Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

An Independent Review of Patient Care at Ysbyty Glan Clwyd

Visit Undertaken in February 2012

December 2012

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Chapter 1: Introduction and Background

1.1 In mid 2011 Healthcare Inspectorate Wales (HIW) was invited by the Chief Executive of Betsi Cadwaladr University Health Board (BCUHB) to undertake an independent review of care provided at Glan Clwyd Hospital, part of BCUHB.

1.2 This invitation arose in part in response to a Public Services Ombudsman for Wales (PSOW) report that was issued in February 2011[1] that related to a case where a gentleman had received poor care at Glan Clwyd Hospital in 2008 and sadly subsequently died. This case raised concerns in relation to nursing care, the failure of staff to recognise clinical deterioration, the lack of recognition of the end of life pathway and inadequate investigations of the concerns raised by the gentleman's family.

1.3 In his report, the Ombudsman cited four[2] separate cases, all relating to care provided at Glan Clwyd Hospital between 2008 and 2009. As a consequence of the gravity of the failings identified, the Ombudsman referred his report to HIW.

Focus of HIW's Review

1.4 Following discussion with BCUHB, it was agreed that HIW would:

- Undertake a review of patient care provided at Ysbyty Glan Clwyd.
- Examine the processes in place for reporting incidents to Protection of Vulnerable Adults (PoVA).
- Examine the processes in place for the management of concerns.
- Consider any other matters that may be relevant to the purposes of the investigation.

[1] Case reference: 2260/200900780.
[2] Case references: 200901463; 2408/200901957 200801789; 200800304.

1.5 The review team included external reviewers with extensive experience of working in an Acute Hospital site environment, this review team consisted of a:

- Consultant General Physician.
- Deputy Director of Nursing.
- Senior Infection Control Nurse.
- HIW Lay Reviewer.

1.6 As part of the review interviews were held with key members of the Health Board's senior management team and staff at Glan Clwyd Hospital. We also held Group discussions with nursing and medical staff.

1.7 The team undertook their fieldwork visit in late February 2012, observations were undertaken on each of the wards and we spoke in depth with patients. During the fieldwork we visited the following wards:

- Accident & Emergency Department.
- Acute Assessment Unit (AMU) (including night visit to witness handover).
- Ward 2 (including night visit to witness handover) - Care of the Elderly.
- Ward 3 (including night visit to witness handover) - Orthopaedics / Trauma.
- Ward 5 (including night visit to witness handover) - General Surgery.
- Ward 7 – Discharge Ward.
- Ward 9 - General Medical / Urology.
- Ward 12 - General Medical / Respiratory.
- Ward 14 - Care Of the Elderly / Acute Stroke.

1.8 Our review highlighted a number of key issues in relation to the patient care provided at Glan Clwyd Hospital. In chapter 5 of this report, we have made a number of recommendations that are aimed at addressing the issues we identified and improving the services provided at Glan Clwyd Hospital.

Chapter 2: Patient Care at Glan Clwyd

Background to Glan Clwyd Hospital

2.1 Glan Clwyd Hospital is an Acute Hospital Site (AHS) located in Bodelwyddan. The hospital opened in 1980 and serves the population of central North Wales. Until 2008 Glan Clwyd was the sole AHS within the previous Conwy & Denbighshire NHS Trust. In 2008 Conwy & Denbighshire NHS Trust merged with the North East Wales NHS Trust creating the North Wales NHS Trust. In 2009 NHS Reform in Wales saw the merger of North Wales NHS Trust, North West Wales NHS Trust and the six Local Health Boards (Conwy, Gwynedd, Anglesey, Flintshire, Wrexham, Denbighshire) leading to the creation of Betsi Cadwaladr University Health Board (BCUHB) which serves the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham) as well as some parts of mid Wales, Cheshire and Shropshire.

2.2 The wider BCUHB is responsible for providing a full range of primary, community, mental health and acute hospital services throughout North Wales. BCUHB has two further AHSs: Ysbyty Gwynedd in the west, Wrexham Maelor in the east.

2.3 Glan Clwyd Hospital has 25 wards, in addition to the Accident & Emergency Department and Acute Medical Unit (AMU). The GP run Out of Hours Service (OOH) also operates from a facility on the Glan Clwyd site. The hospital provides a wide range of medical services that include:

- Cardiology.
- Coronary Care.
- Gastroenterology.
- Respiratory Diseases.
- Renal Haemodialysis.
- Endocrinology.
- Paediatrics.

- Care of the Elderly.
- Dermatology.
- Rheumatology.
- Genito-Urinary Medicine.
- Clinical Haematology.
- Intensive Care Unit.
- Radiology services including C.T. / MRI and Radioisotope scanning.
- Women's and Children's services.

2.4 An acute Assistant Medical Director (AMD) and Assistant Directors of Nursing (ADNs) are based at each of the three acute hospital sites. They report respectively to the Medical Director and the Executive Director for Nursing, Midwifery& Patient Services. The AMD is tasked to lead the site management team of the acute hospital site, in conjunction with the Assistant Executive Director for Nursing (ADNS). The scheme of delegation makes it clear that the AMD is 'in-charge' of the site. The AMD is part of the Board of Directors which provides the Health Board's overall strategic management to the organisation and sets its aims and objectives.

Clinical Programme Groups

2.5 There are 11 Clinical Programme Groups (CPGs) operating across BCUHB each split by clinical speciality. The eleven CPGs are:

- Anaesthetics, Critical Care and Pain Management.
- Cancer, Palliative Medicine and Clinical Haematology.
- Children and Young People.
- Mental Health and Learning Disabilities.
- Pathology.
- Pharmacy and Medicines Management.
- Primary, Community & Specialist Medicine.
- Radiology.
- Surgical and Dental.
- Therapies and Clinical Support.
- Women's Services.

2.6 These CPGs span across the whole of the Health Board. Each speciality is headed by a Chief of Staff who is a clinician, supported by Associate Chiefs of Staff. Each CPG has a formal management board and each Chief of Staff is accountable for the delivery of the services that fall within the CPG for which they are responsible.

2.7 The CPG structure seemed to be working well for some specialties such as cancer care where the concentration of services was well accepted and medics' co-operation across the BCUHB area essential. However the consultants' loyalty appeared to be to the AHS in which they operated and not to the CPG or Health board. We also have concerns that some Chiefs of Staff have too wide a remit and consequently may find it difficult to keep a handle on their span of responsibility.

2.8 While the CPG structure was introduced to facilitate and drive co-operation and consistency across the BCUHB area, we were told that some teams could still feel distant and isolated. We were also told by some staff that parts of the organisation feel disenfranchised and consider that they have lost some of the personal status they had under the NHS Trust structure. There remains some work to do in ensuring a uniformed vision and processes across the Health Board as some key staff remain resistant to change.

Reaction to the PSOW Reports

2.9 It is clear that the Health Board had taken on board the issues that were highlighted in the PSOW reports and had set in motion a number of improvement actions to address these. The Health Board and in particular the Executive Director for Nursing, was proactive in sharing the internal review that had been undertaken following the PSOW report and the Health Board's resulting action plan. However we were concerned that the ownership of the Health Board's review and accountability for the delivery of the action plan rested mainly with Nursing Staff, with there being less evidence of ownership by other clinical leads. It is clear that the issues raised by the PSOW did not relate to nursing issues alone.

Leadership and Culture at Glan Clwyd

2.10 During fieldwork visits we saw evidence of strong leadership in relation to the patient quality and safety agendas. Ward staff told us that the Executive Director for Nursing was a visible and accessible leader and such views were supported by many of the senior nurses. The Executive Director for Nursing had developed a nursing and midwifery *Quality Assessment Framework*[3] that focused on the fundamentals of care and driving improvement of these aspects.

