Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Surgical Services: Trauma and Orthopaedic Care

Morriston Hospital / Abertawe Bro Morgannwg University Health Board / Pre-Operative Assessment Clinic, Ward A, Ward W and Main Theatres

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Fax: **0300 062 8387**

Website: **www.hiw.org.uk**

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

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the trauma and orthopaedic care services[1] at Morriston Hospital within Abertawe Bro Morgannwg University Health Board on the 23, 24 and 25 October 2018. The following wards and departments were visited during this inspection:

- Pre-Operative Assessment Clinic
- Ward A (trauma (unplanned) orthopaedic surgery ward)
- Ward W (elective (planned) orthopaedic surgery ward)
- Main Theatres.

Our team, for the inspection comprised of two HIW Inspection managers, four clinical peer reviewers and one lay reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct inspections of trauma and orthopaedic surgery can be found in Section 5 and on our website.

[1] Trauma and orthopaedics is an area of unplanned and planned surgery concerned with injuries and conditions that affect the musculoskeletal system (the bones, joints, ligaments, tendons and muscles).

2. Summary of our inspection

Comments made by patients and their carers confirmed they were happy with the care and treatment they had received.

We identified that improvements were needed to promote the timely care of patients admitted with trauma and orthopaedic conditions.

Overall, we saw that systems were in place to promote patient safety. We did, however, identify that some improvements could be made to promote a consistent approach to performing key patient safety checks in theatre.

The process for demonstrating that patients had been assessed for their risk of developing blood clots was unclear. This resulted in HIW requiring the health board to provide an immediate improvement plan in accordance with our immediate assurance process.

Management structures with clear lines of reporting and accountability were in place.

It was clear from the comments made by theatre staff that they had concerns about their current working environment. Strong comments were made in relation to staff shortages, lack of equipment and low staff morale.

This is what we found the service did well:

- Patients provided positive comments about the care they had received
- Staff teams were patient focussed and worked well together
- Systems were in place to promote patient safety in relation to surgical procedures
- We saw good use of infection prevention and control procedures

- We saw that controlled drugs were managed safely in theatres.

This is what we recommend the service could improve:

- The arrangements to promote timely care for patients admitted with trauma and orthopaedic conditions
- Compliance with some elements of the Five Steps to Safer Surgery[2], particularly the debriefing
- Clarify the policy in relation to venous thromboembolism (VTE)[3] risk assessment and prophylaxis
- Address the comments made by theatre staff in relation to the working environment, staffing issues and low morale.

Our findings in relation to venous thromboembolism risk assessment and prevention resulted in our concerns being dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

[2] The Five Steps to Safer Surgery - National Patient Safety Agency, 2010. Key safety steps which help prevent patients avoid suffering serious untoward preventable events such as wrong sided surgery, wrong implant insertion or inadvertent retained foreign bodies. These steps improve theatre safety, efficiency and communication. The five steps are briefing, WHO safety checks (3 steps) and debriefing.

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=93286

[3] Venous thromboembolisms or deep vein thrombosis (DVTs) are commonly referred to as blood clots. VTE prevention is an important part of surgical care (especially for hip and knee surgery).

3. What we found

Background of the service

Abertawe Bro Morgannwg University Health Board was formed on 1st October 2009 as a result of a reorganisation within the NHS in Wales and consists of the former Local Health Boards (LHBs) for Swansea, Neath Port Talbot and Bridgend and also the Abertawe Bro Morgannwg University NHS Trust.

The Health Board has four acute hospitals providing a range of services; these are Singleton and Morriston Hospitals in Swansea, Neath Port Talbot Hospital in Port Talbot and the Princess of Wales Hospital in Bridgend.

There are a number of smaller community hospitals and primary care resource centres providing clinical services outside of the four main acute hospital settings.

Morriston Hospital is one of the largest hospitals in Wales, and has over 700 beds. It provides acute general medical and care of the elderly beds (including medical sub-specialties) facilities; it has a trauma and orthopaedic service and a range of surgical and urological specialties. Morriston Hospital is home to the Welsh Centre for Burns and Plastic Surgery, and provides bariatric (obesity surgery) service for Wales.

Morriston Hospital is also the site of the major Emergency Department (A&E) for Swansea and is recognised as the major trauma centre for South West Wales.

The hospital also a paediatric unit with teams caring for children undergoing plastic surgery, maxillofacial surgery, orthopaedics, trauma and general medical paediatrics. The unit has a four-bedded High Dependency Unit caring for children with complex needs and there also an outpatients department.

A full range of high quality diagnostic and therapeutic services are also provided at Morriston Hospital.

The main theatre department consists of a total of 20 theatres and three recovery areas. There is a designated theatre used to perform unplanned (emergency) trauma and three theatres used to perform planned (elective) orthopaedic operations.

Ward A is a 27 bedded ward specialising in trauma and orthopaedic surgery. Patients are generally admitted to the ward via the Emergency Department rather than as planned admissions.

Ward W is a 16 bedded ward specialising in elective orthopaedic surgery (mainly joint replacements). Patients are admitted to this ward as planned admissions.

The Pre-Operative Assessment clinic is led by nurses who assess whether patients are physically fit enough to have surgery and an anaesthetic. Patients are also screened for any infections so that these may be treated prior to patients being admitted to the ward. This service has dedicated consultant anaesthetist clinical session support.

The health board regularly provides data to the National Hip Fracture Database (NHFD). Information on the health board's performance in relation to hip fracture care can be found on the NHFD website[4].

[4] https://www.nhfd.co.uk/tables

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Comments made by patients and their carers confirmed they were happy with the care and treatment they had received.

We saw that staff treated patients with kindness and respect and made efforts to promote their privacy and dignity on the wards and in theatres.

We found that healthcare professionals worked well together when planning and providing care to patients.

Patients told us that they felt they had been provided with enough information about their care. However, we identified that wards could display more health promotion material.

We also identified that improvements were need to promote the timely care of patients admitted with trauma and orthopaedic conditions.

During the inspection we distributed HIW questionnaires to patients and carers on both Ward A and Ward W to obtain their views on the services provided. A total of 20 completed questionnaires were returned.

All patients that completed a questionnaire provided positive feedback on their experience during their time in hospital, with the majority of patients rating their overall experience as excellent.

Patient comments included the following:

> *"Care has been superb, staff have been great & helped me when I needed it very quickly too"*
>
> *"The care has been more than excellent, staff kind and helpful"*

Patients were asked how the hospital could improve the care or service it provides. Patient comments included:

> *"Communicate weekly about treatment plan and ways forward. Only told 48 hours ago what they were looking at, but no update so far; feel out of the loop. Mum not that clear either, even though she spoke to Doctor 2 days ago"*

Other feedback that we received from patients and carers both within questionnaires and from our conversations during our inspection can be found throughout this report.

We also distributed HIW questionnaires to staff working on the wards and within theatres, inviting them to provide their views on the quality of care provided to patients undergoing surgery. We also spoke to staff working on the days of our inspection. Comments received from staff are included throughout the report.

Staying healthy

Pre-Operative Assessment Clinic[5]

Patients waiting for planned joint replacement surgery attended the Pre-Operative Assessment Clinic before their surgery. Following an assessment, clinic staff would determine whether identified medical conditions required further investigation and treatment prior to patients' surgery. Clinic staff were able to arrange investigations and were guided by a set of agreed guidelines. This was to ensure patients were as healthy as possible prior to having their surgery.

Effective arrangements were described to ensure those patients who required a more in-depth anaesthetic review were seen by a consultant (senior) anaesthetist prior to surgery.

Clinic staff confirmed that they followed agreed medication guidelines and protocols. This was to promote the safe and effective management of patients' existing medical conditions (such as diabetes, high blood pressure and those at

[5] The pre-operative assessment clinic is led by nurses who assess whether patients are fit enough to have surgery and an anaesthetic.

risk of blood clots) before patients had their surgery and to help reduce complications during and after surgery.

Clinic staff also confirmed that patients were advised to stop smoking as a part of a healthy lifestyle. We were told advice and support was available to help patients stop smoking should they express a wish to do so.

Ward(s)

Limited information was displayed about how patients can look after their health and wellbeing.

Some posters were displayed and leaflets were available on Ward A that provided information for patients and carers. These included advice for patients on the benefits of getting out of bed and keeping moving whilst in hospital, preventing blood clots and information on nutrition.

There was no such information displayed on Ward W, although we acknowledge that for elective patients, information and leaflets would be available for patients visiting the Pre-Operative Assessment Clinic and the joint school.

Patients being admitted for booked orthopaedic procedures were invited to attend the joint school. This provided patients with the opportunity to learn about their pending surgery and what to expect during their recovery. At the time of our inspection, the joint school had been temporarily stopped. This was attributed to the significant delays in the hospital being able to perform elective joint replacement surgery. As a result, staff felt that if patients were to attend the joint school, it was unlikely to be beneficial to them given they would have to wait a long time for their surgery.

Improvement needed

The health board is required to provide HIW with details of the action taken to improve the provision of relevant health promotion material within the trauma and orthopaedic wards.

