Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Dignity and Essential Care Inspection (Unannounced)

Aneurin Bevan University Health Board: Royal Gwent, D3 West

21 and 22 January 2015

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care Inspection in Ward D3 West at the Royal Gwent Hospital, part of Aneurin Bevan University Health Board on the 21 and 22 January 2015.

Our inspection considers the following issues:

- Quality of the patient experience
- Delivery of the fundamentals of care
- Quality of staffing, management and leadership
- Delivery of a safe and effective service

2. Methodology

HIW's dignity and essential care inspections review the way patients' dignity is maintained within a hospital ward/unit/department and the fundamental, basic nursing care that patients receive.

We review documentation and information from a number of sources including:

- Information held by HIW
- Conversations with patients, relatives and interviews with staff
- Discussions with senior management within the health board
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- General observation of the environment of care and care practice

These inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues about the quality and safety of essential care and dignity.

3. Context

Aneurin Bevan University Health Board was established on the 1 October 2009 and covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

Royal Gwent Hospital is situated in the city centre of Newport and has more than 3,400 staff and approximately 774 beds. The hospital provides a comprehensive range of hospital services for inpatients, day cases and outpatients.

The Health Board as a whole serves a population of more than 600,000 and many of the inpatient and specialist services at the Royal Gwent Hospital support the entire catchment area. Outpatient services are utilised primarily by those in Newport and the surrounding area.

Ward D3 West is a cardiology ward with 12 beds. This comprises two separate bays (one male, one female) of six beds each.

4. Summary

Patients told us they were very satisfied with the quality of care they received and the staff looking after them. We saw staff working to uphold patients' privacy and dignity, carrying out care in a kind and discreet manner.

Patients told us there were not enough toilet and washing facilities. This impacted on patient care in several areas which are outlined in detail in the 'Delivery of Fundamentals of Care' section of the report:

- **Rest, sleep and activity.** Although staff tried to ensure patients were able to rest as much as possible, all patients who wanted to use bathrooms in a timely way had to wake up early. This impacted on patients' rest and sleep.

- **Personal hygiene, appearance and foot care.** The limited toilet and washing facilities meant patients were not always able to access them in a timely way. Despite this, staff did their utmost to try to ensure patients could access facilities as quickly as possible and patients appeared well cared for.

- **Toilet needs.** Whilst staff tried to ensure patients could access toilets in a timely way, the limited number meant this was not always possible and this reduced patients' choice around their toilet needs.

Overall however, in the delivery of the fundamentals of care, we observed patients to be well looked after and found staff were committed to providing high standards of care.

Staff took time to explain patient's care and treatment to them and their relatives.

Staff were respectful, compassionate and dedicated to upholding patients' dignity. Consideration should be given to the use of 'in use' signs for bathrooms because we saw times when patients' dignity was unintentionally compromised.

We saw staff assisting patients to be as independent as possible. However, consideration should be given to making the ward environment as accessible as possible for patients with confusion and complex or sensory needs.

The ward systems and culture ensured patients were assisted to maintain contact with their loved ones during their stay on the ward.

We saw staff helping patients to be comfortable. Records showed that staff assessed patients' pain and provided appropriate pain relief.

Patients' nutritional needs were assessed and staff assisted patients to eat and drink where required. Patients told us there were sometimes delays with accessing meals and snacks which led to their food going cold.

Records indicated staff regularly assessed and provided help to patients to maintain their oral hygiene.

We saw appropriate pressure relieving equipment in use. However, staff told us they sometimes experienced difficulties in obtaining pressure relieving mattresses. Records indicated staff checked patients' skin regularly and we saw staff helping patients re-position to help prevent pressure sores.

There was visible and supportive management and leadership in place and staff told us they were well supported in their roles. There were sufficient staffing levels to meet patients' needs during our inspection but an acuity tool should be used to inform ongoing staffing levels. Not all staff were up to date with mandatory training topics.

