record (WNCR) Audit monthly to be undertaken to monitor progress. • Prompts are offered by WNCR team following system analysis,	• Ward manager • CSM • HoN	Monthly Audit and feedback in team meeting. Weekly with monthly feed into Community Services Group (CSG) Quality and safety group.
The health board must implement a regular formal process of	Listening and learning from feedback	• Feedback surveys implemented on the ward.	• Ward manager/Deputy	Monthly review

collecting patient and family and carer feedback.		• CIVICA scheduling has commenced in PTHB. • Feedback is provided into PTHD Patient experience meeting and shared with teams at ward level. • Feedback forms are given on the day of discharge to reduce the likelihood of bias. • Updated boards on the wards for raising complaints and how to do this, including the ombudsman service, this is located by the entrance/exit to the ward.	• CSM • HoN • Governance Lead	Bimonthly Completed
The health board must review the access arrangements on to the ward to ensure patients are not disturbed.	Managing risk and promoting health and safety	• A doorbell has been requisitioned - this is volume adjustable to reduce opportunities for disturbance.	• Ward manager	April 2023
The health board must ensure the environment remains suitable for patients until the refurbishment,	Managing risk and promoting	• Flooring - tape between surfaces - estates have been	• Estates • CSM	April 2023

which would include, but not limited to, rectifying the issues listed in this report.	health and safety	requested to find an interim solution. • Water Leak - this is limited to non-patient areas and is awaiting reparations to the roof. • Claerwen ward is listed for refurbishment	• Head of Nursing	
The health board must provide evidence of progress and the actions taken since the inspection in relation to improving the health and safety evidence and documentation.	Managing risk and promoting health and safety	• Health and Safety review has been undertaken. • Updated ward risk assessment to be undertaken. • Health and safety folder has been updated with additional risk assessments included; ○ Defib Risk assessment ○ Individual Stress risk assessment tool ○ Expectant mothers Risk assessment	• Ward manager • CSM • Health and safety support • HoN • Directorate H&S Lead	March 2023 April 2023 February 2023 January 2023 January 2023 January 2023 September 2022

		○ Display Screen Equipment risk assessment - Height adjustable chairs purchased as a result of outcome. ○ Manual handling risk assessment ○ COSSH Assessment for Acticlor undertaken. • Health and safety to be added to standard ward leaders meeting and ward meeting agenda to ensure updates/issues are communicated. • Environment Audit created which was updated 14/03/23 to include checking of locked cleaning cupboard when not in use.		January 2023 December 2022 June 2023
The health board must ensure skin care plans are developed as required following skin assessments.	Preventing pressure and tissue damage	• Spot check Audit by CSM in February 2023 found that this was completed without omissions.	• Ward manager/CSM	Monthly review

		• Monthly audits to continue for reporting via CSG Quality and safety group.		
The health board must ensure patients are repositioned throughout the day and night where relevant.	Preventing pressure and tissue damage	• Staff have been reminded to document incidence where maintaining the required timing of care has been delayed along with reason. • Monthly audit will be completed to ensure monitoring. • Hospital acquired pressure Ulcers are reported through pressure scrutiny panel. • Annual Pressure Ulcer Audit to be undertaken and reported.	• Ward Manager • CSM • CSM • HoN • Tissue Viability Nurse (TVN) CNS	Monthly ward manager Audit, exceptions to report through CSM. June 2023
The health board must ensure patients are being checked in line with the required frequency stated in their care plans.	Preventing pressure and tissue damage	• Staff have been reminded to document incidence where maintaining the required timing of care has been delayed along with reason.	• Ward manager/CSM/HoN	Bi-Monthly review

		• Ward handover will include frequency of observations/checks. • Monthly audit will be completed to ensure monitoring.		
The health board must ensure falls care plans are created for patients that require them.	Falls prevention	• Identification of falls risk will lead to a care plan being written for patient centred mitigation of falls		
The health board must ensure that patients receive their falls risk assessment in a timely manner.	Falls prevention	• All patients will have falls risk assessment undertaken within 6 hours of admission. • All falls are reviewed through the falls scrutiny panel and learning/outcomes are shared through ward meetings/feedback.	• Ward manager • CSM • HoN	Weekly WNCR reports - exceptions to be reported through Monthly 1:1
The health board must review the reducing falls policy.	Falls prevention	• Policy due for review	• Assistant Director of Nursing	June 2023