Dignified care

Every patient that gave an answer in the questionnaires felt that they had been treated with dignity and respect during their time in hospital.

Pre-Operative Assessment Clinic

We did not have the opportunity to see clinic staff interacting with patients within the Pre-Operative Assessment Clinic. However, we saw that consulting room doors could be closed when staff were reviewing patients. Privacy curtains could also be used within these rooms for additional privacy. These arrangements help to maintain patients' privacy and dignity.

Ward(s)

We saw that ward staff made considerable efforts to promote the privacy and dignity of patients on the ward. We observed numerous examples of staff being kind and compassionate to patients and treating them with respect.

Arrangements were in place on both wards to promote patient privacy and dignity. These included privacy curtains around beds within multi-bedded bays that could be drawn and doors to cubicles that could be closed when staff were assisting patients with personal care.

Patients on both wards appeared comfortable, well cared for and all were appropriately dressed to maintain their dignity.

Theatres

We saw that theatre staff protected patients' privacy and dignity by ensuring doors to anaesthetic rooms were closed during induction (of anaesthetic). We also saw that staff made efforts to keep patients covered when they were awake and asleep so that they were not unnecessarily exposed during their surgery.

Similarly we saw patients in the recovery area were appropriately covered and their dignity was being maintained.

Pain relief

The majority of patients who completed a questionnaire told us that they waited less than 10 minutes after they had requested extra pain relief before they got it. They also felt that overall they had been given enough pain medication to stop the pain.

We reviewed a sample of ten patients' care records. This sample included the care records for patients on both wards. Those on Ward W showed that nurses had regularly assessed patients' pain. The records on Ward A were not consistent in this regard, with entries being made more infrequently.

Whilst, we found improvements were needed in respect of record keeping on Ward A, during the course of our inspection we saw that patients on both wards appeared comfortable. Staff praised the input provided by the acute pain service.

We considered the arrangements for patients admitted with a fractured hip to receive a pain relieving nerve block pre-operatively. A set of guidelines for administering a nerve block was in place for advanced nurse practitioners. Whilst a protocol was in place, there was a lack of clarity between the advanced nurse practitioners, doctors and the Emergency Department team as to who was responsible for administering nerve blocks. We also identified that there was limited training available for junior doctors in this regard. Given that the advanced nurse practitioners did not provide 24 hour cover, this meant that patients admitted with fractured hips may not receive a nerve block due to a lack of appropriately trained staff.

We also considered the arrangements for managing patient's pain in theatres. We found that anaesthetists gave consideration to national guidelines when determining the type of anaesthetic and pain relief to be given to patients.

Recovery staff assessed patients' pain and addressed this (together with any post-operative nausea reported by patients) prior to them being transferred back to the wards. Equipment (e.g. patient controlled analgesia (PCA) and epidural infusion pumps) was available to manage patients' acute pain and recovery staff confirmed they had received appropriate training in their use.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- Promote the completion of pain assessment and monitoring documentation at appropriate intervals by nursing staff
- Clarify and communicate to surgical and nursing teams the protocol for administering pre-operative nerve blocks
- Promote the timely administration of nerve blocks especially when the advanced nurse practitioners are not working.

Patient information

Patient information and consent[6]

Most patients that completed a questionnaire told us that, overall, they felt that they had been given enough information about all aspects of their care during their stay at the hospital.

The majority of patients that completed a questionnaire told us that they had been involved as much as they wanted to be in decisions about their care. They also said that they had been given enough time to make decisions about all aspects of their care. Patients were asked a series of questions in the questionnaire about the quality of information provided to them by staff both before and after their operation or procedure. The majority of patients that answered this set of questions told us that staff explained everything that would happen to them during the operation or procedure they were going to have. Similarly, all patients told us that the anaesthetist came to see them to explain how they would be put to sleep and/or how their pain would be controlled.

After the operation, all patients that completed a questionnaire confirmed that they were visited by a member of staff who explained to them how their operation went.

Communicating effectively

Handovers of care

We saw that a handover took place between ward and theatre staff when patients were brought to theatres. This helps promote patient safety.

Whilst a verbal handover took place between ward and theatre staff for patients having surgery for trauma injuries, this was not the case for patients having elective surgery. However, a structured, standardised handover form was always used. This prompted theatre staff to check important details such as the patient's identity, weight, known allergies, the surgical procedure to be performed, that the operation site had been clearly marked and the patient's

[6] Consent is the process of informing a patient about the treatment options and starts well in advance of the operation. It is not just the signing of a consent form.

fasting status. Theatre staff involved patients in the handover and sought clarification from ward staff where necessary.

We observed the handover of three patients and confirmed that patients had been prepared for transfer to theatres from the wards. With the exception of venous thromboembolism (VTE)[7] risk assessments, all relevant documentation accompanied patients to theatre. Our findings indicated, however, that most patients requiring VTE prophylaxis had this prescribed. This suggested that a VTE assessment had been completed by doctors. During our inspection, theatre staff identified one instance where VTE prophylaxis had not been prescribed for a patient. Theatre staff then completed a patient safety incident form. This was to ensure the incident was reported and investigated to identify learning to prevent a similar incident from happening again.

The majority of theatre staff who returned a HIW questionnaire agreed that there is an effective staff handover process in place at the hospital that ensures the continuing delivery of safe and effective care to patients. Theatre staff also told us in the questionnaires that patients often arrive in theatre well prepared and with everything in place for their operation. Comments received from ward staff supported the views of the theatre staff.

After patients had their operations, we saw that a formal handover of relevant patient information took place between theatre staff and recovery staff. This handover included both surgical and anaesthetic information. Whilst we saw that essential information was shared, a formal checklist was not used. This means that key information may not always be discussed as part of the handover.

Patient communication

All patients that completed a questionnaire told us that they could always speak to staff in their preferred language; all patients told us that their preferred language was English.

[7] Venous thromboembolisms or deep vein thrombosis (DVTs) are commonly referred to as blood clots. VTE prevention is an important part of surgical care (especially for hip and knee surgery).

Patients seemed to be positive about their interactions with staff during their time in hospital. All patients that completed a questionnaire told us that they could always speak to staff when they needed to and said that they felt that they had been listened to by staff during their stay.

Patients also told us that the staff that treated them introduced themselves the first time they came to provide them with care.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- Ensure all relevant documentation accompanies patients to theatre
- Promote the use of a standardised handover between theatre and recovery staff to ensure key information is always communicated.

Timely care

We considered the arrangements for admitting patients with fractured hips to the ward and for them to have surgery. Whilst we saw good multidisciplinary team working we identified that improvements were needed in the timely care of patients.

Our conversations with staff indicated that there were sometimes delays in patients being admitted to the trauma orthopaedic ward. Reasons for this included workload pressures, staffing and bed availability. There were no designated (ring fenced) beds being used to admit patients with a fractured hip. The use of such beds may promote more timely care for patients in relation to being admitted from the Emergency Department.

In addition, there appeared to be a lack of clarity amongst staff as to when patients could be referred directly (fast track care) to the advanced nurse practitioners for clerking and when a review by a doctor was required. This may also result in delays.

Daily trauma meetings took place and we saw that these were well attended by members of the multidisciplinary team. The purpose of these meetings was to discuss those patients admitted with trauma injuries and to agree on their care and management plans.

We saw that the following was discussed and agreed at the meetings:

- The management of patients recently admitted with trauma injuries

- If patients required surgery; the operation required, its urgency and staff required to safely perform the operation
- The order of the trauma operating list
- Availability of operating theatres and staff.

Anaesthetic staff routinely attended these meeting and so could provide a view on the most appropriate type of anaesthetic to administer to patients.

An orthogeriatrician was employed and provided specialist medical input to the care of frail elderly patients needing orthopaedic surgery. This is identified as good practice[8]. Staff told us that the orthogeriatric medical team covered other hospitals within the locality and so were not on site every day or at weekends. This meant that when the team was not working at the hospital, there could be delays in patients being reviewed and having their surgery. This also meant that the specialist medical advice that could be provided by an orthogeriatrican was not routinely available at the daily trauma meeting.

A trauma operating list ran everyday between 9:00am until 8:00pm. We were told that this did not always start on time. This was attributed to delays in patients arriving in theatre. Staff comments indicated that designated porters for theatre would help resolve this.

Staff told us that in their view the number of operating theatres used for trauma was insufficient and there was often a reliance on using empty slots on other operating lists (running in other theatres) so that patients could have their surgery.

The majority of theatre staff that returned a questionnaire felt that the theatre scheduling in their theatre was fairly well organised and said that enough time is factored into their daily work plan to adequately prepare for each theatre list.

[8] The NHFD has encouraged hospitals to appoint orthogeriatricians – specialists in the care of such people when they are admitted with hip fractures and other orthopaedic problems. These doctors help to make sure that patients are as fit as possible before their operation, support them following surgery and lead the rehabilitation team.