Overall we found arrangements were in place to ensure the care provided to patients was safe. Where there were concerns in this respect, such as the unsafe storage of medicines and re-use of giving sets, these were brought to the attention of staff and the health board and were immediately resolved. Improvements could also be made to documentation to ensure the care management of patients is fully documented, accurately completed and actions initiated as a result.

5. Findings

Quality of the Patient Experience

Patients told us they were very satisfied with the quality of care they received and the staff looking after them. We saw staff working to uphold patients' privacy and dignity, carrying out care in a kind and discreet manner. Patients told us there were not enough toilet and washing facilities. This impacted on patient care in several areas which are outlined in detail in the 'Delivery of Fundamentals of Care' section of the report.

During the course of our inspection patients and their relatives were invited to complete our questionnaires to tell us about their experiences on the ward. These were completed via face to face interviews or returned to us in the post. In total 10 questionnaires were completed by patients and relatives. Patients completing questionnaires ranged in age from 27 – 82years. We also spoke informally with every patient on the ward who was happy to speak with us. We also observed the care and treatment being provided to help us understand the patient experience. Some patients and their relatives gave us permission to include their comments within this report, some of which are found below.

Every person who filled in a questionnaire gave 10 out of 10 for the overall care and treatment provided on the ward and we observed a high standard of care in practice. We saw staff being polite and courteous to patients and their visitors and treating people with dignity and respect. Some comments included:

> *'(He's) been showered today – he's in his own clothes. Sometimes seen him with odd socks etc. on other wards but here they've taken care of him'.*
>
> *'I do find this ward absolutely great'.*
>
> *When asked about the staff looking after them, patients and relatives made overwhelmingly positive comments. For example:*
>
> *'(Staff are) lovely, marvellous'.*
>
> *'…Words cannot be said about tolerance and dedication to their work'.*
>
> *'Cared for by staff on ward D3 West who provided wonderfully caring and professional nursing. They were a credit to the Hospital Trust'.*

Patients and relatives made particularly positive comments about how staff kept them informed and explained their care and treatment . For example:

> *'Kept informed…explain everything in depth'.*
>
> *'When you're on the other end of the phone and not here you worry but when I phoned this morning this nurse told me a lot, so kind and caring, told me he'd had breakfast, was going for a shower and he has. Can't tell you how much it means to get a nice nurse on the phone, shows they care'.*
>
> *'We signed the consent, they explained the risks and benefits – just glad he's in safe hands'.*
>
> *Several people commented they felt staff were very busy and there was a risk of this impacting on the service they received. For example:*
>
> *'Staff are under great pressure to complete their duty, owing to the reduced number on the wards'.*
>
> *'All I can say is that staff are brilliant if sometimes there are not enough of them'.*

The main concern that patients raised and that had the most serious impact on patients' experience was access to toilets and washing facilities. The toilet and shower facilities on the ward were limited with two toilets (one with the only shower) being shared by D3 West, Coronary Care Unit (CCU) and the High Dependency Unit (HDU). This impacted on the ability of staff to deliver the high standard of care they were dedicated to and we have addressed this through the 'Fundamentals of Care' section below. Patients told us:

> *'One thing I found bad was the fact there was only one shower room and two toilets for two wards (men and women). It is a pity that the great care we receive is spoilt by the lack of facilities'.*
>
> *'Could do with more toilets and washing facilities'.*
>
> *'More toilets and showers wanted'.*
>
> *'There are not enough toilet or showers on this ward'.*
>
> *'One criticism not directly covered by this questionnaire is toilet/shower facilities which are disappointing, inadequate for number of patients'.*

Patients and relatives told us they felt the ward was clean and tidy. We saw housekeeping staff on the ward throughout both days of the inspection, working to ensure areas were kept clean. We observed and staff confirmed that they struggled to keep the bathroom facilities clean due to the limited number of facilities for the number of patients. This is discussed further below.

Delivery of the Fundamentals of Care

Overall, in the delivery of the fundamentals of care, we observed patients to be well looked after and found staff were committed to providing high standards of care.