2.11 The Executive Director for Nursing confirmed that she was confident that the Board was aware and assured of the quality and safety agendas, through the Health Board's governance processes. For example the Executive Director for Nursing is made aware of any issues, through the regular meetings that she has with nursing staff, which offer opportunities to discuss quality issues and share audit reports and actions. The Executive Director for Nursing also produces an annual Fundamentals of Care report which is submitted to the Quality and Safety Committee. It was evident from the discussions we had with staff that there is still more work to be done to strengthen arrangements relating to the Quality and Safety Committee and in particular, in relation to developing and emphasising its role and status in governance arrangements. At the time of our visit a new chair had been appointed to this committee and it was expected that this would strengthen the committee's role.

2.12 A key priority for Nursing is empowering Ward Sisters, through clinical leadership and the *Transforming Care*[4] agenda. The Health Board has aspirations to develop and re-energise senior nurses and improve their authority and

[3] The Quality Assessment Framework is a programme introduced by BCUHB. The programme incorporates the fundamentals of care with staffing levels and allows BCUHB to score under the Red, Amber, Green (RAG) scoring system to identify areas at risk.

[4] The Transforming Care Programme has been developed and delivered by the National Leadership and Innovation Agency for Healthcare and is a key part of 1000 Lives Plus, the national improvement programme supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales. The initiative has been created to empower frontline NHS staff across the health board to make changes that have improved the patients' experience of care and the safety and quality of services in both hospitals and the community.

accountability. The Health Board has launched the 'Dignity Pledge[5]' which is focused on supporting dignity and respect and making it a key priority across all disciplines. All ward managers had been provided with a copy of this and had circulated it amongst the nurses on their respective wards.

2.13 Senior nurses described to us their corporate and strategic roles and responsibilities, as well as their more operational roles. Senior nurses were visible on the wards and it was clear from our observations that they took the opportunity to speak to staff and patients on a regular basis. They appeared to work closely with junior staff to support them to deliver high standards of care and ensuring leadership at ward level. However, it was noted that ensuring visibility and leadership across all wards could be challenging due to the size of some of the CPGs which operate across the different hospital sites.

2.14 Escalated issues or concerns raised by ward based nursing staff are usually managed by the Ward Managers and Matrons through to the relevant Assistant Chiefs of Staff (ACOS) for their CPG. The Executive Director for Nursing retains professional accountability for all nursing staff and the ACOS retains operational accountability for nursing staff within their CPG area. Whilst senior management were clear about these arrangements they must accept that staff generally find them confusing. They need to take steps to reinforce these arrangements and ensure clarity at all levels.

2.15 The CPGs have responsibility for all aspects of the quality and delivery of services within their CPG, yet there is an AMD and ADN who site outside the CPG physically located at each AHS. The Health Board needs to ensure that clear and consistent messages are being communicated across the Health Board as some medical staff seem reluctant to work within these arrangements.

[5] BCUHB developed the dignity pledge following consultation with service users to improve dignity whilst in hospital. The pledge asks staff at BCUHB to: communicate with compassion, ensure patients' personal care and hygiene standards are met, help to relieve patients' pain and distress and work with patients to meet their dietary needs.

The Matron Role

2.16 The Health Board took the step of re-introducing the role of the Matron to its hospitals in late 2011 replacing the Clinical Nurse Manager role as it had been identified that leadership at ward level needed to be strengthened and more support needed for the ward staff. The Matron role was also reintroduced in part as a response to the findings of the PSOW with the aim of driving forward excellence in bedside, clinical care and enhancing the performance of the Ward Sister by supporting the authority of the Ward Sister in ensuring consistent dignified and respectful care[6].

2.17 The introduction of the Matron role has been a positive development. Matrons are required to work clinically with an expectation that they cover a ward shift a week – which usually results in them working clinically for one to two shifts a week. While the Matrons that we spoke to enjoyed the opportunity to carry out clinical work, balancing the clinical and managerial requirements of the role (for example, bed management responsibilities) was a difficult task.

2.18 The fact that Matrons are working clinically is almost certainly assisting with upholding standards of care on the wards and providing staff with role models. They are able to influence the delivery of care at ward level and also provide emotional support to the nursing staff some of whom work in a challenging environment.

2.19 From the observational work that we carried out on the wards at Glan Clwyd and the discussions held with patients and staff, effective ward leadership was apparent, including visible ward leaders both in terms of ward managers and Matrons. There was no tension apparent for instance in relation to the relationships between doctors and nurses on the wards as can be the case in some instances.

[6] Taken from BCUHB's action plan for PSOW Case 200900780.

Staffing Levels

2.20 It was clear to us from observations and discussions that staff were feeling under pressure and working at a perceived 100% bed capacity. Staffing levels were felt to be impacting and affecting the flow of patients through the hospital. We were also told of high sickness levels amongst some nursing teams (up to 6.75%) which was resulting in high levels of bank staff being used to cover shifts, sickness and vacancies.

2.21 A nursing skill mix review is performed annually and there has been a recent establishment review, based upon the *Telford model* [7] of professional judgement. The current review supports the implementation of supernumerary ward sisters and a 65:35 trained to untrained ward staffing ratio. Most wards are trying to achieve this ratio by using bank nurses. In addition the Health Board are looking at the skill-mix at night. We heard that beds were being closed at Glan Clwyd due to concerns about patient safety arising from low staffing levels.

2.22 During our visit to one ward we escalated concerns to the Executive Director for Nursing as staffing levels were insufficient to ensure appropriate levels of care given the complexity of patient being cared for on the ward. There were only two trained nurses and one untrained healthcare assistant on the nightshift that we observed.

2.23 There appeared to be time lapse issues with recruitment which was putting significant pressure on the nurse bank which was unable to fulfil all the requested shifts. Concerns were consistently expressed to us about bed pressures, increased patient dependency and the inability to fill gaps in staffing. We heard about the current temporary staff recruitment campaign, but the delays in recruitment had an impact on staffing levels. When we asked about tackling and managing the recruitment process, ward sisters raised with us that there was a perceived lack of support from Human Resources (HR). Some staff felt that this support was not as responsive as it used to be under the previous smaller NHS Trust.

[7] The Telford Method (sometimes known as the 'consultative approach') utilises the professional views of nurses to determine how many nurses are required to staff a clinical area.

2.24 Staff highlighted to us that morale, *'was not great in some areas'* and also aired with us their frustration at being unable to provide high standard of care due to a lack of staffing. There were difficulties in relating to staff accessing any training other than mandatory training. Whilst we were told that the Health Board had looked at nurse staffing levels, using Royal College of Nursing (RCN) guidance to set consistent levels across the organisation and of plans to recruit new Band 5 nurses to each CPG to achieve a ratio of 65%:35% qualified/unqualified; clearly staffing is an issue that needs to be addressed as a priority and actively managed by the Health Board.

2.25 We found in relation to junior medics, that staffing was tight and that this limited their overall experience to work across areas. For example the junior staff we spoke to explained that access to other departments such as outpatients and carrying out invasive procedures may be limited because they were required on the ward. However the general impression we got from the junior medical staff that we spoke to was very positive. They liked working at the hospital, confirmed that they had good training opportunities and good support from their consultants. They felt there was an open culture where their contribution and their opinions counted. We were told that the clinical coordinators at the Postgraduate Centre made particular effort to be welcoming and to respond to any concerns.

The Patient Journey

2.26 During our fieldwork visit to Glan Clwyd Hospital we focused on the patient pathway through the hospital from admission to discharge, spending time on the wards, conducting discussions with staff, patients and carrying out general observation work.

2.27 We began by focusing on the point of entry for many patients. The Accident and Emergency Department (A&E).

The Accident & Emergency Department

2.28 We visited the A&E department on a Monday afternoon and spent time there observing activity and talking to staff. The A&E department in Glan Clwyd was an extremely busy environment, operating under significant pressures both in terms of its ability to accept patients and admit to beds, or discharge patients onwards. Whilst the commitment of the staff that we spoke to was unquestionable, they were clearly working to capacity in conditions that were unsuitable.