However, almost three quarters of theatre staff told us that they experienced daily restrictions to patient flow in their theatres. Some of the reasons given by theatre staff for the restrictions to patient flow included:

> *"No beds. Delays on Ward. Short staff with porters. Surgeons not around for team briefing"*
>
> *"No beds, Patients not ready, no porters to bring patients and no trolleys to put patients on"*
>
> *"Late starts, ward delays, no beds, inadequate pre-assessment and portering"*

Around three quarters of theatre staff told us that they felt operations were cancelled or delayed daily, or weekly, in their theatre because of staffing issues, and a similar proportion of theatre staff felt that operations were cancelled or delayed daily, or weekly, in their theatre because of bed availability issues.

Improvement needed

The health board is required to provide details of the action taken to promote the timely care of patients requiring orthopaedic surgery.

Consideration must be given to:

- reducing avoidable delays in admitting patients (with trauma injuries) to an orthopaedic ward and in patients receiving their surgery
- ensuring relevant staff are aware of and follow agreed protocols and care pathways relating to trauma and orthopaedic care

Individual care

Planning care to promote independence

Multidisciplinary care

We considered how healthcare professionals worked together when providing care and treatment to patients admitted with a fractured hip. Overall, we found effective multidisciplinary team working arrangements that provided patient centred care. However, comments made by staff indicated that improvements could be made in this regard.

An orthogeriatrician was employed and provided specialist medical input to the care of frail elderly patients needing orthopaedic surgery. Whilst an

orthogeriatrican was employed, we identified that the level of input could be improved (see above). We were told that whilst medical teams were based on site, they were reluctant to review patients given that an orthogeriatric medical team was available. Comments from staff indicated that a more effective service could be provided if an orthogeriatric medical team was based on site.

We found that there was an effective and timely system for referring patients for physiotherapy. This is important so that care can be planned with the aim of helping patients to be as independent as their condition allows after their surgery, especially in getting out of bed and moving around. Patients that required mobility support after their procedure told us that they had been given enough support with mobility issues since their operation. A physiotherapist routinely attended the daily trauma meeting and so was aware of those patients requiring physiotherapy input.

We were told that there was no dedicated weekend physiotherapy service for the trauma wards. Whilst a physiotherapist may attend to see patients with chest problems (to prevent patients developing serious chest infections after surgery) or to facilitate early discharge, the weekend service did not provide specifically for getting patients out of bed. Comments from staff indicated that an appropriately equipped, designated ward for patients who had suffered a fractured hip would help facilitate an improved service.

Positive comments were received in particular regarding the role of the trauma coordinator in coordinating the care and management of patients admitted with trauma injuries.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- increase the input of an orthogeriatrican
- promote the early post-operative mobilisation of patients admitted with fractured hips

People's rights

We found that arrangements were in place to protect peoples' rights to privacy and saw staff treating patients with compassion and kindness. We also saw that patients could maintain contact with their friends and family whilst in hospital.

Listening and learning from feedback

We found the health board made efforts to make patients and carers aware of how to provide feedback. However, comments we received from patients indicated that they required more information in this regard.

Patients that receive care, and their families, must be allowed the opportunity to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not.

Patients were asked whether they had been asked what they thought about the care they had received during their stay in hospital, for example through patient questionnaires. More than a half of patients that completed a questionnaire said that they had not been asked for their views about the care they had received during their stay in hospital.

Three quarters of patients that completed a questionnaire told us that they would not know how to make a complaint if they weren't happy about the care they had received during their stay in hospital.

Improvement needed

The health board is required to provide HIW with details of the action taken to increase awareness amongst patients and their carers of how they may provide their feedback about the care they have received.

Consideration must be given to increasing awareness of 'Putting Things Right'.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We found that the health board had taken action to implement the National Safety Standards for Invasive Procedures (NatSSIPs). However, we identified that further work was needed in this regard and that efforts were needed to improve staff awareness of the health board's NatSSIPs implementation programme.

Overall, we saw that systems were in place to promote patient safety. We did, however, identify that some improvements could be made to promote a consistent approach to performing key patient safety checks in theatre.

Whilst we identified that improvements were needed in relation to the completion of care documentation, we saw that ward staff placed a focus on preventing pressure sores and patient falls.

The policy for demonstrating that patients had been assessed for their risk of developing blood clots was unclear. This resulted in HIW requiring the health board to provide an immediate improvement plan in accordance with our immediate assurance process.

Wards and theatres were clean and generally tidy. We saw good use of infection prevention and control procedures.

We saw that medicines were managed safely in theatres

Safe care

Managing risk and promoting health and safety

Environment

Overall, we saw that the clinical areas were generally well maintained.

Comments made by staff indicated that Ward A was in need of upgrading to improve the environment for patients and staff. Senior staff confirmed that the ward had already been identified as an area that was to be upgraded. To facilitate this process the health board should give consideration to identifying and using a decant area to allow this work to progress whilst reducing the impact of upgrading work on the services provided.

The National Safety Standards for Invasive Procedures (NatSSIPs[9])

The health board completed and submitted a self-assessment form to HIW in June 2018 (prior to the inspection). This confirmed that whilst work was ongoing, action was being taken to implement the introduction of the NatSSIPs.

At the time of our inspection, the identified senior member of staff who had been leading on this work was no longer involved. From our discussions with the theatre managers, it was unclear who was responsible for taking this work forward. In addition, our conversion with staff indicated they were not fully aware of the health board's implementation programme for the NatSSIPs.

We found that some Local Safety Standards for Invasive Procedures (LocSSIPs) had been developed in light of the NatSSIPs for use in theatre. Others needed to be developed so that they are compliant with the NatSSIPs and to further promote patient safety.

Work also needed to be progressed to develop LocSSIPs for other clinical areas (outside of theatres) that performed invasive procedures.

[9] National Safety Standards for Invasive Procedures (NatSSIPs) refers to the implementation of surgical safety systems and processes. Implementing the standards is expected by all NHS services by September 2017. http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/NatSSIPs%20WALES%20%28FINAL%29%20September%2020161.pdf

The Five Steps to Safer Surgery[10] [11]

We looked at how the Five Steps to Safer Surgery were performed within the trauma and elective operating theatres. The five steps are Safety Briefing[12], Sign in[13], Time Out[14], Sign Out[15] (the three steps of the WHO Surgical Safety Checklist) and Debriefing[16].

Around two thirds of theatre staff that completed a questionnaire agreed that the priority in theatres in the hospital is on delivering safe and effective care for all patients rather than achieving a quick turn-over of patients.

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[10] The Five Steps to Safer Surgery - National Patient Safety Agency, 2010. Key safety steps which help prevent patients avoid suffering serious untoward preventable events such as wrong sided surgery, wrong implant insertion or inadvertent retained foreign bodies. These steps improve theatre safety, efficiency and communication. The five steps are briefing, WHO safety checks (3 steps) and debriefing.

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=93286

[11] Standards 7, 8, 9, 12 and 13 (Safety Briefing, Sign In, Time Out, Sign Out, Debriefing respectively) of the National Safety Standards for Invasive Procedures. Welsh Government, 2016.

[12] Safety Briefing is where the operating team meets to share their safety concerns and discuss patients individually as a team for the first time.

[13] Sign In refers to the first safety check which is performed when the patient immediately arrives in theatre.

[14] Time Out refers to the final safety check which is performed before the operation starts.

[15] Sign Out refers to the safety check which is performed immediately after the operation. It checks the right procedure has been performed, that items (such as swabs and needles) have not been left in the patient and checks that everyone knows if there has been a problem.

[16] Debriefing is the fifth and final step of the essential five steps to safer surgery. After operating has finished the operating team meets to discuss what went well and what needs to be improved. Anything important is written down and fed into the local safety network so staff in theatres learns from mistakes and good practice is shared. Debriefing also contributes towards creating a safety culture.

Safety Briefing

Our findings indicated that the safety briefings promoted safe and effective care to patients whilst in theatre.

Almost two thirds of theatre staff that completed a questionnaire confirmed that a surgical safety briefing always happens before the start of each theatre list. Theatre staff we spoke to within the trauma and elective operating theatres also confirmed that briefings were performed.

We saw that briefings took place in the operating theatres before patients arrived. This helps to maintain patient confidentiality. We also saw that noise and interruptions were minimised during the briefings to promote effective communication between the team members.

Whilst briefings were performed, we were told that sometimes there were delays with them starting due to the need to wait for relevant staff to be present. These delays were attributed to surgeons having to complete ward rounds and theatre staff completing equipment checks in the interests of patient safety.

Arrangements were described for the effective leadership of the briefings and for team members to ask questions and raise concerns. We identified this as noteworthy practice as this approach would help to promote patient safety.

We saw that important aspects relating to each individual patient were discussed. Whilst a standardised model to guide the briefing was used within the elective operating theatre (using a laminated checklist) the same approach was not used within the trauma operating theatre. Rather, the operating list was used to guide the briefing. The lack of a standardised model may mean that aspects relevant to a patient's safe and effective care may be missed. A record of the briefing was made and displayed within the operating theatre so that it was visible to staff for reference.

We saw that prostheses (artificial joints) and associated equipment requirements were confirmed at the briefing and it was clear who was responsible for ordering and checking these prior to the operation. When a prosthesis was to be used, we were told that the surgeon inspected this before the patient was sent for. These arrangements helped to prevent delays and

cancellations as a result of equipment being unavailable or incomplete at the time of the operation.