Communication and information

People must receive full information about their care in a language and manner sensitive to their needs

Staff took time to explain patient's care and treatment to them and their relatives.

We saw staff taking their time to explain aspects of patients' care and treatment to patients and their family members. Patients and relatives confirmed that they felt staff gave them excellent information. This meant that patients and relatives were given the time they needed to understand their care and treatment.

Staff gave us examples of how they communicated with patients with additional communication needs. Staff told us they used picture cards and had access to interpreting services. There was no hearing loop on the ward to assist staff in communicating with patients with hearing difficulties. We observed staff having to raise their voice to explain aspects of care to patients with hearing difficulties which meant others could overhear and compromised patients' privacy and dignity.

Recommendation

The health board should ensure staff have the appropriate tools to enable them to communicate with patients with hearing loss in a discreet way.

Patients had access to a wide variety of information leaflets relevant to cardiac health needs. The cardiology rehabilitation team provided information to patients on discharge in relation to their condition and any ongoing patient self care advice.

Respecting people

Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

Staff were respectful, compassionate and dedicated to upholding patients' dignity. Consideration should be given to the use of 'in use' signs for bathrooms because we saw times when patients' dignity was unintentionally compromised.

We saw staff being polite, courteous and treating people respectfully when assisting them and providing treatment. We saw many examples of this in practice and saw staff being particularly kind and caring to one confused patient.

We saw that staff maintained patients' privacy by discussing sensitive matters regarding patient care in the office where they could not be overheard. We observed a medical ward round and saw that staff were as discreet as possible.

The toilets were mixed gender and although there were locks on the door, we saw that there were no signs on the door to indicate when the toilets were in use. This meant that when staff assisted patients to the toilet who were unable to lock the door themselves and left them briefly to attend to another task, the door could be opened by others. This happened on a number of occasions which compromised patients' dignity and privacy.

Recommendation

The health board should consider how staff can ensure patients' dignity is upheld when using toilet facilities, e.g. through the use of 'in use' signs.

Promoting independence

The care provided must respect the person's choices in making the most of their ability and desire to care for themselves.

We saw staff assisting patients to be as independent as possible. Consideration needs to be given in relation to making the ward environment as accessible as possible to those with confusion and complex or sensory needs.

We saw staff encouraging patients to be as independent as their condition allowed, providing assistance as needed.

We saw some clutter in the corridors over the course of the two days which was not always conducive to allowing patients with mobility aids to mobilise as freely and independently as possible. We saw staff moving equipment when they became aware of this, allowing patients to move more freely.

At the time of our inspection there were patients on the ward who presented with some confusion. We saw that the health board's 'forget me not' scheme (a scheme whereby patients with confusion are identified with a flower symbol to indicate that they may require a higher level of assistance) was in use on the ward. This was being implemented with one patient during the inspection. Not all staff had an understanding of this scheme but the ward was small enough that we saw staff recognised those patients who had additional needs and provided the higher level of support they needed.

We saw that the ward environment was not particularly accessible or user friendly for patients with confusion, additional and/or sensory needs. For example, toilet and shower facilities did not have clear colour coding or signage. This may help assist patients to find these areas more easily and independently as their condition allows.

Recommendation

The health board should consider how to make the ward environment as accessible as possible to patients with confusion/dementia and complex or sensory needs.

Relationships

People must be encouraged to maintain their involvement with their family and friends and develop relationships with others according to their wishes.

The ward systems and culture ensured patients were assisted to maintain contact with their loved ones during their stay on the ward.

The ward had structured visiting hours in place from 3-5pm and 7-8pm. We saw that visitors were welcomed outside of these hours when needed and the relatives we spoke with had appreciated the flexibility of the ward.

There was a visitor's room available where patients could spend time with their loved ones in relative privacy. However, this room was also shared with CCU and the staff could only access their staff room by walking through the visitor's room. This was not conducive to allowing privacy and most patients saw their loved ones at the bed side.

