Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Ward 5, Princess of Wales Hospital,
Cwm Taf Morgannwg University Health Board
Inspection date: 25 and 26 January 2023
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This summary document provides an overview of the outcome of the inspection

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Patients provided very positive feedback about the care and treatment they had received on Ward.5.

We saw some useful information was displayed for patients and their carers, however, specific information for patients about their stoke care was lacking.

We found good arrangements were in place to prevent patients from developing pressure and tissue damage and to prevent patient falls. However, improvement was needed around some aspects of stoke care, infection prevention and control, some aspects of medicines management and managing written information relating to patients.

A suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated.

Generally, staff responses were positive regarding management, teamwork and the action taken by the organisation in relation to health and wellbeing. However, the responses indicate improvement was needed around involving staff in important decisions and the staffing levels on the ward. We also identified improvement was needed in relation to compliance with some mandatory training.

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

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 Ward 5, Princess of Wales Hospital, Cwm Taf Morgannwg University Health Board on 25 and 26 January 2023. Ward 5 provides acute care and rehabilitation for patients following a stroke.

Our team, for the inspection comprised of one HIW Senior Healthcare Inspector, one HIW Healthcare Inspector and two clinical peer reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

This summary version of the report is designed for members of the public.

A full report, which 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 can be found on our website.

Quality of Patient Experience

Overall Summary

Patients provided very positive feedback about the care and treatment they had received on the ward.

We found staff treated patients and their carers with dignity, respect, compassion and kindness. We also saw staff encouraging and assisting patients to be as independent as their condition allowed.

While we saw some useful information for patients and their carers displayed in the ward and the hospital, there was generally a lack of written information displayed for patients specifically about their stoke care. In addition, there was a lack of equipment to aid communication between staff and patients.

We found the ward had suitable arrangements in place for managing complaints and concerns. However, responses from staff showed they did not always receive updates on feedback provided by patients.

Where the service could improve

- The health board must review the provision of equipment on the ward to aid communication between staff and patients
- The health board must take suitable action to ensure patients on the ward and their carers can easily access written information regarding stroke care
- The health board must take suitable action to promote the 'Active Offer' on the ward
- The health board must review the therapy facilities used by patients on the ward and take suitable action to ensure they are sufficient for providing therapy to patients as part of their care
- The health board must take suitable action to ensure patients on the ward and their carers can easily access information on the health board's complaints process.

What we found this service did well

- We saw many examples of staff treating patients with respect and kindness
- We saw noteworthy practice to help maintain patient confidentiality during the board round

- We found innovative arrangements were in place to update carers, who lived away, using video link
- We saw staff encouraging and assisting patients to be as independent as their condition allowed.

Patients told us:

"Everyone here works very hard, remains cheerful with all interactions and really give confidence to patients that they are being well looked after."
"Staff are very supportive. My care has been excellent."

We asked what could be done to improve the service. Patients told us:

"I don't know how it could. Everyone here works to a very high standard, even remaining cheerful through long shifts."
"More staff."

Delivery of Safe and Effective Care

Overall Summary

We saw the hospital and ward was accessible to patients, staff and visitors. However, we found the ward was cluttered with equipment.

We found good arrangements were in place to prevent patients from developing pressure and tissue damage and to prevent patient falls. We also found good arrangements were in place to meet the nutritional and hydration needs of patients on the ward.

Generally, arrangements were in place to provide safe and effective care to patients on the ward. However, we did identify some improvement was needed around some aspects of infection prevention and control, medicines management and managing written information relating to patients.

In addition, we found improvement was needed around aspects of stroke care delivered at the hospital. Senior staff were already aware improvements were needed around stoke care and described significant work was being undertaken to make improvements in this regard.

Suitable arrangements were described for responding to safeguarding concerns, however, we were not fully assured staff were escalating concerns to relevant staff.

Where the service could improve

Immediate assurances

- We saw equipment was stored in the area outside the therapy room located on the ward and were not assured the fire officer was in agreement with this arrangement
- We found medicines used on the ward were not always stored securely, which posed a potential risk to the safety and wellbeing of patients and other individuals who may access and ingest medication not meant for them.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board must review the storage arrangements on the ward to ensure they are sufficient

- The health board must take suitable action to remind staff to wash their hands in accordance with the health board's policy and to ensure sharps boxes are replaced when needed
- The health board must take suitable action to ensure written policies are reviewed and updated in accordance with the health board's frequency rules
- The health board must take suitable action to ensure staff report safeguarding concerns to senior staff as appropriate
- The health board must take suitable action to reassure staff their concerns will be addressed
- The health board must take suitable action to ensure staff handle patient information in a way that protects patient confidentiality.

What we found this service did well

- We found checks of the emergency equipment and the sepsis trolley were being completed regularly
- We found good arrangements were in place to prevent patients on the ward from developing pressure and tissue damage, to prevent patient falls and to meet the nutritional and hydration needs of patients
- We saw staff were diligent in cleaning shared equipment
- We saw staff were engaging positively with patients during the mealtime and saw a good example of consideration being given to meeting a patient's particular meal preference
- We saw patient records were up to date and they showed evidence of how decision making relating to patient care had been made.

Quality of Management and Leadership

Overall Summary

A suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated.

Suitable arrangements were described for reporting on and monitoring the quality and safety of the services provided on the ward. In addition, a Task and Finish Group had been set up and positive action was described to improve the stroke service provided to the health board's population.

Staff responses made within HIW's questionnaire were mixed. Generally, staff responses were positive regarding their immediate manager and senior managers, teamwork, training, incident reporting and the action taken by the organisation in relation to health and wellbeing. However, the responses indicate improvement was needed around involving staff in important decisions and the staffing levels on the ward.

The health board had a comprehensive mandatory training programme, and generally staff training compliance was good. However, we identified poor compliance with mandatory resuscitation training, safe moving and handling training and infection prevention and control training.

Where the service could improve

Immediate assurances

- We identified poor staff training compliance with mandatory resuscitation training, safe moving and handling training and infection prevention and control training, which meant we were not assured there were a sufficient number of staff who had the required up to date skills.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- Ward systems for following up progress from actions identified from staff meetings and when issues have been escalated should be reviewed to ensure these are robust

- The health board must take suitable action to respond to the less favourable comments made by staff during the course of our inspection, especially around staffing.

What we found this service did well

- Most staff who answered the question in the HIW questionnaire would recommend their organisation as a place to work and they felt the organisation takes positive action on health and wellbeing matters
- We saw good evidence of multidisciplinary team working and the lead consultant promoting compassionate, and patient focussed care.

Staff told us:

"The ward always appears understaffed with not enough HCSWs to support patients, relying on agency staff who do not understand the needs of the patients."
"[We need] More information for relatives. Booklets, handouts, signposting guidelines."
"[We need] health support for relatives."

We asked what could be done to improve the service. Staff told us:

"More democratic approach to decision making and feedback from patients. I feel certain members of staff are kept more up to date than others."
"… due to the ward moving location in COVID we have lost therapy space and the ward environment is not conducive to effective therapy as it is often loud and very busy…"
"Flow through the stroke ward is an issue as it is a combined unit and we do not have stroke specific community teams or ESD to aid discharge of patients in a timely manner."

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health board to provide documented evidence of action taken and/or progress made.