Word Health Organisation (WHO) Surgical Safety Checklist[17]

Overall, our findings indicated that the WHO checklist steps were performed well by the theatre team.

We saw that a standardised (electronic) WHO checklist had been developed and was to read aloud by theatre staff at each step (i.e. Sign In, Time Out and Sign Out). This helps ensure that all relevant checks are conducted at each step to promote patient safety and wellbeing whilst in theatre and before the handover to recovery staff.

In the elective theatre, we saw that the Sign In was clearly performed within the anaesthetic room. We also saw that two members of theatre staff were present as recommended by the NatSSIPs.

In the trauma theatre it was unclear whether the Sign In was performed. A conversation with staff indicated that the pre-operative checklist used at the handover stage doubled as the Sign In. This involved one member of theatre staff, rather than the recommended two, and the format differed from the electronic WHO checklist used in theatre. The same member of staff then completed the electronic version of the WHO without conducting a formal Sign In with a second member of staff. The lack of a second person confirming the information may increase the risk of error.

The majority of theatre staff who completed a questionnaire told us that the Time Out (before knife to skin) was always completed for each patient, and that the whole theatre team were mostly present during the completion of the Time Out.

We saw that the Time Out was always clearly performed in both theatres and that all team members involved in the procedure were present. Noise and interruptions were minimised during check. Whilst nothing was missed out, we

[17] These are checks ensuring the correct patient is undergoing the correct operation, on the correct part of the body with the correct implant. The WHO checks consist of Sign In, Time Out and Sign Out. http://www.who.int/patientsafety/safesurgery/ss_checklist/en/

saw that the checklist was not always referred to by those staff leading the Time Out. Rather, it appeared they relied on remembering the Time Out elements of the WHO checklist. This may increase the risk of omitting key information. A check of each patient's identity was again performed at this stage which is an important element to promote patient safety.

Theatre staff who completed a questionnaire told us that the Sign Out (before patient leaves operating room) check was rarely completed for each patient, and said that the whole theatre team were rarely present during the completion of the Sign Out part. However, we observed that the Sign Out was clearly performed in both theatres. There was one occasion when not all members of the theatre team were present. During the Sign Out we saw that relevant safety checks were completed at the end of the procedure. These checks included confirmation that cannulae had been flushed of anaesthetic drugs administered in theatre. This is important to promote patient safety[18].

Debriefing

Over two thirds of theatre staff who completed a questionnaire said that the surgical safety debrief rarely, or never, happens at the end of each theatre list. This was confirmed by our findings during the inspection.

As debriefing rarely occurred after operations had finished, there was no clear mechanism for identifying what had gone well and what needed to be improved on a daily basis.

Theatre staff were asked in the questionnaire how much time is factored into their daily work plan to complete the above safety steps. Almost a half of theatre staff that answered the question told us that the time that they are given to complete the safety steps is not long enough.

[18] Patient Safety Notice PSN040 / January 2018 Confirming removal or flushing of lines and cannulae after procedures

http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/PSN040%20Removal%20or%20flushing%20lines%20%26%20cannulae%20after%20pro.pdf

Site Marking

We found that there was a system to ensure that parts of patients' bodies were appropriately marked (for their operation) before entering the anaesthetic room.

Prevention of retained foreign objects

We found a safe and effective system was in place to prevent surgical items from being retained (i.e. inside patients) unintentionally. This system involved strict processes for recording and accounting for items used during the surgical procedure.

Prosthesis verification

We found a safe and effective system was in place to reduce the risk of errors associated with the use of prostheses. This involved only keeping the selected prosthesis for the current patient in theatre (and not for other patients on the same operating list) and strict checks and records made of the prostheses used. We saw that checks were made in a quiet environment to prevent errors resulting from the surgeon and other staff being distracted.

Incident Reporting (Theatres)

We identified that there was a system for reporting, recording and investigating patient safety incidents in theatre.

We were told that incidents were reported via the health board's electronic reporting system. Theatre staff who completed a questionnaire told us that they felt able to speak up about anything that they saw that was wrong when working in the theatres. However, almost a half of theatre staff said that they rarely or never receive feedback of the actions taken from any reported incidents.

During the course of the inspection we identified that a clinical incident met the criteria for reporting to Welsh Government (WG) under the NHS Wales serious incident reporting requirements. We discussed this with the senior staff at the time who confirmed that the incident had not been reported to WG but provided a verbal assurance that action was being taken in response to the incident and that if necessary the incident would be reported.

Whilst HIW was assured that the incident was being fully investigated, we required the health board to provide an update on the action taken to report this to Welsh Government (if appropriate). The health board provided a response and was reminded of the correct process to follow.

List scheduling

We found there was a process in place for scheduling elective and emergency surgical procedures.

We saw that printed theatre lists included relevant details relating to patients and the procedures to be performed. However, we identified that improvement could be made by including additional patient information such as known allergies and significant medical conditions. This would further promote patient safety and is recommended by the NatSSIPs.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- Complete upgrading work to Ward A
- Progress the implementation of the National Safety Standards for Invasive Procedures (NatSSIPs)
- Increase staff awareness of the health board's NatSSIPs implementation programme
- Promote a consistent approach to staff conducting safety briefings and completing the Sign In and Time Out steps in accordance with the NatSIPPs
- Ensure that debriefings take place in accordance with NatSSIPs.

Consideration must be given to factoring sufficient time into the daily work plans of theatre teams to allow them to complete the above safety steps.

Preventing pressure and tissue damage

Ward(s)

For the purposes of this inspection, we focussed on the prevention of pressure and tissue damage for patients on Ward A. Overall, we found that efforts were made to prevent patients from developing pressure and tissue damage.

We reviewed a sample of five patients' care records. We saw that all patients had been assessed for their risk of developing pressure sores using a recognised risk assessment tool. We also saw monitoring records that showed staff had checked patients' skin for signs of damage and had helped patients to

move position. Regular repositioning helps to relieve pressure on patients' skin and reduce pressure sores from developing.

Whilst monitoring records had been completed, we saw that the frequency for checking patients' skin had not always been prescribed by nurses. In addition, we saw that entries had not been made during the night. This meant that it was not clear how often patients need to have their skin checked and whether any checks had been completed by nurses overnight.

Pressure relieving equipment (e.g. specialist mattresses) was available and being used to prevent patients from developing pressure sores. We also found that staff placed an emphasis on getting patients out of bed and walking after their surgery. Early mobilisation helps to reduce pressure sores from developing.

Ward staff confirmed they could contact a specialist nurse for advice on pressure sore prevention and management.

The ward was displaying a safety cross that showed the incidence of pressure ulcers that had developed on the ward. This allowed the ward team to see, via a simple system, the incidence of pressure ulcers with the intention of taking timely action to prevent them. This demonstrated a positive approach was being taken by the ward team in relation to preventing pressure sores.

Theatres

We saw that theatre staff took care when handling and positioning patients onto the operating tables. Equipment was available and used by staff to help prevent patients from developing pressure sores during procedures.

Theatre staff had also developed a document that was used to record checks of patients' skin when in the theatre to help prevent pressure damage and promote patients' wellbeing. We also saw theatre staff checking patients' skin for signs of pressure damage.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote the correct completion of skin monitoring records by nursing staff on the trauma and orthopaedic wards.

Falls prevention

Ward(s)

For the purposes of this inspection, we focussed on falls prevention for patients on Ward A. Whilst we saw that efforts had been made to asses and identify patients at risk of falls, we identified that improvements were needed to the documentation being used.

We reviewed a sample of five patients' care records. We saw that all patients had been assessed for their risk of falls. However, the assessment did not result in an individualised care plan being developed. Rather, we saw generic care plans were in place. Comments received from staff indicated that the health board's falls risk assessment needed to be reviewed to make it more meaningful for use within wards.

The ward used a Patient Status at a Glance (PSAG) Board. Staff used this to record key information about patients' care needs and helped ward staff and other members of the multidisciplinary team (e.g. physiotherapist and occupational therapist) easily identify those patients at risk of falls.

We saw clutter within the ward that may pose a trip hazard to patients.

Theatres

As previously described, theatre staff took care when handling and positioning patients onto the operating tables. We saw that there was a sufficient number of staff present to promote the safe moving and handling of patients. Moving and handling aids were available and used.

When patients were being transferred, staff were considerate of equipment that needed to be in place (e.g. catheters) to prevent these becoming dislodged or causing injury.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote the development of falls prevention care plans that are individualised to patients care needs.

Infection prevention and control

Pre-Operative Assessment Clinic

We saw that the Pre-Operative Assessment Clinic was clean and tidy. Arrangements were in place to promote effective infection prevention and control.

Staff confirmed they had access to personal protective equipment (PPE) (e.g. disposable gloves and aprons). The use of PPE helps protect patients and staff from cross infection. Hand washing and drying facilities were available within consulting rooms. Effective hand washing is important to reduce the spread of infection.

Ward(s)

We saw that both wards were clean and found that arrangements were in place to promote effective infection prevention and control.