Rest, sleep and activity

Consideration is given to people's environment and comfort so that they may rest and sleep.

Although staff tried to ensure patients were able to rest as much as possible, all patients who wanted to use bathrooms in a timely way had to wake up early. This impacted on patients' rest and sleep.

We found the ward to be comfortable in terms of heating, lighting and ventilation.

Some patients told us they had to get up very early to ensure they were able to access the shower facilities. Patients who were more independent told us they had to wake up before 7.30am to make sure they could access the facilities. Staff told us they woke all patients up at 7.30am to ensure they were able to assist everyone who required assistance to wash and access facilities in a timely way. Patients told us they were able to go back to bed afterwards. However this meant the limited shower facilities impacted on patients' routine and patients woke up early.

Recommendation

The health board should review the impact the lack of washing and toilet facilities is having on patient care in regards to the ward routine and disturbed sleep.

We saw the ward had sufficient quantities of bed linen available during our inspection allowing beds to be changed promptly and provide extra warmth for patients when sleeping. Staff told us the ward sometimes ran out of clean linen but they were able to access additional linen when needed.

One television was provided in each bay and the volume was kept low when patients were sleeping. We saw a trolley came around which enabled patients to buy newspapers and other items. Other than this, patients had to rely on their own resources for entertainment and activity.

Ensuring comfort, alleviating pain

People must be helped to be as comfortable and pain free as their circumstances allow

We saw staff helping patients to be comfortable. Records showed that staff assessed patients' pain and provided appropriate pain relief.

We saw staff helping patients to be comfortable when getting into bed or when assisting them to sit in chairs. Patients told us that staff were kind, caring and understanding.

Staff used a recognised pain assessment tool to assess patient's pain levels where needed. We saw that staff assessed people's pain levels and provided pain relief medication promptly to alleviate pain. Patients confirmed they received adequate and appropriate pain relief.

Personal hygiene, appearance and foot care

People must be supported to be as independent as possible in taking care of their personal hygiene, appearance and feet.

The limited toilet and washing facilities meant patients were not always able to access them in a timely way. Despite this, staff did their utmost to try to ensure patients could access facilities as quickly as possible and patients appeared well cared for.

As outlined above, there were limited washing facilities available for patient use with only one shower shared by the ward (12 patients), CDU and HDU. This meant patients were not always able to access shower facilities in a timely way.

Staff did their utmost to try to ensure all patients were able to access facilities as quickly as possible and the ward routine worked around access to facilities. We saw that the healthcare support worker and nurses prioritised patients who were waiting, particularly those who required assistance with their personal care routines. We saw a queue often formed with patients waiting to access facilities.

Recommendation

The health board should consider the impact of the limited washing facilities on patient care in regards to patients' access to timely personal care.

When assisting patients with personal care we found that staff were discreet and sensitive.

Staff told us that the ward frequently ran out of hospital gowns. On investigation we discovered that the number of gowns provided to the ward had recently been reduced due to changes in protocol and a standard amount was now issued, despite the need for more.

Recommendation

The health board should ensure the ward receives sufficient numbers of gowns to assist patients' comfort and ensure their dignity is maintained.

Eating and drinking

People must be offered a choice of food and drink that meets their nutritional and personal requirements and provided with any assistance that they need to eat and drink.

Patients' nutritional needs were assessed and staff assisted patients to eat and drink where required. Patients told us there were sometimes delays with accessing meals and snacks which led to their food going cold.

Patients we spoke with were positive about the choice and quality of food. However, one patient commented, *'it's whisked away if I go to the toilet for long'.* We observed a meal time on the first day of our inspection and found the food to be appetising with catering staff offering a range of choices and portion sizes to meet people's individual preferences. There were options available for those patients requiring soft and diabetic diets.

Patients made choices from a menu the day before and catering staff brought the meals onto the ward on a hot trolley. However, on the day of the inspection we saw that when the trolley arrived, there were not sufficient numbers of the meals patients had requested. This meant patients had to wait around 20 minutes until catering staff brought up additional meals which met their choices. Patients told us their meals were sometimes delayed and cold as a result. Staff told us this happened regularly and some patients told us their meals were always cold. Two diabetic patients also confirmed they experienced delays with accessing meals and snacks.