2.29 Consultant numbers within the A&E department were significantly below the Health Board's set complement. This raises clear questions with regards to the Clinical Leadership of the A&E department and we question the adequacy of the arrangements in place at the time of our visit where Consultant Care was being provided by a Consultant predominantly based at the Wrexham Maelor A&E Department. We advised the Health Board in March 2012 that this required urgent action as the lack of constant on-site medical leadership was exacerbating inappropriate or avoidable admissions to Glan Clwyd. We were subsequently advised that the Health Board was aware of the inadequacy of arrangements and was attempting to address this issue.

2.30 During the week that we spent at Glan Clwyd it was clear that Ambulances queuing up outside the A&E department was a daily occurrence – we often witnessed up to five Ambulances parked outside because the department was full to capacity. We were told that this situation was not unusual and indeed was a very regular problem.

2.31 The Delivery Support Unit[8] (DSU) has been engaged with the Health Board since late 2011. This is due in part to consistent poor performance in relation to the four hour A&E waiting time target set by Welsh Government. While we did not examine any waiting times data as part of our review, we were concerned in relation

[8] The Delivery and Support Unit (DSU) was formed in 2005 to assist NHS Wales' organisations to continually improve and sustain their performance against the national access targets set by the Minister for Health and Social Services.
http://www.wales.nhs.uk/sitesplus/documents/861/Item%206.4_DSU%20Report.pdf

to the patient safety and quality of care issues that the poor performance of the Glan Clwyd A&E department raises. For example, in some instances patients were being held on the ambulances outside A&E for some significant time before being admitted to A&E.

2.32 We were advised of a number of schemes that were in operation to help avoid inappropriate admissions to A&E: for example the ambulatory care assessment[9], *HOT Clinics*[10] and *Home Enhanced Care Service* (HECS)[11]. However we were concerned that there still seemed to be unnecessary admissions; an A&E audit[12] had indicated that about 20% of referrals into Glan Clwyd could have been avoided.

The Out of Hours Service (OOH)

2.33 OOH and A&E are in close proximity at Glan Clwyd (they are physically located across the car park from one another) however we were told of issues in relation to limited communication between these services. We were told that patients who could have been seen safely by the OOH service were turning up at the A&E department.

2.34 We were also advised of some difficulties that the Health Board has faced in recruiting medical staff to cover the OOH service, partly due to its perceived unattractiveness to medical staff in terms of remuneration for GPs.

2.35 During discussion with palliative care staff we were told of specific problems in relation to patients nearing the end of life being referred for admission via A&E when other more appropriate avenues were available. These patients would have been more appropriately cared for and able to die at home rather than the hospital environment.

[9] Assessments run by Advanced Nurse Practitioners.
[10] Hospital Outpatient Treatments (HOT) clinics. An admission avoidance clinic.
[11] HECs provide an intensive level of care for patients with medical needs at home for a short and focussed period.
[12] Undertaken by the Health Board.

2.36 We were told of the excellent service provided by OOH and confirmed by patient surveys. However these surveys were confined exclusively to patients who had accessed and used OOH and will not have picked up on those who had bypassed the service and presented directly to A&E.

2.37 It was acknowledged during interviews that there are issues that require addressing, in particular, with regard to the ability of the Health Board to utilise the beds available at the various community hospitals across north Wales. The effective use of these beds would ease some of the pressure at Glan Clwyd in particular. However there were barriers to this as there were tensions in relation to consultant and GP beds at these community hospitals. The integration of primary and secondary services is clearly an area that needs to be addressed to ensure the efficient use of resources across the whole Health Board.

2.38 The Health Board had plans for the introduction of a new 'Emergency Quarter' at Glan Clwyd. In this new department the OOH would be co-located within the A&E department. Whilst the new department is clearly a step in the right direction, efforts need to be made to address the issues currently apparent in relation to Unscheduled Care, both in regards to addressing the chaotic nature of the A&E department, ensuring constant clinical leadership on-site and the OOH communication issues.

2.39 We believe that greater involvement of paramedics, nurse specialists and allied health professionals in home visits would also be a helpful development that may assist in preventing unnecessary admissions. Strengthening the community service and having effective liaison with hospital teams would certainly help lessen inappropriate admissions to the A&E department at Glan Clwyd.

The Acute Medical Unit

2.40 The Acute Medical Unit (AMU) is the first point of entry for patients referred to hospital as emergencies by their GP and those requiring admission from the A&E Department. Transfer from A&E to the AMU and direct admission from GP referral to AMU seemed generally well organised. However the availability, or lack of beds,

made this pathway very difficult at times. Invariably this was one of the prime reasons why ambulances queued up at the A&E front door – a lack of beds 'upstream' within the hospital itself.

2.41 Staff told us of their concern that more patients perhaps could be admitted directly to the main wards, avoiding the need to admit to the AMU. While there can be advantages to having a common portal of entry via the AMU, such a pathway does not add value if it leads to a bottleneck, which appears to be the case at Glan Clwyd.

2.42 Allowing for the busy and unpredictable nature of work in an acute unit, the care on the AMU at all levels seemed efficient and friendly, all grades of staff appeared to work well as a team and the handovers that we witnessed were well organised. However we were consistently told that patients were spending more time on the AMU than expected; some patients were spending three or four days on the AMU as opposed to the 'expected' 24-48 hours. In addition, we were also told of patients being moved from the AMU to wards where beds were available, irrespective of the appropriateness of the ward. This approach is clearly unsuitable and poses an increased risk to patient safety should a patient be located on a ward that does not have the required level of expertise or provide the care appropriate to the patient's condition.

2.43 The feedback that we received from patients about staff on the AMU and the department itself was generally very good, with positive views expressed about the attentive and respectful care received. However this was countered by some patients who, despite rating their care as excellent, raised some concern about certain aspects of their time on AMU. For instance one male patient told us that his urine bottle had been left on his bedside dinner table for over an hour and he had to eat his breakfast on the same table while the full urine bottle was on it.

The Acute Wards

2.44 Over the course of our week at Glan Clwyd we visited several wards, during daytime and night time and spoke to staff and patients, ranging from the cleaning staff up to the ward sisters and doctors. We also used the *Dignity and Essential Care Inspections (DECI) Observational Tool*[13] to assess the ward environment.

2.45 Much like our visit to the A&E department, it was clear to us that the acute wards at Glan Clwyd were operating under significant pressures – bed management and staffing issues were regularly cited as being issues of concern. Despite these pressures there was a clear focus on the Fundamentals of Care.

2.46 We found the wards to be generally clean and de-cluttered, with a good focus on infection control. There were examples of good hand hygiene witnessed (including bare below the elbow), clean equipment available on the wards, commodes that were clean and ready to be used and hand gel available. However staff told us that the Infection Control Team was not as visible at ward level as they used to be. It was also felt that the Infection Control Team tended to focus on the practice of nurses and were not so proactive in approaching doctors who may not be complying with infection control practices.

2.47 Ward sisters were prepared and ready to challenge poor practice on the wards and intervene if they had concerns about the conduct or competence of nursing staff.

2.48 Matrons explained to us that they were very anxious and eager to improve the environment on wards from a dementia perspective; for example they spoke of their wish to implement measures such as the painting of washroom and toilet doors in a different colour to other doors to help orientate patients who may be confused. The Matrons that we spoke to had some good ideas and they were empowered to make identified changes; however the lack of resources available to them undermined the ability to make these changes.

[13] DECI is outlined here: http://www.hiw.org.uk/page.cfm?orgid=477&pid=57445

2.49 As mentioned previously, fundamental patient care is a key priority for the organisation and this was supported by the launch of the regular Intentional Rounds[14]. This practice appeared to be embedded across the hospital. It was also apparent to us that nutrition was being highlighted as an extremely important aspect of nursing care, with the implementation of the *Nutritional Care Pathway*[15] and the *All Wales Food Record Chart*[16] and close working was apparent with the nutrition support team and dieticians. We observed patients being supported with nutrition (although there were occasions when the review team had to point out some patients that needed assistance with their meals). We also saw the use of red topped jugs on some wards to highlight patients who required assistance. Protected meal times were also in operation at the wards we visited.