Ward W was designated as an elective (booked) admission ward and as such patients were screened for the presence of infection prior to admission. This helps to prevent infection on the ward. This approach was not possible on Ward A as the ward was designated as an emergency admissions ward for patients who had trauma injuries. Ward A had a number of cubicles that could be used for patients as a means of promoting effective infection prevention and control on the ward.

There were sufficient supplies of personal protective equipment (PPE) available on both wards for staff to use. Hand washing and drying facilities were available on both wards.

We saw that that equipment used on the wards was clean and had been labelled by staff to show that it had been decontaminated and safe to use.

Both wards were displaying safety crosses that showed the incidence of healthcare acquired infections. These allowed the ward teams to see, via a simple system, the incidence of infections with the intention of taking timely action to prevent them. This demonstrated a positive approach was being taken by ward teams in relation to infection prevention and control.

Theatres

We found that there were arrangements in place for effective infection prevention and control in theatres and the anaesthetic rooms.

Staff confirmed that the operating theatres were cleaned at the end of an operating session and our observations also confirmed this. We saw that both the operating theatres and anaesthetic rooms were clean. We found that the air circulation systems made air flow away from operating theatres to reduce cross infection. However, we identified that improvement was needed in respect of regular servicing of the circulation system (see section - Medical devices, equipment and diagnostic systems). We also identified that an area of the flooring in the trauma theatre was cracked and uneven making it difficult to clean effectively and so posing an infection control risk.

We saw there were adequate supplies of personal protective equipment (e.g. disposable gloves, gowns, goggles and masks) available and being used by staff. Arrangements were in place to segregate waste to ensure it was disposed of safely. In addition designated sharps boxes were used to dispose of medical sharps to reduce injuries to staff.

We saw that staff were vigilant when opening instrument sets, checking for any damage that may pose an infection control risk. We also saw that staff followed a 'scrubbing up' procedure that included strict hand washing and the wearing of surgical gown, mask and gloves. This promotes effective infection prevention and control during surgical procedures. Whilst most staff adopted a 'bare below the elbow' approach we saw that some surgeons did not always adhere to this. This may increase the risk of infection.

During surgical procedures, we saw control measures were taken to reduce the number of staff entering the operating theatre. This again helped prevent the spread of infection.

We confirmed that prophylactic antibiotics were prescribed for patients using agreed guidelines to prevent the inappropriate and over use of antibiotics.

Improvement needed

The health board is required to provide HIW with details of the action taken to repair the flooring within the trauma theatre.

Nutrition and hydration

Pre-operative fasting

Fasting before an operation is essential to maintain patient safety. This is to minimise the risk of a patient vomiting or regurgitating fluids or food, and then aspirating during the operation, when they are asleep under anaesthetic.

The amount of time that patients should go without a drink before an operation will depend on the procedure; however, it is usually about two hours. For food this is usually six hours.

Patients were asked in the questionnaire how long before their operation did they go without a drink. Of the five patients that had received an operation, four patients told us that they were without a drink for between four and eight hours before their operation, while one patient told us they went more than eight hours without a drink.

Most patients said they had been able to eat and drink when they needed to after their operation or procedure.

Nutrition assessment

We saw that patients had been assessed for their risk of becoming malnourished. This involved the use of an assessment tool that provided an overall risk score. The score then indicated the level of care patients required to meet their eating and drinking care needs. Whilst assessments had been completed, we identified an inconsistent approach was being taken that may result in patients being incorrectly scored. This may then lead to them not having the care they require in this regard. We informed senior staff of our findings and they acted quickly and efficiently to ensure that all patients had been correctly assessed. We were assured that immediate action was taken to ensure patients' eating and drinking care needs were addressed. Senior staff were also making arrangements to review the wording on the assessment tool for additional clarity and to promote a consistent approach by staff.

During the course of our inspection we saw staff assisting patients to eat and drink at their own pace and promoting their dignity.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure that patients are not fasted for longer than is necessary prior to their surgery.

Medicines management

For the purposes of this inspection, we focussed on the arrangements for medicines management in theatres. We found medicines were managed safely.

We saw that medicines were stored securely in cupboards or fridges in an organised manner. We also saw that fridge temperatures were between the

recommended ranges for storing medicines that required refrigeration. This is important to ensure the effectiveness of these types of medicines.

We saw that drugs for intravenous administration were stored in the same cupboard as those for non-intravenous use. These were separated by using different shelves, to reduce the risk of medicine administration errors. The health board may wish to consider using different cupboards to provide a greater degree of separation of these medicines to further help reduce the risk of errors in this regard.

Controlled drugs (CDs), which have strict and well defined management arrangements, were stored securely. We saw that complete records had been maintained that showed appropriate checks had been made when administering and disposing of CDs. We also saw that CDs used within theatres were subject to frequent stock checks.

Safeguarding children and adults at risk

Almost all ward staff confirmed that they are encouraged by their work colleagues to report safety events (e.g. errors, mistakes or incidents that may or may not result in patient harm) and to report any safeguarding concerns (protecting people from harm, abuse or neglect) they may have.

Most theatre staff confirmed that they are encouraged by their work colleagues to report safety events (e.g. errors, mistakes or incidents that may or may not result in patient harm) and to report any safeguarding concerns (protecting people from harm, abuse or neglect) they may have.

Blood management

Ward(s)

At the time of our inspection there were no patients on the ward that had required a blood transfusion. Therefore, the arrangements for managing blood products on the ward were not considered.

Theatres

We found that there was a safe and effective system to ensure the timely availability of blood products in theatre.

Staff we spoke to were knowledgeable about the systems in place for the management of blood products. An electronic tracking system was described for safety and audit purposes. Unused blood products could also be returned to minimise wastage.

There was a major haemorrhage system in place, which aimed to ensure that patients who suffered significant bleeding during surgery, received blood products immediately, as a priority. This arrangement promoted patient safety.

Identifying the risk of significant blood loss during surgical procedures formed part of the Sign In (the first of the three steps of the WHO Surgical Safety Checklist).

Medical devices, equipment and diagnostic systems

Pre-Operative Assessment Clinic

Staff confirmed that a range of equipment was available within the clinic for them to provide a safe and effective service to patients. We saw monitoring equipment was available within the consulting rooms.

Ward(s)

The majority of ward staff that completed a questionnaire felt that they regularly have access to the equipment they need to deliver safe and effective care to patients. However, some ward staff did tell us that there was some equipment that they felt was needed at the hospital, including a bladder scanner, footstools for limb elevation and additional fall alarms.

We saw that moving and handling equipment and patient monitoring equipment were readily available. Comments made by staff on Ward A indicated that an additional standing hoist would promote more timely care for patients who were unable to walk (e.g. to the toilet or washing facilities).

Whilst there appeared to be adequate storage space on Ward W, the storage of equipment on Ward A presented challenges to the staff working on the ward. We saw that some equipment on Ward A was being stored in corridors that may present trip hazards.

Theatres

We found that key equipment to deliver care to patients was available and working within theatres and the recovery area. However, comments received from staff confirmed that improvements were needed in this regard.

The majority of staff that completed a questionnaire felt that they don't always have access to the equipment they need to deliver safe and effective care to patients; equipment that theatre staff felt was needed at the hospital included lateral supports, gel pads, cardiac epidural pumps and more patient trolleys.

We saw that equipment was available to safely monitor patients during their operations. We also saw logbooks had been maintained to demonstrate that anaesthetic equipment had been checked to make sure it was working properly.

Staff confirmed that a spare operating table, diathermy machine and anaesthetic machine were available to help prevent operations from being cancelled in the event of equipment failure. Staff we spoke to felt that more equipment was needed for bariatric patients.

Arrangements were described for training staff on the use and storage of surgical instruments used during surgical operations.

Planned maintenance programmes were in place for equipment used within theatres to ensure that it was safe to use. However, we could not confirm whether annual inspections and verification of the specialised theatre ventilation system were being carried out to ensure the efficiency of these in accordance with best practice[19]. We informed senior staff of our findings and arrangements were made for the system to be checked and serviced during our inspection.

Equipment and medication for use in the event of a patient emergency (collapse) were readily available for use in theatres and the recovery area. Staff we spoke to were aware of the location of this equipment. We found that staff checked and inspected the emergency resuscitation trolleys daily to confirm that equipment was available and suitable to use.

Printed guidelines were readily available for staff to refer to in the event of a patient emergency.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- Ensure sufficient equipment is available within the wards and in theatres so that staff can deliver safe and effective care (taking into account staff comments in this regard)

[19] Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises. Part B - Operational management. DOH, 2007.

- Demonstrate that annual checks of the theatre ventilation system are taking place and that corrective action is taken as appropriate.

Effective care

Safe and clinically effective care

Venous thromboembolism (VTE) prevention[20]

We considered the arrangements in place for assessing patients for their risk of developing a venous thromboembolism (VTE). We did this by reviewing a sample of ten patients' care records and by speaking to nursing and medical staff who complete the assessments. We also considered the health board's current policy for VTE prophylaxis.