Recommendation

The health board should ensure that sufficient numbers of patient meals are provided from the kitchen in line with patients' menu choices. Patient meals should be served warm.

We were told the ward had protected mealtimes [1]in place and we saw that staff adhered to this. This meant patients were not disturbed whilst eating their meals.

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[1] **Protected Mealtimes.** This is a period of time over lunch and evening meals, when all activities on a hospital ward are meant to stop. This arrangement is put in place so that nurses

We saw that staff assessed patients' nutritional needs using a nutritional risk assessment tool[2] . Where required, staff recorded patients' food and fluid intake using All Wales food record charts.

We saw several red trays being used by patients but staff told us they did not use the Red Tray system[3] to physically identify those patients who needed assistance at mealtimes. Staff told us they used the patient board in the office to identify who needed support at mealtimes and we saw that the ward was small enough for staff to recognise which patients needed assistance. We saw staff appropriately assisting patients to eat and drink according to individual needs.

We saw that staff offered hot drinks throughout the day and if patients missed meals due to procedures, staff accessed hot and cold meals for patients from the canteen. We saw staff offering snacks to patients but staff told us the process for ordering meals/snacks outside of meal times could be time consuming as they had to fill in a request form. Two diabetic patients confirmed they had experienced delays in accessing meals and snacks.

Recommendation

The health board should ensure staff are able to easily access meals and snacks outside of meal times.

Oral health and hygiene

People must be supported to maintain healthy, comfortable mouths and pain free teeth and gums, enabling them to eat well and prevent related problems.

Records indicated staff regularly assessed and provided help to patients to maintain their oral hygiene.

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and housekeepers are available to help serve the food and give assistance to patients who need help.

[2] **Nutritional assessment** is used to evaluate nutritional status, identify disorders of nutrition and determine which individuals need instruction and/or support.

[3] The **Red Tray system** helps to reduce nutritional risk in hospitals by providing a signal that vulnerable patients need help and support from staff, or has a poor dietary intake.

The records we saw indicated staff were assessing patients' oral hygiene regularly and providing assistance.

We saw that there was a supply of toothbrushes and denture pots for patient use. We observed staff providing oral hygiene care assistance to patients. This meant that patients were supported to maintain their oral health whilst on the ward.

Toilet needs

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

Whilst staff tried to ensure patients could access toilets in a timely way, the limited number meant this was not always possible and this reduced patients' choice around their toilet needs.

As outlined above, there were limited toilet facilities with 12 patients on D3 sharing two toilets with patients on CDU and HDU. Over the course of the two days we often observed patients waiting for toilets and at times a queue formed. Patients told us and we observed that during times when the toilet facilities were particularly busy, staff offered patients commodes as an alternative. We saw that staff tried their utmost to ensure patients did not have to wait to access facilities. However, the limited access to facilities meant this had an impact on patient choice and dignity around their toilet needs.

Recommendation

The health board should consider the impact the lack of toilet facilities has on patient care in regards to patients' toilet needs, dignity and choice.

Staff told us the facilities had recently been refurbished to ensure they were fit for purpose. We spoke with cleaners on the ward who told us they tried to clean the toilet facilities four to five times per day. We checked the toilets on several occasions during our inspection and found varying levels of cleanliness. Due to the high number of patients accessing the facilities they were almost always in use and this meant there were limited opportunities for cleaning staff to access them.

Recommendation

The health board should ensure that toilet facilities can be cleaned and maintained to an appropriate standard.

Commodes were clean and well maintained reducing the risk of cross infection. We were told there were no patients on the ward requiring a continence assessment, but the All Wales bundle[4] to assess people's continence needs was used when required. We noted the ward stocked continence products should patients require them.

Preventing pressure sores

People must be helped to look after their skin and every effort made to prevent them developing pressure sores.