2.50 The patients we spoke to were generally complimentary about nursing staff and nursing care. Generally patients felt that staff treated them with dignity, were attentive and provided timely care. Indeed we observed very good interaction between staff, patients and visitors during our time on the wards. However some patients felt that they had poor experiences, with some patients believing that nursing staff *'spoke down to them'* and were dismissive of their needs. These dissatisfied patients tended to be significantly younger than the other patients on the wards. Some, but not all, of the wards at Glan Clwyd have 'dignity champions' (in critical care) and also 'dementia champions'. We would question why this initiative has not been rolled out hospital wide and indeed Health Board wide.

2.51 During ward observations we noted on more than one occasion inconsistency with regards to the completion of nursing care plans and nursing documentation. We found some incomplete risk assessments and care plans and some of the care plans we reviewed were inadequate. Clearly this is an area that needs significant attention from the Health Board as assessment and care planning were issues raised by the PSOW. The Health Board needs to ensure that the practice of always fully

[14] Intentional rounding is the use of a formal checklist when checking on the patient and undertaken every one to two hours by responsible nursing staff.
[15] A new tool introduced by Welsh Government to provide clear standards and guidance on nutrition in hospitals.
[16] A new tool introduced by Welsh Government to provide clear standards and guidance on nutrition in hospitals.

completing documentation is embedded across the organisation, both from a nursing and medical perspective.

2.52 The ward handovers between nursing that we observed staff seemed to be comprehensive, with staff being made aware of all the main issues in relation to each individual patient on the ward. Following the handover sessions we witnessed nursing staff taking the time to introduce themselves to each patient. Staff used a printed handover sheet that they carried with them at all times. The doctors' handover that we observed on the AMU was generally good, although doctors complained to us of the electronic systems not being up to speed – they complained of the over-use of paper based notes.

2.53 The implementation of the *National Early Warning Score*[17] (NEWS) and *RRAILS*[18] (Rapid Response to Acute Illness) are positive developments and there appeared to be a good awareness of Transforming Care amongst nursing staff. Managing the acutely unwell patient has been seen as a priority, with a focus on providing training to aid staff in recognising the deteriorating patient. This training needs to be embedded across Glan Clwyd and indeed across the Health Board. Staff clearly need to recognise and know what to do when faced with a rapidly deteriorating patient. At the time of our visit the Transforming Care programme had been rolled out to 52 wards (out of a total of approximately 80) across the Health Board and was highlighted in a recent high profile event at which the Health Board launched its dignity pledge. We would urge the Health Board to ensure that the Transforming Care Programme is fully embedded across the organisation.

The Patient Experience

2.54 A key aspect that we sought to focus upon during our review was examination of patient experience at Glan Clwyd. As mentioned previously, we spent a significant time carrying out observations and talking with patients on the wards.

[17] National Early Warning Score - based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital.
[18] http://www.1000livesplus.wales.nhs.uk/rrails

This enabled us to build a more accurate picture of what it felt like to be a patient in Glan Clwyd.

2.55 There appears to be a need for significant work on the part of the Health Board in regards to the integration of primary and secondary care. This is an area that has an impact on the patient pathway at Glan Clwyd and across the wider Health Board.

2.56 We were told of issues in relation to the ability of the wards to refer patients to a social worker (if required) until a specific discharge date had been identified. Further, while the implementation of the Discharge Ward[19] is a good development, we were told of issues that were apparent in relation to links with social services which hampered efforts to discharge some patients. This presents problems with the efficiency of the discharge process from the hospital and could in some circumstances cause a 'log-jam' further downstream within Glan Clwyd. Patients on this ward told us of their dissatisfaction with the communication they received regarding their own discharge planning. The care links into the community did not appear to be robust. While there are initiatives to enable rapid discharge, for instance HECS, these may be compromised by long delays in social workers responding to referrals and inadequate support for patients in the community.

2.57 Staff expressed concern to us about the environment for patients with dementia and end of life care in particular. Matrons explained to us that they try to get extra staff to help with confused patients. We were also told that the Psychiatric Liaison Team work closely with ward staff and provide dementia training, with the liaison nurse for dementia providing a two hour session on caring for patients with that condition. While we felt that staff were generally aware of the needs of patients with dementia, caring for these patients can have significant resource implications. We were pleased to observe healthcare assistants and nursing staff treating patients with confusion compassionately.

[19] A ward intended as an interim ward prior to discharge from the hospital.

2.58 Glan Clwyd has recently appointed a consultant in palliative care (part of a team of consultants working across north Wales). The Health Board's *End of Life Pathway* has been updated following the PSOW reports but in practical terms there are issues in regards to the of lack of side-rooms to care for these patients, as infection control appears to take priority and therefore these rooms are often occupied by patients who are being barrier nursed.

2.59 The data that the Health Board gathers for end of life care is audited and end of life decisions are included in the mandatory training for FY2[20] doctors in Wales. In addition work has been undertaken by the Health Board to look at patients who have died on individual wards at Glan Clwyd and the proportion of these patients who were on the *All Wales Care Pathway for the Last Days of Life*[21]; the percentage has been used as a quality marker and this has allowed the Health Board to identify which wards are using the care pathway and on which wards they need to concentrate their efforts.

2.60 Do Not Attempt Resuscitation (DNAR) issues were raised by the POSW reports as an area that needed examination and strengthening. We found that the DNAR principles seemed to be well embedded in the clinical staff's culture. The linchpin for such decisions appeared to be the medical registrar but whenever possible he would speak to the relevant consultant, the family and, if competent, the patient. The junior staff confirmed that they had received relevant training in regards to DNAR. However, communication regarding DNAR could be improved, in particular documenting communication with patients and relatives. We observed that not all DNAR forms were completed in patients' medical records. This is an issue that requires addressing by the Health Board.

2.61 While it was apparent to us that generally dignity and respect was a key focus for staff at Glan Clwyd, we were concerned with some aspects of care. Of particular concern to HIW was the use of mixed sex accommodation in the AMU. At the time of our visit an elderly lady on the AMU complained to HIW that she was not happy

[20] Foundation Year 2 – Doctors in their second year of their postgraduate training.
[21] A Care Pathway to provide care for the patient and their family during the last days of life http://www.wales.nhs.uk/sites3/documents/362/Pathway%20for%20L%E2%80%A6st%20days%20of%20li.pdf

being cared for in a mixed sex bay, in particular when she had had to use a commode with only a curtain separating her and a male patient. Despite the AMU being an admissions / assessment unit and not technically classed as an acute ward, this lady had been an inpatient for a number of days and we consider that the AMU wasn't appropriate for such a long period of stay.

2.62 Attempts had been made to segregate the male and female patients on the AMU, but this was not considered to be possible at all times due to the throughput of patients and the pressures on beds.

2.63 We also had significant concerns regarding the pressures on the A&E department and the AMU. We were told by many patients of long waits both within the departments and on ambulances queuing outside the door. This has a significant and detrimental impact on patient safety and also patient experience. While HIW understands that the dignity and respect issues are unlikely to be fully resolved at the AMU until there is a new build to incorporate A&E, CDU, AMU and the OOH centre, we urge the Health Board to find a workable solution urgently in the meantime. Patients queuing up on ambulances for significant periods of time before even receiving an assessment at the A&E department is unacceptable.

2.64 We were concerned that on occasion patients were being inappropriately moved around the hospital. This not only causes inconvenience to the individual patient and their families and carers but also raises patient safety issues. We were informed of a patient who had a respiratory problem, but was admitted to a ward that could not cater for the needs as the equipment needed for his care was not on that ward. This raises significant concerns. Patients also reported to us that the number of ward moves they had experienced while at Glan Clwyd had had a negative impact on their experience.