The health board's VTE risk assessment documentation was in the format of a flowchart. The documentation used on Ward A was an amended format of that within the policy. There were checks in place for the assessor to complete. However, none of the written risk assessments we reviewed demonstrated that these had been completed. We did identify that patients had been prescribed VTE prophylaxis which suggested that an assessment had been completed but not documented.

Our conversations with staff indicated that a local protocol had been developed. We were provided with a copy and this described that Tinzaparin[21] was to be prescribed for 35 days as per NICE Guidelines. Reference to this policy was not made within the risk assessment documentation or the patients' notes as a variance to the health board's policy. Our conversations with nursing and medical staff indicated that the protocol would be referred to, but that decisions around VTE assessment and prophylaxis were not always recorded on the risk assessment documentation. In the main, staff confirmed that Tinzaparin would

[20] Venous thromboembolisms or deep vein thrombosis (DVTs) are commonly referred to as blood clots. VTE prevention is an important part of surgical care (especially for hip and knee surgery).

[21] Tinzaparin is an anticoagulant that helps prevent the formation of blood clots.

be prescribed for 35 days but it was unclear whether the health board's VTE risk assessment was always used.

In addition, we found that patients had not always had their VTE risk assessed within 24 hours of admission or re-assessed daily or as their condition dictated. This was not in accordance with the health board's policy. This was attributed to patients being prescribed Tinzaparin for 35 days and there appeared to be confusion amongst staff as to whether patients needed to be re-assessed. Furthermore, when patients arrived in theatres, we could not identify that an assessment had taken place, although VTE prophylaxis had been prescribed where appropriate.

We saw that most patients on Ward W had a documented VTE risk assessment that had been completed by staff. However, not all patients had their VTE risk re-assessed within 24 hours of admission. Staff confirmed patients having elective surgery would be prescribed a course of Aspirin for VTE prophylaxis, however, the health board's policy described that Aspirin is not recommended for this. The use of Aspirin was attributed to a local protocol that had been developed for patients having elective arthroplasty surgery.

From our findings, we therefore could not be assured that a safe and consistent approach to VTE risk assessment, re-assessment and associated prophylaxis was being used by medical and nursing staff.

Our concerns regarding the above were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Peri-operative[22] hypothermia[23]

We looked at a sample of five patients' care records and saw that all patients had their temperatures checked on the ward in the pre-operative phase. The records showed that all the patients also had their temperatures checked at the recommended frequency (every four hours) in the post-operative phase on the ward. Sufficient bed linen and blankets were available on the ward to help keep patients warm after their surgical operations. Staff confirmed that warming equipment (e.g. specialist warming blanket) could be borrowed from theatre should this be required for patients following surgery on the wards.

Theatre staff confirmed that, where able, patients could walk to theatre to help reduce peri-operative hypothermia. Patients we saw arrived on trolleys and with blankets which helped to keep them warm and promote their dignity.

During the post-operative phase in Recovery, we saw that patients had their temperature checked and recorded at appropriate intervals. Recovery staff described that patients were not transferred back to the ward until their temperature was satisfactory (i.e. above 36 degrees Celsius). Equipment was available and routinely used both in theatres and the recovery area to actively warm patients to prevent peri-operative hypothermia.

Intravenous (IV) access

Arrangements were in place that promoted the timely insertion of intravenous (IV) devices so that fluids and medication could be given through patients' veins.

Ward staff told us that doctors, nurse practitioners and nurses working on Ward A were able to insert short term intravenous (IV) devices. This meant that

[22] Perioperative refers to the periods around an operation. These are the pre-operative phase (before the operation), intra-operative phase (during the operation) and post-operative phase (after the operation).

[23] Hypothermia (getting too cold) can occur during operations and can cause problems such as infected wounds, blood clots, more blood loss, pressure ulcers and it can take longer for patients to wake up from anaesthetics.

where IV access was required, this could be gained during the day and night without unnecessary delay.

Nurses on Ward W were not trained to insert such devices as this was felt to be unnecessary given that patients were admitted for planned surgery. Staff confirmed that IV fluids and medication were only used in the short term on Ward W and that existing arrangements to reinsert IV devices were adequate.

Ward staff also confirmed that arrangements were in place for patients to have long term intravenous devices inserted within one to three days of them being required. This is in accordance with professional guidelines.

Quality improvement, research and innovation

The trauma and orthopaedic service regularly provided data to the National Hip Fracture Database (NHFD) and the National Joint Registry[24].

Staff confirmed that data from the NHFD was regularly audited and presented at surgical morbidity and mortality meetings[25] to discuss findings and identify areas for improvement.

The health board completed and submitted a self-assessment form to HIW prior to the inspection. This confirmed that the health board takes action in response to findings from the NHFD and the NJR Clinical Report with a view to making improvements as appropriate.

The anaesthetic department had current plans to gain Anaesthesia Clinical Services Accreditation[26] (ACSA) for external accreditation status; however, this is not a mandatory requirement.

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[24] The National Joint Registry (NJR) of England, Wales, Northern Ireland and the Isle of Man exists to define, improve and maintain the quality of care of individuals receiving joint replacement surgery across the NHS and the independent healthcare sector.

[25] Morbidity and mortality meetings are seen as a key activity for reviewing the performance of the surgical team and ensuring quality.

[26] Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary scheme for NHS and independent organisations. It is an externally accredited quality improvement initiative from the

Information governance and communications technology

Theatre information systems

We found that the theatre information system used in theatre promoted the safe, effective and efficient running of theatres.

We were told that the information system in use was easily accessible by theatre staff via the use of individual personal identification numbers.

The system captured a range of key information that could be used to produce efficiency reports for the management team.

Record keeping

Our findings in relation to the quality and completeness of record keeping have been described throughout the report. Arrangements were in place to keep written and electronic information secure against unauthorised access.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Management structures with clear lines of reporting and accountability were in place.

Overall, comments from ward staff indicated that they felt supported in their roles by their managers and colleagues. Some comments indicated that ward staff felt that more staff were needed.

It was clear from the comments made by theatre staff that they had concerns about their current working environment. Strong comments were made in relation to staff shortages, lack of equipment and low staff morale. Theatre staff also felt that the working arrangements were impacting negatively on the efficiency of theatre and the quality of care.

We saw that most staff were up to date with training relevant to their role.

Governance, leadership and accountability

Management structures with clear lines of reporting between the clinical areas and senior hospital and health board managers were in place.

The management of healthcare services delivered by the health board was delegated to six service delivery units, each with its own area of responsibility and senior management team. There were service delivery units for community services, mental health and learning disability services and the services provided at each of the acute hospitals within the health board.

The Morriston Hospital Service Delivery Unit was responsible for the delivery of healthcare services provided from the Morriston Hospital site. Clear lines of management reporting were described and demonstrated within the clinical areas we inspected. This contributed to the local and the wider health board's governance arrangements. We saw senior hospital managers were visible and supporting teams working within the wards and theatres. Staff at all grades contributed positively with the inspection process demonstrating a culture of learning and service improvement.

Theatre managers described the systems in place monitoring the quality and safety of the theatre service. They confirmed that the department had an up to date risk register. This identified potential and actual risks to the delivery of the service and identified actions to mitigate against these. Theatre managers also confirmed that regular audit activity takes place to identify areas for service improvement.

During our inspection we distributed HIW questionnaires to staff working on both wards and theatres to find out what the working conditions are like, and to understand their views on the quality of care provided to patients undergoing surgery at the hospital.

In total, we received 28 completed questionnaires from ward staff and 28 from theatre staff.

The majority of ward staff that completed a questionnaire agreed that they were given enough support and leadership by management staff to carry out their role effectively, and said that they were often supported by management staff to make their own decisions.

The majority of theatre staff that completed a questionnaire said that they were rarely, or never, supported by management staff to make their own decisions. However, the majority of theatre staff agreed that they were given enough support and leadership by management staff to carry out their role effectively.

Staff and resources

Workforce

Ward(s)

Our observations indicated that ward teams had the right knowledge and skills to meet the care needs of patients on the wards.

The majority of ward staff who completed a questionnaire felt that the staff working there did have the right mix of skills to ensure the delivery of safe and effective care to patients. However, more than a half of ward staff felt that there is an insufficient number of staff working there to ensure the delivery of safe and effective care to patients.

Staff were asked in the questionnaire about the potential risks of the levels of staff leaving and joining the hospital, and about the arrangements in place at busy periods. The majority of ward staff felt that the delivery of safe and effective care to patients was at risk due to the number of staff leaving or joining the organisation, but did also tell us that during busy periods arrangements are always put in place to ensure patients continue to receive the care they need.

The majority of ward staff that completed a questionnaire said that they were only sometimes given access to training to maintain their continuous professional development while working in their current role.

Training information provided by ward managers showed that most staff were up to date with relevant training.