The health board must remind staff about their responsibilities in relation to effective hand hygiene and ensure audits are effective at highlighting poor compliance	Infection prevention and control	• Standard item on ward meeting agenda • IP&C link nurse team now established and leading positively. • IP&C to undertake spot checks in ward and do Ultraviolet Hand hygiene training. • IP&C Mandatory training to reach 85% • Hand Gel added to notes trolley following identification of need for improved practice.	• Ward manager • Infection Prevention & Control (IP&C)	March 2023 February 2023 April 2023 August 2023 February 2023
The health board must take action to ensure staff adhere to the uniform policy at all times.	Infection prevention and control	• Daily inspection by nurse in charge - watch wearing has been eliminated and jewellery wearing has decreased, including agency staff. • All staff have signed to say they have read and	• Ward manager • IP&C Lead • Deputy ward manager	Completed

		understand the uniform policy. • Monthly monitoring and update on standard ward meeting agenda. • P-File conversations to be recorded for repeated breaches.		
The health board must ensure the cleaning cupboard is locked at all times when not in use to prevent unauthorised access to hazardous cleaning materials.	Infection prevention and control	• Daily spot checks to ensure domestics have locked cupboard when not in use. • Notices have been added to the doors as a visual reminder.	• Facilities • Ward manager • CSM	Weekly monitoring.
The health board must ensure that the individual needs of each patient are documented, particularly around specifying what assistance was required.	Nutrition and hydration	• Patient boards in bedspace used to identify individual needs. • Foodcharts in place where patients require monitoring of food and fluids and completed where they are in use.	• Ward Manager • CSM • HoN	Monthly review Annual Nutrition and Hydration Audit program

		• This is me documentation is in use and includes food preferences. • Red tray/Jug in place to identify patients who have specific requirements/need assistance with being fed. • Food preferences/drink preference added to the patient's board, along with dietary specifications.		
The health board must ensure that enough staff are available to help patients eat once food has been served to ensure the food remains hot and edible.	Nutrition and hydration	• Patients requiring support with eating are identified at the start of meal service and staff deployed to support. • Acuity and patients' needs are assessed and additional staffing are requested. • Patients/family members are invited to attend at mealtimes to support patients - sociable mealtimes are identified as improving nutritional intake.	• Ward Manager • CSM • HoN	Monthly observational Audit.

		• Annual Catering/Nutrition Audit undertaken		
The health board must ensure the room temperature is consistently logged in the clinic room.	Medicines management	• Daily log is kept and maintained daily - 100% compliance including weekends.	• Ward manager • CSM spot check confirms 100% completion • Pharmacy	Completed with monthly review.
The health board must add guidance to the temperature checking sheets.	Medicines management	• Guidance to temperature checking is contained within the file	• Pharmacy • Ward manager	Completed
The health board must ensure that All Wales Drug Charts are written clearly and contain the correct prescribed dose for staff to administer.	Medicines management	• Spot check of charts by CSM in February 2023 - all correct and clear • Health board plan to progress to e-prescribing in 2023 • Staff know how to challenge an incorrect prescription and get this amended. • Incidents to be recorded on Datix for monitoring and escalation through	• Ward manager • CSM • Digital team • HoN	Monthly

		appropriate health board lead.		
The health board must increase the availability of needles with safety mechanisms.	Medicines management	• There is a full supply of safety needles, the issue related to stock control and a stocking issue which has been resolved. • Staff have been updated on stock rotation and restocking.	• Ward manager	Completed
The health board must ensure that DOLS assessments take place as required and recorded appropriately within the patient records to ensure patients are not illegally deprived of their liberty.	Safeguarding children and safeguarding adults at risk	• Staff updated on the correct process/policy for documentation of DOLS assessment. • Allocated link person on ward. • Exception reporting into safeguarding strategic group. • Team to achieve 85% in level 1 & 2 Safeguarding training, DOLS training and Mental capacity act training.	• Ward manager • CSM • Safeguarding	Monthly reviewing of training compliance