2.65 A broader range of patient feedback would be beneficial to the Health Board. Whilst we were told of and examined the *Picker*[22] inpatient survey that had been

[22] http://www.pickereurope.org/surveys/

undertaken by the Health Board, there did not appear to be a strategic drive to gain real-time feedback from patients currently on the wards.

2.66 In terms of the physical environment at Glan Clwyd, it was clear to us that facilities on the wards were poor. While the wards had day rooms, they were very unappealing, with poor facilities for patients – for example, none of the beds had individual TV or radios, instead there was a single TV or radio per bay (roughly four beds) which proved to be disruptive and intrusive to those patients who did not wish to watch TV or listen to the radio.

2.67 Some of the bay areas on the wards were being used as storage areas. We do recognise that that there are challenges with finding storage space across the hospital estate. Concern was expressed by staff about the lack of equipment in particular when setting up a new ward or opening escalation beds, or replacing old furnishings, including patient chairs lockers and tables etc. with delays in responding to requests for maintenance and replacement. A shortage of laundry was also a big issue, with wards reporting that they regularly ran out of linen. One of the wards we visited has lockers which were over 20 years old and in poor condition. There were also shortages of pressure relieving mattresses and delays in obtaining new mattresses. Staff told us that they felt that an equipment library would considerably ease pressure in accessing fit for purpose equipment.

Medical Issues

2.68 There was a feeling amongst medical staff that senior nurse support on the wards at night was limited. It was explained that this issue can lead to inappropriate callouts from the medical perspective, with junior medical staff being called out inappropriately (in their view) by junior nursing staff.

2.69 A perception amongst some doctors was that some of the nurses respond to the *NEWS*[23] score in isolation, rather than the patient as a whole. In addition

[23] National Early Warning Score - based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital.

concern was raised regarding possible over-reliance on *NEWS* scores by nursing staff, for instance patients with neutropaenic sepsis may have a low *NEWS* score but still need very urgent attention.

2.70 Generally the junior doctors we spoke to felt there was low visibility from hospital management generally, but they reported that this was not an issue of concern for them personally.

2.71 Consultants at Glan Clwyd have loyalty and commitment to Glan Clwyd hospital, but perhaps rather less so to BCUHB. There appeared to be a sense of 'victim culture' amongst some of the senior clinicians with a feeling that Glan Clwyd is discriminated against by the Health Board; a view predicated on alleged previous broken promises (we were told of the promise of extra staff in the past not materialising) and uncertainty over the future of the hospital. There is a perception amongst some consultants that the hospital site (Glan Clwyd) is now seen as more important than the Health Board. The consultants told us that they miss the opportunity to 'rub shoulders' with executive directors and that the attendance of some directors at the medical staff committee meetings was poor.

2.72 Many of the consultants we spoke to seemed not to have bought in to the CPG concept and for many specialties it appears an irrelevance to the consultants. However in general the consultant body appeared positive in their attitudes and very patient centred; there was particular comment that they had the opportunities to develop their full potential at Glan Clwyd and it was a good place to work. The consultant staff we spoke to had particular concerns about the Human Resources department of the Health Board who in their view, seemed not to appreciate the importance of swift action when trying to recruit new junior medical staff.

2.73 The junior staff we met seemed well versed in the dignity and respect agenda and confirmed that this is taught at medical school and at Glan Clwyd during the communication skills module there is major emphasis on respect and dignity and how to talk and deal with a variety of patients. We were also advised that there are dignity sessions as part of the regular weekly lecture programme. We were told that if staff heard a colleague speaking to a patient with disrespect or felt that they had

witnessed a dignity and respect issue, the group responded that they felt it their responsibility to speak to that individual directly and if it needed escalation then they would bring the issue to the attention of a senior consultant. If it was a senior they had an issue with then they would speak directly to the Clinical Director. However, the dignity and respect agenda did not appear to be as high profile for senior clinicians.

2.74 We were told by medical staff that electronic systems, particularly for handover, tracking patients, status boards, bleeping staff and discharge summaries, are urgently needed. The separate systems used in A&E and the AMU are of particular concern and we were told that the Patient Administration System (PAS) was *'not fit for purpose'*. The clinicians we spoke to would like to see the introduction of paperless records at the hospital. We understand a Welsh clinical portal is being developed but the timeframe for this is uncertain.

Chapter 3: Protection of Vulnerable Adult (PoVA) Arrangements

3.1 As part of our review we examined the PoVA arrangements in place at Glan Clwyd and tested staff awareness of the process for referring issues to PoVA. This area was reviewed due to issues highlighted by the PSOW[24] and also because intelligence and information received by HIW that highlighted some inconsistency in relation to the recognition of what may constitute a PoVA issue.

3.2 The Executive Director for Nursing is the Health Board's Executive Lead for Safeguarding (safeguarding is the term used by health services that encompasses both vulnerable adult and child protection arrangements) with a new supporting structure below her in place to support this activity, linking with domestic abuse and safeguarding children and young people. We were told that safeguarding has been prioritised across the organisation as a key area of focus.

3.3 The Health Board had already recognised the need to prioritise the safeguarding agenda and had invited the Older People's Commissioner to a forum prior to the publication of the PSOW report in February 2011.

Staff Training

3.4 There are four levels of PoVA training provided by BCUHB. These are:

- Level 1 – General awareness training. Usually delivered during staff induction.
- Level 2 – Part of the foundation training programme for staff.
- Level 3 – Addresses the multi agency approach and is mandatory for staff working in Mental Health.

[24] Case References: 2260/200900780; 200901463; 2408/200901957 200801789; 200800304.

- Level 4 – The highest level of training, provided to those staff working in Mental Health and Learning Disability Services who chair strategy meetings.

3.5 All Health Board staff receive level 1 PoVA training and there is an induction e-learning package for all new employees. In addition there is mandatory face to face level 2 training for some staff and level 3 and 4 training provided for appropriate staff, (we were informed that around 70% of staff have completed level 1 across all hospital sites). There is room for improvement and strengthening in relation to ensuring that all relevant staff receive the minimum in PoVA training. In addition the Health Board needs to ensure that training is targeted at both nursing and medical staff.

Links with Complaints

3.6 There appears to be good scrutiny and links made between concerns and incidents within the Health Board in the context of PoVA issues and that this is leading to number of concerns being referred onwards as safeguarding / PoVA issues. We were told that some (but not all) of the CPGs have their own Safeguarding Forums and there are also links with dementia services. It is unclear why not all the CPGs have Safeguarding Forums – clearly this is an issue that the Health Board should seek to address. There also appears to be a good relationship and links with Primary Care and the Local Authorities with regard to safeguarding; it was explained to us that previously there had been issues with referrals and subsequent investigations being carried out (and by whom) but this has been largely addressed. Indeed the local authority staff who we spoke to in relation to links with the Health Board provided us with positive feedback regarding PoVA at Glan Clwyd in particular.

3.7 In terms of safeguarding activity on the wards at Glan Clwyd, this was seen as positive on the whole with good recognition apparent generally amongst nursing staff and appropriate reporting of tissue damage. We were less confident in the ability of staff to recognise poor care and neglect that may have arisen from within the

organisation – for example, while it appeared that staff would recognise pressure damage on patients admitted from care homes as a potential PoVA referral, staff would not necessarily recognise the same issue in patients who had been waiting in A&E for a long time without food / drink, or in relation to slow and delayed discharge planning. We acknowledge that Intentional Rounding is assisting somewhat, but there generally appeared to be a lack of recognition that tissue damage suffered from within Glan Clwyd could constitute a PoVA referral.

Process for Referral

3.8 In terms of the process and procedure for referring matters to PoVA, staff reported to us that they knew how to report and escalate safeguarding concerns. For example we were informed that they knew how to risk assess patients in A&E and AMU for signs of pressure damage arising from the community and that they were aware of the need to report pressure damage of grade 3 as a PoVA issue. We were also informed that staff recognise compromised dignity issues as potential PoVA issues, linking with the *Free To Lead Free To Care*[25] agenda, Intentional Rounding, the introduction of regular turn charts, the involvement of the Tissue Viability Nurse in patients with grade three pressure damage and the introduction of safety crosses. These are all positive developments that the Health Board needs to maintain and embed across the organisation.