Staff told us (within questionnaires) that the team generally worked well together, but was under pressure from staff shortages and from staff being moved to cover other wards. Ward staff comments in the questionnaires included:

> *"Nice atmosphere to work in. Staff friendly and professional. Made to feel part of the team"*
>
> *"Senior Management use Ward W Healthcare Support Workers as bank nurses on some occasions putting patient's safety at risk, to cover other areas of the hospital, without risk assessing Ward W's patients or needs. As a busy surgical ward we and our patients should never be put in a position where we feel unsafe, but senior management make this a regular occurrence"*
>
> *"The nursing team is a friendly and supportive team. A team that helps each other when members are struggling. The ward is very busy and can experience multiple admissions at once; this is the only difficult issue experienced"*

Theatres

Our observations indicated that theatre teams had the right skills and knowledge to perform their roles.

Senior hospital managers explained that as part of an organisational development review, a full, theatre wide, staff engagement and consultation exercise had taken place. This had resulted in a restructure within theatres. We were told that the restructure was based on what the majority of staff identified as wanting and we saw that a new theatre leadership team was in post. We were also told that the restructuring was not fully implemented at the time of our inspection.

A quarter of theatre staff that completed a questionnaire said that they were rarely, or never, given access to training to maintain their continuous professional development while working in their current role.

Theatre staff that completed a questionnaire told us that they attended monthly multi-disciplinary training, such as clinical audit days.

Training information provided by theatre managers showed that most staff were up to date with relevant training.

Theatre staff were asked a series of questions in the questionnaire specifically related to patient safety in their theatres. The majority of theatre staff members that completed a questionnaire agreed that the theatres at the hospital have a good patient safety culture.

A number of concerns and issues were raised by theatre staff in the questionnaires about the current working environment at the hospital, including staff shortages and low morale, and how these issues were putting the delivery of safe and effective care to patients at risk. Comments from theatre staff included:

> *"Morale is dropping as experienced staff are leaving. There is becoming more of a divide between staff working in different specialities. Staff are losing basic skills to work in different theatres, so when a member of staff from one theatre is off there is not often someone who can take over and do their job. Theatre etiquette is slowly diminishing. Newly qualified staff are leaving"*

> *"Poor staff morale due to over working because of staff shortages. Too much priority of elective work over emergency. Huge delays due to portering / sending, especially in the afternoon"*

"There is a lot of pressure on staff to get on with things even with shortages and poor skill mix. Lists can sometimes be unachievable i.e. too much booked on list, so staff have to rush to get patient done. Staff morale very low - a lot of people leaving / looking to leave due to staff shortage"

Following our inspection, senior staff confirmed that the restructuring process had been concluded and all staff vacancies had been filled.

Improvement needed

The health board is required to provide HIW with details of the action in response to the comments raised by ward and theatre staff during the course of the inspection.

4. What next?

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 when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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.

5. How we inspect trauma and orthopaedic surgery

Our inspections of trauma and orthopaedic surgery look at the following:

- Trauma surgery pathway (unplanned surgery for broken bones)
- Planned orthopaedic surgery
- National Safety Standards for Invasive Procedures (safety checks and processes during surgery).

Trauma and orthopaedic inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

We look at the care a patient receives before an operation, during the operation and after the operation.

Our surgical inspection involves more than just the operating theatre and looks at the pathway the patient takes. It involves multiple areas in the hospital including:

- Surgical out patient clinic (decision to proceed with surgery made here)
- Pre-assessment clinic (checking patient is fit for surgery is made here)
- Pre and post-operative orthopaedic surgery ward (one trauma ward and one planned orthopaedic surgery ward)
- Operating theatres (in particular one trauma theatre and one planned orthopaedic surgery theatre if possible).

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our 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
Whilst nutritional risk assessments had been completed, we identified an inconsistent approach was being taken that may result in patients being incorrectly scored.	This may lead to patients not having the care they require in this regard.	We informed senior staff of our findings.	Senior staff acted quickly and efficiently to ensure that all patients had been correctly assessed. We were assured that immediate action was taken to ensure patients' eating and drinking care needs were addressed.

Appendix B – Immediate improvement plan

Hospital: Morriston Hospital

Ward/department: Pre-Operative Assessment Clinic, Ward A, Ward W and Main Theatres

Date of inspection: 23 – 25 October 2018

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.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to ensure that patients are suitably assessed and reassessed for their risk of developing a venous thromboembolism and that appropriate treatment is prescribed as necessary to reduce the risk of VTE. The health board is required to provide details of specific action taken to ensure that VTE assessment procedures are robust across all relevant delivery units.	Standard 2.1, 3.1, 3.5	Actions Taken Thus far: Morriston Hospital Delivery Unit closely monitors VTE assessment compliance of VTE risk assessment in line with policy and this is independently audited monthly by the pharmacy department and reported on via the Delivery Unit Performance Dashboard. Since February 2018 the Unit's performance has been consistently		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		between 90 & 95%. W/c 29/10.2018 - An audit of 14 patient records admitted with femoral neck fractures undertaken - identified that a VTE assessment was undertaken on all 14 patients All being documented on page 4 of the inpatient medication administration record, in line with Health Board Policy. All of these patients received Tinzaparin VTE thromboprophylaxis. Actions: The Pharmacy Team will undertake an additional process check to ensure the VTE assessment has been completed as per policy & report outcome to the MSK Clinical Lead. The latest All-Wales in-patient medication administration record (last review June 2018) has changed the location of the risk assessment for VTE from page 1 to page 4 of the record. In the ABMU	MSK Clinical Lead / Pharmacy Manager Health Board Medical Directors Team	From 02.11.18 30th November 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Policy for Thromboprophylaxis (last review July 2017) the VTE risk assessment refers to page 1 of the All-Wales in-patient medication administration record (last review July 2017). Consequently, the Health Board VTE policy needs to be updated so that it refers to the correct page of the All-Wales in-patient medication administration record (last review June 2018) in order to avoid any confusion and ensure clinical staff are working with consistent documentation.		

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): **Nicola Williams**

Job role: **Unit Nurse Director, Morriston SDU**

Date: **2/11/2018**

Appendix C – Improvement plan

Hospital: Morriston Hospital

Ward/department: Pre-Operative Assessment Clinic, Ward A, Ward W and Main Theatres