We saw appropriate pressure relieving equipment in use. However, staff told us they sometimes experienced difficulties in obtaining pressure relieving mattresses. Records indicated staff checked patients' skin regularly and we saw staff helping patients re-position to help prevent pressure sores.

The ward had pressure relieving mattresses to reduce the risk of patients developing pressure sores. The mattresses we saw were visibly clean and appeared to be functioning correctly.

Records we saw indicated that patients were appropriately assessed and those patients at high risk of developing pressure sores had a pathway in place to ensure they received appropriate care and treatment.

Staff told us they sometimes experienced difficulty obtaining suitable pressure relieving mattresses and sometimes waited up to two days. This meant patients were not always having specialist equipment (identified as being necessary to reduce the risk of pressure sores developing) in a timely manner. On investigation, we found that the system for obtaining mattresses had changed so that if a mattress was not available the same day, staff had to telephone every day to re-request the mattress until the mattress was provided. Staff told us this took up a great deal of their time and meant they had to remember to phone every day for any patient who required a mattress.

[4] **Continence bundle** is a tool which enables all nurses in Wales to assess the continence needs of their patients, audit the care provided and offer patients the opportunity to give feedback.

Recommendation

The health board should identify the reason(s) for staff having difficulty obtaining pressure relieving mattresses and take suitable action to prevent delays from happening.

The monitoring records we saw indicated staff regularly checked patients' skin for signs of pressure damage. We saw staff helping patients reposition to help prevent pressure sores developing.

Quality of Staffing, Management and Leadership

There was visible and supportive management and leadership in place and staff told us they were well supported in their roles. There were sufficient staffing levels to meet patients' needs during our inspection but an acuity tool should be used to inform ongoing staffing levels. Not all staff were up to date with mandatory training topics.

Staffing levels and skill mix and professional accountability

At the time of our inspection the management structure on the ward was made up of one ward sister and a deputy. The ward sister was on leave when we visited but we were well supported by the deputy ward sister, nurse in charge and senior nurse across the two days. The ward team also consisted of medical staff, registered nurses (including three Band 6 nurses), one healthcare support worker and housekeeping staff.

On both days of our inspection there were two nurses and one healthcare support worker (who worked 7am – 3pm, Monday to Friday). This meant that staffing arrangements met the Chief Nursing Officer for Wales guidelines for safe levels of staffing. We found staffing levels and skill mix to be suitable to meet the needs of the patients during our inspection. For example, on the first day one of the nurses was newly qualified and was on shift with, and supported by, the deputy ward sister, ensuring sufficient breadth of experience.

Staff told us that the acuity level on the ward had increased and many patients admitted onto the ward now came from the CCU, almost as a step down facility. Staff told us that night shifts when staffing levels reduced, and after 3pm when the health care support worker left, were busier and they sometimes struggled during these times. The senior nurse told us they were currently gathering data for the acuity tool to see if staffing levels needed to be increased. Staff told us the ward sister was usually included in the numbers when staffing the ward and it was difficult for them to access supernumerary time for non clinical duties.

Recommendation

The health board is advised to use the outcome of the acuity tool exercise to inform ongoing staffing levels and to ensure there is sufficient staffing for the ward sister to access supernumerary time.

There were two medical teams which rotated on a fortnightly basis. This meant patients had the same consultant and medical team for two weeks which provided patients with a degree of continuity in medical care.

The senior nurse told us the ward rarely used agency staff because there was a CCU bank of staff in place which they could use to cover shifts. All staff working on the ward across our two day inspection were staff familiar with the ward. Staffing was shared across CCU and Ward D3 West. This meant patients were cared for by staff who were familiar to them.

We found the nurses in charge and senior nurse were visible on the ward and they provided support and direction to the staff team. We found that the staff team as a whole worked well together, had a patient centred perspective and supported each other to meet the care needs of patients.

The vacancy rate across CCU and D3 West was low and recruitment, sickness, bank/agency use was monitored on a weekly basis by the senior nurse and directorate manager.