3.9 We heard that neglect issues, such as long trolley waits, patients feeling cold and lack of hydration, would be reportable under PoVA. IR1[26] forms are also monitored for potential PoVA issues. We were told by the staff who we spoke to that they were all aware of the need to escalate potential PoVA incidents / issues appropriately and it was reported to us that there has been a definite rise in PoVA referrals due to increased staff awareness.

[25] http://www.wales.nhs.uk/documents/Cleanliness-Report.pdf
[26] An Incident Form used within the NHS.

PoVA and Medical Staff

3.10 PoVA principles generally seemed well embedded for the junior medical staff, but perhaps less so for the senior staff - although the latter have training every two years and have to confirm attendance. The juniors assured us that training had been covered at both undergraduate and postgraduate level in regards to PoVA. We confirmed from the Postgraduate Centre programme that a session was included as part of the first day's induction for new junior staff. We were also told that overall 75% of medical staff in the central (Glan Clwyd) area had completed PoVA training and that the Health Board was trying to devise ways of reaching the other 25%. Clearly this is work in progress and the Health Board needs to maintain and improve training levels for medical staff.

3.11 During the time that we spent at Glan Clwyd we witnessed two examples of PoVA processes in action: in the first case a young man with learning difficulties was admitted to a surgical ward and in the second case an elderly patient was admitted to the AMU with a bedsore. In both cases we were encouraged that the patients had been appropriately identified and the PoVA process seemed to be working well.

3.12 The CRB processes have been reviewed by the Health Board and all new employees receive a CRB check. In addition individuals who move post also receive a CRB check. Only in some key areas however are retrospective CRB checks undertaken. We would urge the Health Board to assure itself that the CRB checking processes is rigorous and that all appropriate members of staff are appropriately checked.

Chapter 4: Responding to Concerns

4.1 HIW examined the concern handing procedures at the Health Board, partly in response to the issues uncovered by the PSOW reports, but also due to the correspondence that HIW had independently received or been made aware of in relation to the Health Board's arrangements in handling concerns.

4.2 HIW had been in contact with a number of individuals who'd had a poor or unsatisfactory experience of raising a concern against the Health Board and concerns were raised to HIW in terms of not only the timeliness of the responses to these concerns, but also in relation to the content and tone of the substantive responses received.

4.3 As of April 2011, the Welsh Government introduced new guidelines called *Putting Things Right* [27] in relation to handling concerns and outlined the requirements for the Health Boards in dealing with concerns. Part of the requirements relate to the timescales in which complainants should receive responses from the Health Boards. For instance, complainants should receive an acknowledgement within two days and a substantive response within 30 days.

4.4 It is clear from our examination of the process and following discussion with staff at the Health Board that performance in relation to these prescribed response rates is very poor. Whilst 77% of concerns are acknowledged within two days, only 28% of concerns meet the 30 day deadline. This is concerning. Whilst HIW acknowledges that there has been an increase in number of concerns received by the Health Board, due in some part to the increase in activity and in part due to the introduction of Putting Things Right.

4.5 It emerged from our discussions that there appears to be a significant backlog and delays in the system that responds to concerns. This was in the main due an overly complex process regarding the management of complaints across BCUHB and that consideration may be given to streamlining the process at an operational

[27] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

level. The complaint handling processes had recently changed within BCUHB and that this has led to a significant backlog and delays in the system. However there were a number of complex processes in place, including developing some of the complaint handling to the CPGs, with inconsistency across the CPGs in terms of how concerns are handled. Staff within the CPGs were confused as to the process and their role and responsibility within that process. This had led to little overall responsibility being within the CPGs to manage the concerns process.

4.6 While the accountability for the management of concerns within the Health Board rests with the Director of Governance and Communications, there appeared to be a diffusion of and lack of ownership and accountability for the management of concerns at some levels in the organisation, in particular within the CPGs. The number of concerns has risen over the 12 months prior to our review and in one CPG we heard that the number of concerns had doubled in the last 12 months.

4.7 We were informed that a Quality & Safety Lead Officers Group meets monthly to review all concerns received by the Health Board. This is chaired by the executive Nurse Director and membership includes Medical Director, Director of Therapies & Health Science and Director of Primary, Community & Mental Health Services and Director of Governance & Communications as well as their senior leadership teams. They look at PSOW cases and consider all the various elements so that they can identify any themes or areas of particular concern. In effect this is a subcommittee of the Quality and Safety Committee; it feeds issues into this committee and then to the Board.

4.8 Whilst it appears that staff are proactive in dealing informally with concerns, for instance, at local level the Matrons are involved with handling concerns that arise on the wards, we witnessed unfamiliarity with the concerns process generally at ward level amongst staff, in addition there was a real inconsistency with the availability of concern leaflets on the wards. Indeed some of the concerns literature we saw was significantly out of date. Some patients we spoke to directly were unaware how to raise a formal concern and we were not confident that staff would be able to advise them effectively either.

4.9 Staff told us that the main themes arising from concerns on the wards are around communication and clinical care. In terms of the learning from concerns, we were told that feedback is provided to ward sisters at their team meetings, at Clinical Governance meetings and through patient stories. Key messages are then expected to be cascaded back down to ward staff. From our discussions with staff on the wards this did appear to be the case generally. In addition we were also told that the relevant staff have attended training which includes formulating responses, root cause analysis techniques and redress.

Summary

4.10 The ability of the Health Board to handle the concerns it receives appeared to be inconsistent and requires strengthening. This is not only in terms of the timeliness of the responses and increasing the awareness of the processes at ward level, but also in terms of the substance of the responses that are provided.

4.11 We viewed several examples of concern responses which were inadequate and insensitive. In one example a complainant whose relative had received a poor standard of care and subsequently died had their case examined by the PSOW. As a result of the PSOW's report a cheque was sent to the complainant[28], however this cheque was not accompanied by a letter or an apology and worse still was merely in the form of a remittance advice note that could not be used by the complainant. This naturally greatly upset the complainant. In another example a complainant whose father had died received, after a significant delay, a substantive response in which the deceased's name was incorrectly spelt.

4.12 While these are isolated examples, it must be remembered that each of the complainants that contact the Health Board do so because they feel aggrieved regarding the care and treatment that they or their loved ones had received. It can require great effort to recount in detail a concern and for that concern to be handled in a poor and sometimes insensitive manner greatly exacerbates the issues.

[28] The Ombudsman had instructed the Health Board to pay the complainant a sum of £250 as acknowledgment of the injustice suffered due the failings identified.

4.13 The Health Board needs therefore not only to strengthen the process of dealing with concerns in a timely manner, but also take considerable effort to ensure the quality and thoroughness of the substantive response that is compiled.

Chapter 5: Conclusion, Next Steps and Recommendations

5.1 While we were impressed by the response of the Health Board to the concerns that had been raised in the PSOW reports, our visit highlighted that there is still more work to be done to ensure that the highest standards of patient care are reached at Glan Clwyd Hospital. In addition, the tension between the Glan Clwyd Hospital and the Health Board needs to be recognised.

5.2 It was clear that Glan Clwyd is a hospital that is working to capacity, with committed staff who are working under intense pressure. Staff are eager to provide the highest standard of care that they can, but they are being constrained and hampered by the environment of the hospital. Recruitment of extra nurses must also be a priority – tied in with addressing the skill mix on the wards at night.

5.3 Considerable work remains to be done in relation to unscheduled care and the proposed new build which is to include A&E, the OOH centre and the AMU (the latter with single sex wards) must be seen as a high priority. In addition there are clear challenges facing Glan Clwyd in ensuring that the patient pathway through the hospital is efficient, of high quality and safe. In particular, admission avoidance schemes need further development and strengthening in collaboration with primary care. Community and social services input must be improved, particularly to facilitate early discharge.