The health board must ensure weighing scales, and other similar equipment on the ward, are calibrated regularly to ensure they give accurate measurements	Medical devices, equipment and diagnostic systems	• Medical devices program for calibration and servicing in place. • Where devices fall outside the recommended date, this is escalated through medical devices panel. • Team to understand correct processes for managing equipment. • Ward level assignment of equipment link.	• Ward Manager • CSM • Medical Devices	Monthly
The health board must ensure a system is implemented to monitor when the servicing or replacement of equipment is due.	Medical devices, equipment and diagnostic systems	• Medical devices program for calibration and servicing in place.	• Medical devices • Ward Manager • CSM	Completed
The health board must ensure that decisions around escalation procedures in suspected cases of sepsis are clearly documented for staff to follow.	Safe and clinically effective care	• Sepsis board has been created on the ward. • Treatment escalation plans are in place in PTHB to ensure that escalation of deterioration is considered	• Palliative care lead • Ward Manager • HoN • CSM	Monthly exception reporting

		in the care planning for each patient. • PTHB is reviewing the care decisions pathway to ensure that there is one place for documentation to clarify process. • Palliative NEWS charts are being considered in line with the care decisions pathway through palliative care strategic group.		
The health board must improve the process of recording and displaying contemporaneous information about patients to staff.	Safe and clinically effective care	• Patient Status at a glance (PSAG) board update and is now considered live. • PSAG board awaiting relocation to the Nurses office	• Ward manager/Deputy • Estates	Completed but under monthly spot check review. May 2023
The health board must ensure that the 'How we are doing' board is kept up to date to provide real time information and raise awareness of any improvements needed.	Quality improvement, research and innovation	• Updated immediately. • Monthly updates in place • Spot check Audits by visitors to the ward.	• Ward manager • CSM • HoN	Completed - Monthly oversight/spot check.

The health board must ensure all nursing documentation is maintained in accordance with clinical standards guidance.	Record keeping	• Bedside folders for patient care plans have been relocated from the corridor to the patient's bed space and contents ratified with standards and team updated to clinical standards guidance.	• Ward manager	Completed
The health board must provide further assurance on the processes put in place since the inspection to improve the security of patient records in the room behind the nursing station and during ward rounds.	Record keeping	• Lockable notes trolley has been requisitioned. • Change in practice required - staff reminded during monitoring that they should be closed during use, this extends to medical staff. • Events will be datixed when compliance is not achieved to ensure monitoring, oversight and escalation.	• Ward manager • CSM • HoN • Assistant Medical Director	Monthly datix review Monthly audit Spot check observational audit
The health board must ensure all staff receive their annual PADR in a timely manner.	Governance, Leadership and Accountability	• PADR HCSW has improved to 80% RN has improved to 64% • Trajectory for improvement in place	• Ward manager/Deputy	85% by August 2023

		• Some long-term sickness is causing a partial delay in achieving 85% • Aiming to achieve 85%		
The health board must implement a better system of monitoring training compliance.	Governance, Leadership and Accountability	• HCSW Mandatory training improved to 86% RN training has improved to 70%. • ILS/BLS booked as far as dates are available. • Dementia/Falls/Paull Ridd to be added to mandatory training for wards. • Staff being managed who have consistently and persistent low % of compliance. • Training is reviewed monthly by ward Manager and CSM and exceptions are reported through Quality and safety group.	• Ward manager • CSM • HoN • Education team	Monthly review of % position.

The health board must ensure staff compliance with Intermediate Life Support is taken into account when creating rosters to ensure staff working each shift have the appropriate skills in the event of an emergency.	Governance, Leadership and Accountability	• All staff booked onto Immediate life support ILS. • Roster planning focuses on ensuring we have staff with ILS training. Notes added to Roster. • Request made for all wards to implement the same. • Roster scrutiny in place - to be added to scrutiny sign off form for audit trail in respect of compliance.	• Ward manager • CSM • HoN	Monthly
The health board must ensure staff are kept informed of any improvements identified from audits, incidents or national patient safety notices.	Governance, Leadership and Accountability	• Standardised ward agenda implemented in ward areas to ensure feedback is captured. • Communication folder in place for all staff to read to ensure access to minutes, safety notices etc.	• Ward manager • HoN • CSM • Ward nursing team • Ward Manager • Governance Lead CSG	Completed - minutes to be shared with CSM monthly for analysis and audit purposes. Completed

		• SOP for patient safety notices to be established and disseminated. • Ward meeting room has notice board with all updates present.		May 2023
The health board must involve and communicate with staff when evaluating the evidence as part of the next staffing establishment review.	Workforce	• Each staffing review consists of data triangulation and professional judgement. • Ward nursing teams are made aware in advance of the reviews and ward managers are encouraged to share team views during those discussions. • Staff suggestions box has been added to the ward environment. These have been reviewed and some good suggestions such as summer uniforms have been taken forward as a result.	• Ward Manager • HoN • DDON	Bi-Annually Bi-Annually Monthly review

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): Linzi Shone

Job role: Professional Head of Nursing

Date: 14 March 2023