Effective systems for the organisation of clinical care

We saw that each day the nurse in charge the shift was visible and provided clear leadership. We saw that each bay had their own allocated nurse and the healthcare support worker worked under the direction of the nurses. The senior nurse attended the ward regularly, focussed on patient flow to ensure any potential delayed discharges were identified and carried out a walk through of the ward every day. This meant there was a clear structure in place to support staff in their roles.

We observed one medical round which was attended by the nurse to ensure any changes to patient care were identified and communicated to the rest of the team.

There was a ‘patient safety at a glance’ board in place in the office, so that staff could easily see the most important aspects of patient’s care and treatment. We saw that written handovers were in place to ensure continuity in patient care.

We saw that appropriate referrals were made where required, for example, to the cardio rehab team which provided support and guidance to people about self care on discharge, as well as professionals such as the diabetic specialist nurse and dietician.

Training and development

Staff told us they were supported to access mandatory training and they also attended annual away days to cover training. The health board provided us with current training statistics for D3 West and CCU and there were several areas where the ward was having difficulties maintaining staff compliance with mandatory training. From the 19 mandatory topics, eight of these topics had a

staff compliance rate of fewer than 50% which included topics such as IV drug administration, syringe driver and protection of vulnerable adults (POVA). Management staff told us they were putting together an action plan to improve compliance.

Although the staff we spoke with on the day were clear about their roles in identifying and reporting abuse, staff training compliance with protection of vulnerable adults training was particularly low at 15%. This meant we could not be assured that all staff were up to date with this important area and their roles and responsibilities in reporting abuse.

We saw that several patients on the ward were confused and staff told us there was not a mandatory requirement for them to undertake training on dementia/confusion. Not all staff we spoke with were aware of the 'forget me not' scheme used by the health board to identify those patients with confusion. We also saw that staff training compliance with the Mental Capacity Act was low at 27%. This meant we could not be assured that all staff were up to date with supporting patients with these particular needs.

Recommendation

The health board should ensure staff are supported to keep up to date with mandatory training to ensure they maintain their skills and can work safely and effectively with patients. The health board should ensure staff receive the training they require to support vulnerable patients (e.g. POVA, Mental Capacity Act and dementia/confusion).

Just over two thirds of staff had an up to date PDR in place. Staff told us they felt well supported in their roles.

Handling of complaints and concerns

We held discussions with staff and found that patients and their relatives were encouraged to discuss care and treatment with ward staff through daily face to face contact. Patients told us they felt able to raise concerns with staff and would ask if they wanted to make a complaint. We saw records for complaints and we were assured that they were managed appropriately.

Delivery of a Safe and Effective Service

People's health, safety and welfare must be actively promoted and protected. Risks must be identified, monitored and where possible, reduced or prevented.

Overall we found arrangements were in place to ensure the care provided to patients was safe. Where there were concerns in this respect, such as the unsafe storage of medicines and re-use of giving sets, these were brought to the attention of staff and the health board and were immediately resolved. Improvements could also be made to documentation to ensure the care management of patients is fully documented, accurately completed and actions initiated as a result.

Risk management

Incidents

We found that ward based clinical incidents were reported using an electronic system. Incidents were followed up by management and the ward sister and learning disseminated through daily staff safety briefings. We saw records for incidents and we were assured these were dealt with appropriately.

Policies, procedures and clinical guidelines

We held discussions with the ward sister and staff. As a result of this it became evident that they were able to obtain a range of guidelines and policies which supported aspects of their patient activity (via the ward computer).

We scrutinised policies in relation to medication management and discharge policy. We found the discharge policy had an expiry date of October 2010. This meant we could not be assured staff had access to up to date information regarding patient discharge when working with them.

Recommendation

The health board should ensure staff have access to an up to date discharge policy to inform practice.