Date of inspection: 23 – 25 October 2018

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	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board is required to provide HIW with details of the action taken to improve the provision of relevant health promotion material within the trauma and orthopaedic wards.	1.1 Health promotion, protection and improvement	Trauma & Orthopaedic Wards to establish a patient / relative Health Promotion Board in a visible area that includes information relating to: falls prevention; healthy eating; smoking cessation; & exercise.	Matron T&O Wards	28.02.2019
		A Health Promotion Champion to be appointed for each ward to ensure that health promotion information & leaflets remain up to date and available	Matron T&O Wards	28.02.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Heath Promotion information to be made available for patients that includes Healthy Eating, exercise and Smoking Cessation within MSK Pre Assessment	Matron T&O Wards	28.02.2019
		The requirement for Health Promotion information / leaflets within visible areas on all clinical areas to be raised at matron & sisters meeting	Nurse Director, Morriston Hospital	28.02.2019
The health board is required to provide HIW with details of the action taken to: Promote the completion of pain assessment and monitoring documentation at appropriate intervals by nursing staff	4.1 Dignified Care	Communication to be provided to all Trauma & Orthopaedic Nurse Practitioners and Medical Staff regarding the importance of completion of robust pain assessments of patients, provision of appropriate pain relief and review of effectiveness.	Matron Cecilia Carpenter, Paul Williams & Mark Holt Trauma & Orthopaedic Clinical Leads	28.02.2019
Clarify and communicate to surgical and nursing teams the protocol for administering pre-operative nerve blocks Promote the timely administration of nerve blocks especially when the advanced nurse practitioners are not		A clear protocol for the provision of pre-operative nerve blocks to be devised, signed off by Trauma & Orthopaedic Board & ECHO Board and fully implemented. To include responsibilities and accountabilities 24/7 and, within ED & Ward settings.	Trauma & Orthopaedic Clinical Leads & Head of Nursing ECHO & Clinical Lead for Emergency	30.04.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
working.			Medicine.	
		ED Advanced Nurse Practitioners to be trained in the administration of nerve blocks.	Head of Nursing ECHO	30.05.2019
The health board is required to provide HIW with details of the action taken to: Ensure all relevant documentation accompanies patients to theatre	3.2 Communicating effectively	The importance of all VTE risk assessments being transferred to theatres with the patients to be stressed to all staff within Trauma & Orthopaedics	Matron T&O Wards	28.02.2019
		An audit of provision of VTE risk assessments to theatres to be undertaken	Senior matron Theatres	31.03.2019
Promote the use of a standardised handover between theatre and recovery staff to ensure key information is always communicated.		A standardised Handover process between theatres & recovery staff to be developed and implemented across all Morriston Theatres	Senior matron Theatres	30.05.2019
		An audit of the standardised Handover process between theatre & recovery staff to be undertaken and reported to the Clinical Services Board	Senior matron Theatres	30.06.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide details of the action taken to promote the timely care of patients requiring orthopaedic surgery. Consideration must be given to: reducing avoidable delays in admitting patients (with trauma injuries) to an orthopaedic ward and in patients receiving their surgery	5.1 Timely access	Review theatre priorities – surgical leads & anaesthetic leads	Clinical Director Anaesthetics & Associate Service Director	28.02.2019
		Reduce late starts to ensure theatre optimisation	Senior Matron, Theatres Head of Nursing Surgery	28.02.2019
ensuring relevant staff are aware of and follow agreed protocols and care pathways relating to trauma and orthopaedic care		Decisions to be made during the daily trauma meeting regarding theatre prioritisation	Associate Service Director, Surgery.	31.01.2019 -completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Theatre Trauma & Orthopaedic timetable review to be undertaken to take into account transfer of some elective operating transfer from Morriston to other ABMUHB sites to increase further trauma capacity	Associate Service Director, Surgery.	30.04.2019
		A review to be undertaken to align medical and nursing teams to optimise capacity to ensure it is mapped to demand	Associate Service Director, Surgery & Head of Nursing, surgery	30.04.2019
The health board is required to provide HIW with details of the action taken to increase awareness amongst patients and their carers of how they may provide their feedback about the care they have received.	6.3 Listening and Learning from feedback	Patient Information Boards on each MSK ward to be updated and ensure that Putting Things Right Regulations & how to raise concerns information is available for patient and the visitors	Matron T&O Wards	31.01.2019 - completed
		Laminated posters to be placed on each ward outlining Putting Things Right Regulations & how to raise concerns on MSK wards	Matron T&O Wards	31.01.2019 -completed
		The requirement for information on Putting Things Right Regulations & how to raise concerns to be visible areas on all clinical	Nurse Director, Morriston Hospital	28.02.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		areas to be raised at matron & sisters meeting As a health board, we continually collect Friends and Family Feedback and All Wales surveys throughout the year. To date we collect in 367 areas across ABMU. There are posters in ward areas and also in high traffic areas. Patient are prompted to complete the Friends and family Feedback when they login to the Hospital Wi-Fi. The feedback links are also on ABM websites. Online feedback is gathers using the mobile iPads and standalone kiosks across ABMU. We receive approx. 1,200 – 1,500 returned feedback forms weekly. Feedback reports are presented back to the ward/clinic managers every week.	Director of Nursing & Patient Experience	Completed
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to: Complete upgrading work to Ward A	2.1 Managing risk and promoting health and	No further ward refresh work can be undertaken until April 2019 due to pending winter pressures. Ward A to be placed on the 2019/2020 Ward Refresh programme	Nurse Director, Morriston Unit	31.10.2018 -completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	safety	for Morriston Hospital to be undertaken as first ward in April 2019. Morriston Ward refresh Programme to be placed on the Morriston IMTP to ensure release of the required capital allocation		
		Ward A refresh to be undertaken and completed	Assistant Director of Capital	31.07.2019
		Decant facility to be made available at Morriston	Assistant Director of Capital	30.11.2019
Progress the implementation of the National Safety Standards for Invasive Procedures (NatSSIPs)		A status position of LoSiPs within Morriston theatres to be undertaken and presented to Theatre Board & Morriston Quality & Safety Group & a prioritised programme of development to be developed to address any gaps	Senior Matron & Clinical Director Anaesthetics & Theatres	All to be developed by 31.03.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
Increase staff awareness of the health board's NatSSIPs implementation programme		Present current status and availability of NatSSIPs & LOCSSIPs audit day and Band 7 specialty manager meeting. Align responsibilities in relation to NatSSIPs & LOCSSIPs as part of PDR process for all specialty mangers	Senior Matron	31.01.2019 -completed
		Action to be taken to ensure all staff know and understand the LoCSiPs that have been developed and signed off within Morriston to date & to update in real time as they are further developed	Matrons & Senior Matron	28.02.2019
Promote a consistent approach to staff conducting safety briefings and completing the Sign In and Time Out steps in accordance with the NatSIPPs		Re-issue WHO sign in,& time out & debrief process via Clinical Cabinet / Anaesthetic Email and agenda item in Governance meeting 27/11/18 and attend CD/ Clinical Lead meeting 12/11/18. Generic email to all theatre staff	Clinical Director Anaesthetics & Theatres	30.11.2018 -competed

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that debriefings take place in accordance with NatSSIPs Consideration must be given to factoring sufficient time into the daily work plans of theatre teams to allow them to complete the above safety steps.		Audit compliance of sign in, time out and debrief processes	Clinical Director Anaesthetics & Theatres	28.02.2019
		• Mandate sign in now completed in anaesthetic room by anaesthetist and assistant. • Consideration on occasions when sign in completed for a child.	Clinical Director Anaesthetics & Theatres	09.11.2018 – completed
		Generic email to all anaesthetic staff involved issued November 2018	Clinical Director Anaesthetics & Theatres	31.11.2018 -completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Audit compliance	Clinical Director Anaesthetics & Theatres	28.02.2019
The health board is required to provide HIW with details of the action taken to promote the correct completion of skin monitoring records by nursing staff on the trauma and orthopaedic wards.	2.2 Preventing pressure and tissue damage	A full pressure ulcer audit to be completed within all trauma & orthopaedic wards and provided to the March Morriston Pressure Ulcer Scrutiny Panel.	Matron T&O Wards	31.03.2019
The health board is required to provide HIW with details of the action taken to promote the development of falls prevention care plans that are individualised to patients care needs.	2.3 Falls Prevention	A full review of all patient care plans and how they are linked with risk assessments to be undertaken across all MSK wards and appropriate action taken with all relevant registrants to address any areas where assessment outcomes do not reflect in individualised care plans & to be presented to Morriston Professional Nursing Forum in February 2019	Matron T&O Wards & Senior Matron	28.02.2019
		A full falls audit within all Trauma & Orthopaedic Wards to be undertaken in line with Health Board falls policy and presented to the February Morriston Unit Falls Group.	Matron T&O Wards & Senior Matron	28.02.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to repair the flooring within the trauma theatre.	2.4 Infection Prevention and Control (IPC) and Decontaminatio n	The flooring to be repaired / replaced within the trauma theatre	Assistant Director of Estates	28.02.2019
		A full review of all theatre flooring to be undertaken and all non-compliant with standards to be replaced / repaired.	Assistant Director of Estates	30.04.2019
The health board is required to provide HIW with details of the action taken to ensure that patients are not fasted for longer than is necessary prior to their surgery.	2.5 Nutrition and Hydration	A full awareness training programme to be put in place across all Surgical Wards in Morriston regarding surgical fasting requirements & a surgical fasting standard operative procedure to be developed and implemented.	Head of Nursing Surgery	31.05.2019
		An audit of compliance with the surgical fasting standard operating procedure to be undertaken	Head of Nursing Surgery	30.06.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to: Ensure sufficient equipment is available within the wards and in theatres so that staff can deliver safe and effective care (taking into account staff comments in this regard)	2.9 Medical devices, equipment and diagnostic systems	A full review of equipment availability to be undertaken with staff in theatres and across Wards A & W to ascertain what essential equipment is not in place. A risk assessment to be undertaken and a purchase priority plan developed and implemented.	Head of Nursing Surgery & Senior Matron Theatres	28.02.2019
Demonstrate that annual checks of the theatre ventilation system are taking place and that corrective action is taken as appropriate.		An audit trail of theatre ventilation system checks and corrective action to be provided to the Morriston Environmental Group in March 2019	Assistant Director of Estates	31.03.2019
Quality of management and leadership				
The health board is required to provide HIW with details of the action in response to the comments raised by ward and theatre staff during the course of the inspection.	7.1 Workforce	Theatre Recruitment and retention plan to be developed & shared with directorate and discussed at next directorate meeting. To be provided to Morriston Nurse Workforce Meeting.	Senior Matron	30.11.2018 -completed
		Morriston theatre Open / recruitment day to be held with large publicity	Senior Matron	31.03.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Theatre induction training plan & competency framework generic & MSK specific to be completed and signed off at Morriston Nurse Workforce meeting.	Senior Matron	31.11.2018 -completed
		Senior Matron Theatres to undertake a review of when theatre staff are being moved to areas they are less familiar with and provide a summary detailing the frequency to Head of Nursing & Unit Nurse Director. Appropriate action to be agreed following review	Senior Matron	28.02.2019
		Repeat Pulse Survey	Senior HR Manager / Senior Matron	28.02.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Develop Staff council with representatives from all grades nominated to represent their colleagues • Meet the manager dates weekly where staff can share concerns in a supportive manner with Matron and Senior Matron. • Increase wellbeing champions • Targeted Sickness management action plan for theatres • Introduce in January audit day senior team feedback on Theatre Improvement plan and outstanding actions	Matrons & Senior Matron	31.11.2018 -completed
		• Regular MDT human factor training sessions to be instigated. Programme to be shared • Prof AB to continue to support human factors training for MDT on audit days • RH Co-pilot training days for airway management and MDT human factors • Dr SN to support paediatric MDT human factors scenarios • Dr L R to support anaesthetic emergencies and human factors	CD Anaesthetics & Theatres, Senior Theatre nursing team and Anaesthetics Speciality Managers	30.01.2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Consideration for reintroducing 10-12 audit days to support theatre/ MDT training needs.		

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 – for Morriston Unit Actions

Name (print): **Nicola Williams**

Job role: **Nurse Director, Morriston Unit**

Date: **01.02.2019**