5.4 We were broadly encouraged by the work that had been carried out by the Health Board in relation to PoVA and Safeguarding. There is a clear understanding of the safeguarding agenda. Staff were professional in their dealings with patients and we observed care being delivered in a way that was compassionate and maintained patients' dignity. However there remain significant and continual challenges in ensuring that staff receive the relevant level of training; both nursing and medical staff, in addition to the primary care sector.

5.5 The Health Board's performance in relation to the handling and management of concerns was less encouraging. There are issues not only in relation to issuing

responses in a timely manner, but also in ensuring the comprehensiveness of eventual responses and most importantly, that complainants are communicated to in a sensitive and compassionate manner. There is a need to review and simplify structures and to hold staff accountable for achieving targets.

5.6 Overall the work taken forward since the PSOW report must be continued; there is no place for complacency. Audit and quality measures must continue to be built into the Health Board's culture.

5.7 The Health Board will be required to formulate an action plan in response to the recommendations we have made and progress against these actions will be monitored by both Welsh Government and HIW. In addition, we will continue to undertake unannounced visits to the hospital as part of our DECI and Unannounced Cleanliness Spot Checks.

5.8 While some of the following recommendations are made specifically in relation to Glan Clwyd Hospital, they should be considered across the Health Board generally:

Recommendations

1. The Health Board needs to ensure that actions identified in its own work relating to the PSOW reports and also in relation to this report, encompass both nursing and medical staff.

2. The Health Board should undertake regular audits of Unscheduled Care. Audits should seek to asses issues in relation to extended waiting times, quality of care and dignity and respect issues.

3. The Health Board must ensure a greater involvement of paramedics, nurse specialists and allied health professionals in home visits, with a view to assisting in preventing unnecessary admissions to the A&E Department. Strengthening community services and having effective liaison with hospital

teams and primary care should help lessen inappropriate admissions to Glan Clwyd. This work needs to be carried out in collaboration with Primary Care.

4. The Health Board should broaden the introduction of its 'dignity champions' across, not only Glan Clwyd Hospital, but across the wider Health Board.

5. The Health Board must assure itself that care plans and nursing documentation are completed fully and that risk assessments and care plans are adequate. This practice should be embedded across the organisation from both a nursing and medical perspective.

6. The Health Board must to sustain momentum in relation to ensuring that the Transforming Care Programme is fully embedded across the organisation.

7. The Health Board should examine the possibility of implementing the SBAR[29] format (situation; background; assessment; recommendation) for communicating key information between staff, in particular during handover from nursing to medical staff.

8. The Health Board's plan to make Ward Sisters supernumerary needs to be implemented as soon as financially possible.

9. The Health Board should address the issues that are apparent in relation to staffing, in particular it should:

    a. Review and audit its staffing levels to ensure that appropriate skill mix of nursing staff is achieved on all wards, in particularly during night shifts.
    b. Address the delays that are being encountered in recruiting to vacant nursing and medical posts.
    c. Ensure that nursing staff are afforded the time and opportunity to attend training other than the mandatory training that they receive.

[29] http://www.institute.nhs.uk/

10. The Health Board should reinforce the fact that the Dignity and Respect agenda is an organisational responsibility and ensure that the focus does not rest solely on nursing staff.

11. The Health Board should strengthen its links with social services in order to improve its ability to discharge patients in a safe and timely way. The Health Board must assure itself that discharge arrangements are operating as intended.

12. The use of side rooms on wards at Glan Clwyd Hospital should be reviewed to ensure that they are being appropriately utilised, giving particular focus and attention to the need to utilise these rooms for patients on the end of life pathway whenever possible.

13. The Health Board should review arrangements within the AMU in order to seek a workable solution that adheres to the Dignity and Respect agenda. There should be a set protocol for the management of patients should it be necessary to place patients in a mixed sex area.

14. The Health Board should to address the issue of ambulances queuing up outside the A&E Department and the detrimental affect this has on patient safety and quality of care.

15. The Health Board should audit the number of patient safety incidents that arise from inappropriate ward placements. The number of patient moves during a period of admission should be kept to a minimum and where appropriate patients only moved to wards that are able to provide the relevant and suitable care. This may involve implementing 'patient flow simulation' tools.

16. The Health Board needs to assess its processes in maintaining and servicing the equipment on the wards. Consideration should be given to developing a patient equipment checklist to ensure equipment is safe and fit for purpose prior to opening emergency capacity beds. In addition consideration should

be given to utilising an equipment library which may ease the pressure on staff in accessing fit for purpose equipment.

17. The Health Board should consider options and the possibility of obtaining a broader range of patient feedback, in addition to gathering more real-time information from patients currently on the wards. This would assist in creating a more accurate picture of the patient experience within BCUHB.

18. The Health Board should ensure that patients and public are fully informed of the practical implications of the movement to more community based services. This programme of engagement should be constant and dynamic.

19. The Health Board should seek to implement more a more regular programme of patient safety walkabouts by its senior clinicians, nurses and managers. This would tie in with the 'Demonstrating Visible Leadership' ethos of the 1000 Lives Campaign and provide an informal method for leaders to talk with front-line staff about safety issues in the organisation and show their support for reporting of errors.

20. The Health Board needs to assure itself that documentation in relation to Do Not Attempt Resuscitation (DNAR) is fully completed. Particular attention should be given to documenting communication with patients and relatives.

21. The Health Board should ensure that the standards of acute medical care provided at Glan Clwyd and across the wider Health Board, should comply with the Royal College of Physicians guidance in *Acute care toolkit: High-quality care*[30].

22. In relation to PoVA:

    a. The Health Board needs to strengthen arrangements to ensure that as many staff as possible receive the minimum level PoVA training.

[30] http://www.rcplondon.ac.uk/resources/acute-care-toolkit-2-high-quality-acute-care

b. Action needs to be taken to ensure that PoVA training is targeted appropriately at both nursing and medical staff.
c. Training levels in respect of PoVA need to maintained and improved.
d. The Health Board should seek to expand the implementation of Safeguarding Forums across all relevant CPGs.
e. The PoVA training being provided should seek to emphasise the varying circumstances that may constitute a PoVA referral, with a focus on the neglect issues that may arise within the hospital environment itself.
f. The Health Board should undertake an audit to ensure that all appropriate members of staff have received CRB checks.

23. In relation to the handling of and management of concerns:

a. The Health Board should review resources within the concerns handling team to ensure there is adequate provision to meet the increasing needs of the organisation.
b. The Health Board should assess and measure performance in relation to concerns and the quality of the concern responses.
c. The Health Board should ensure that up to date literature regarding the concerns process is provided on all wards of its hospitals.
d. The Health Board needs to assure itself that staff are aware of the concern handling process and able to address concerns appropriately at ward level.

Postscript: Response from Betsi Cadwaladr University Health Board

Since the review was undertaken in February 2012, the Health Board has continued to work to improve the quality and safety of patient care in Ysbyty Glan Clwyd at a number of levels. This has included ensuring greater clinical executive presence at Ysbyty Glan Clwyd.

The Health Board accepts the recommendations of the review and will continue to work to address the issues raised. The Quality and Safety Committee on behalf of the Health Board will oversee the progress made and seek evidence and assurance that the matters raised are being addressed and that any changes implemented are delivering improvement. A report will be brought to Quality & Safety Committee within 6 months of publication which will be co-ordinated by the Assistant Medical Director (based at YGC) and Deputy Nurse Director (based at YGC).

Improving Unscheduled Care – The Health Board has instigated an intervention plan for Ysbyty Glan Clwyd unscheduled care which has delivered a marked improvement in performance against waiting times. The plan takes a whole systems approach and has focused on improving medical and nursing leadership, escalation and de-escalation processes and discharge planning including discharges before 11am. These arrangements are monitored closely by Executive Directors and reported to the Quality & Safety Lead Officers Group and Committee to ensure that improvement is sustained. Enhanced Care Services are in place for North Denbighshire to prevent unnecessary admissions and step up and step down services are available on daily basis which has seen an increase in referrals. A General Practitioner has also been appointed to the Emergency Department and is providing a “see and treat” service to minimise unnecessary admissions.
The Health Board is working in partnership with Welsh Ambulance reviewing the role of Advanced Paramedic Practitioners and their role in reducing ambulance conveyances and working with General Practitioners and Out of Hours services. Paramedics are working closely with Respiratory Specialist Nurses undertaking home visits on patients with chronic respiratory conditions to help prevent

unnecessary hospital admissions. In addition Specialist Nurses, including the Acute Coronary Syndrome Nurse, Respiratory, Stroke and Diabetes Nurse visit the Acute Medical Unit and Emergency Department undertaking daily patient reviews in order to avoid inappropriate admissions.

Improving the Patient's Experience – A dignity pledge has been launched across the Health Board and compliance audits have been conducted by lay volunteers, which demonstrate that patients routinely report being treated with dignity and respect. A face to face engagement communication survey has also commenced on two wards in Ysbyty Glan Clwyd which is currently being analysed. This pilot is a direct response to the Florence Nightingale Dignified Care Scholarship and the launch of the Dignity Pledge. A Dignity / Customer Care Ambassadors programme has been developed based on work done by Imperial College NHS Trust.

The Health Board has worked in partnership with Glyndwr University and all student nurses take the Dignity Pledge at their graduation ceremony. The first set of students took the pledge in the presence of the Health Minister at the graduation ceremony in October 2012.

Patient and visitors can now give real time feedback by completing comment cards. Feedback is analysed monthly and the trends identified and acted on.
The comments card data is useful as it provides timely qualitative data about the patient's experience.

The Service User Experience team have also been recording patients' stories and these are being used to ensure that the patient's experience shape and influence decisions at all levels. These are used to inform the monthly patient safety item which is shared across the organisation and since September 2012, a patient's story has been taken to each Health Board meeting to reinforce key items on the board's agenda.

Patient Safety – Leadership Walkabouts have been in place for some time in Ysbyty Glan Clwyd. The Health Board has implemented a programme of leadership walkabouts using Independent Members of the Health Board, Executive Directors

and Members of the Board of Directors. As such the leaders visiting Ysbyty Glan Clwyd include Chiefs of Staff and Clinical Executives. The site Assistant Medical Directors and Deputy Director of Nursing regularly engage in safety walkabouts, on a scheduled basis. In addition, as practicing Doctors, the Assistant Medical Director, Chiefs of Staff and Clinical Directors are visible and approachable during the normal course of day to day clinical care. The Health Board acknowledges the steer within this report toward improving this further.

The Health Board continues to work to ensure patients are admitted appropriately and the number of moves they experience is kept to a minimum. Additional clinical staff are now in place whose role it is to 'progress chase' to ensure that patients are reviewed on a daily basis by the consultant team and bed managers so that patients are only moved when absolutely necessary.

Protection of Vulnerable Adults (POVA) – The Health Board has a robust training structure and strategy in place for adult protection. This includes primary care and the third sector and uptake has continued to improve during the year. In addition, the Board has been exploring an e-learning module for level two training to improve access.

Managing Concerns – A review of the processes in place to deliver Putting Things Right (PTR) guidance on dealing with concerns about the NHS within the Health Board was conducted in April 2012. This resulted in a number of changes within the team so they could work more effectively and improve the handling of concerns within required standards and in line with good practice.

Since the review undertaken by HIW in February 2012, all literature available to the public regarding 'Putting things Right' has been reviewed and leaflets and posters have been revised and reissued across the Health Board. These are also available on the Intra and Internet.

The Health Board has made significant progress in strengthening the processes of dealing with concerns in a timely manner and improved performance against the national targets demonstrates the success of the changes implemented thus far.

However the Health Board is not complacent and recognises there is further work to be done particularly with training and developing frontline staff to support patients who wish to raise a concern. Plans are in place to continue to deliver improvement.

Discharge Planning – The Health Board has jointly developed a discharge from hospital protocol in conjunction with the six Local Authorities and there was a multi-agency launch in October 2012. This was informed by a discharge planning audit undertaken in August 2012, which showed much has improved but there is more work needed in YGC to increase the number of patients discharged by 11am and ensure all patients have an expected date of discharge identified on admission.

Local authorities now routinely attend the monthly meetings where patients whose care is delayed are discussed and plans to facilitate the discharge are agreed.

Improving Documentation – New nursing documentation has recently been developed which includes an adult inpatient risk assessment booklet which includes manual handling, falls, bed rails, tissue viability and nutrition. The risk assessment booklet has been recently piloted and updated and will be launched across the Health Board in December 2012.

Monthly audits are undertaken utilising the National Care Metrics Tool which assess compliance against a number of indicators. The Strategic Nursing & Midwifery Committee continues to monitor the quality and compliance with nursing documentation.

The new core adult nursing assessment documentation has the SBAR format already incorporated into the document for the purpose of professional handovers. Amendments were made following the recent pilot of the document. This, together with feedback received from the All Wales documentation group, will ensure that it is fit for purpose to meet service user needs.

In full consultation with clinical colleagues, revised guidance and processes have been put in place to ensure appropriate documentation for DNARCPR, which came into effect at the beginning of 2012. This is becoming embedded in the organisation

and within Ysbyty Glan Clwyd as evidenced in the weekly mortality case note reviews. This includes the documentation of communication with patients, relatives, next of kin and members of Staff.

The Health Board have also been active at a national level in developing and proposing an information leaflet for patients and relatives. This has been approved for use in the Health Board and currently with publishers.

Annex A

Terms of Reference

Healthcare Inspectorate Wales (HIW) is to undertake an independent review of patient care provided at Ysbyty Glan Clwyd, part of the Betsi Cadwaladr University Health Board (BCUHB).

Following a series of Ombudsman Reports that highlighted failings, BCUHB invited HIW to undertake a review of the standard of patient care provided at Ysbyty Glan Clwyd and wider BCUHB approaches to concerns and Protection of Vulnerable Adults (PoVA).

In taking this review forward HIW will:

- Undertake a review of patient care provided at Ysbyty Glan Clwyd.
- Examine the processes in place for the management of concerns.
- Examine the processes in place for reporting incidents to Protection of Vulnerable Adults (PoVA).
- Consider any other matters that may be relevant to the purposes of the investigation.

HIW will report upon its findings and where appropriate make any recommendations to ensure any necessary improvements in relation to the quality and safety of care are made.

Annex B

Arrangements for the Review

The Review Team

The Review was commenced in October 2011. A Review Team was constructed to include relevant expertise. The members of the Team were:

Dr Ian Mungall	Medical Director of Invited Service Reviews (ISR), Royal College of Physicians and Consultant in General and Respiratory medicine
Susan Mackie	Deputy Director of Nursing, North West London Hospitals NHS Trust
Liz Waters	Infection Control Nurse Lead, Aneurin Bevan Health Board
Richard Young	HIW Lay Reviewer
Rhys Jones	Head of Investigation
Leigh Dyas	Assistant Investigations Manager
Matthew Thomas	Assistant Regulation Manager

The Review consisted of three stages:

a. Collection and analysis of documents.
b. Fieldwork during which Glan Clwyd Hospital was visited and patients and staff interviewed.
c. Identification of findings, formulation of recommendations and completion of this report.

Annex C

The Roles and Responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- Making a significant contribution to improving the safety and quality of healthcare services in Wales.
- Improving citizens' experience of healthcare in Wales whether as a patient, patient, carer, relative and employee.
- Strengthening the voice of patients and the public in the way health services are reviewed.
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003.
- Care Standards Act 2000 and associated regulations.
- Mental Health Act 1983 and the Mental Health Act 2007.
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001.
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.