Effective systems for audit and clinical effectiveness

We held a discussion with the deputy ward sister and senior nurse in relation to clinical audits and found that there were suitable systems and processes in place to check aspects of the quality of patient care. Specifically, we saw that checks were being undertaken regularly of hand hygiene, pressure ulcers,

nutrition, MRSA, credits for cleaning and falls. The results of audits and any changes to practice on the ward were shared with staff on an ongoing basis.

Staff were able to give examples where practices on the ward had changed as a result of quality assurance and audit activities. For example, they had increased the number of monitors available for patients when this need had been recognised. They had also identified on one audit that a specific piece of equipment was not on the cleaning schedule and this had been added to the schedule as a result.

We saw that initiatives from the 1000 Lives campaign[5] were being used, such as safety crosses displayed on the ward wall to make highly visible the incidence of avoidable adverse events. This meant the ward had considered and implemented a system in order to make the team and public aware of avoidable events.

Patient safety

The ward used 'safety briefings' to ensure the whole staff team kept up to date with any patient safety risks or incidents. These happened three times a day and were used to structure staff handover which meant there was continuity in passing on relevant concerns across the staff team. This was an area of best practice.

Medicines management

Administration and recording of medicines

Medicines were administered on an individual basis from stock cupboards. We observed staff administering medicines and found them to be skilled and competent, correctly positioning patients and making accurate recordings in patients' Medication Administration Records (MARs).

We found the controlled drugs book was being completed in line with legal requirements and health board policy.

We saw practice on the ward of re-using giving sets for patients. This involved the practice of discontinuing the line with infusion bag with added drug

[5] **The 1000 Lives Campaign** aims to improve patient safety and increase healthcare quality across Wales.

(antibiotic) attached and then storing this in the treatment room. When the patient was ready for their next dose (of the same drug), the empty infusion bag was disconnected, a new bag was connected and the line re-used. Staff on the ward told us they had learned this at training, had investigated this with the health board and had been told they could use the same giving set for the same patient up to three times within a 24 hour period. We saw infusion lines had been labelled accordingly and were stored in the treatment room for re-use on a number of occasions.

We raised concerns with staff about the higher risk of error with storing several lines together in this way and higher risk of cross infection and contamination. We also raised this at the feedback session and requested further clarification about whether this was health board policy. We received a response on 23 January 2015 stating staff had misinterpreted teaching on the IV therapy course and actions were being taken to stop this practice immediately on the ward and to ensure other areas across the health board had not misinterpreted training. We raised this as an immediate action following the inspection and received a sufficient response from the health board confirming all actions had been taken to stop this practice.

Storage of drugs

During the two day inspection we found that not all medication was stored securely to prevent access by unauthorised persons. On one occasion we saw that the trolley had been left unlocked. We brought this to the attention of staff who secured the trolley immediately.

Recommendation

Staff should ensure the trolley containing medicines is secure at all times to avoid access by unauthorised patients.

Within the treatment room we found boxes of IV antibiotics on the side of the counter and IV drugs laid out for later use. The treatment room door had been propped open by a bin and on investigation we discovered that there was no lock on the treatment room door. We brought these concerns to the immediate attention of ward staff and they made the area secure. A lock was fitted to the treatment room door by the end of our inspection.

Recommendation

The newly fitted lock to the treatment room door should be used by all staff to ensure this area is secure at all times.

We found IV fluids were being stored in a cupboard which was permanently open as it also housed the pod system for sending specimens for analysis. We raised immediate concerns about the security of IV fluids and potential infection control issues. Staff moved all IV drugs to a separate drug storage room.

Recommendation

The health board should ensure suitable storage for IV drugs on an ongoing basis.

Documentation

Patient Assessment

We looked in detail at four patients' care plans and notes relating to their care. The organisation of paperwork made it difficult to follow the care management of the patient and to understand at what stage care bundles had been initiated and why. This was because patients' notes were not found to follow any particular order and risk assessments carried out on admission were kept separately to the nursing notes. At times, patient risks continued to be assessed using these admission packs whilst at other times we found patient risks had been transferred to the patient's main nursing notes.

Recommendation

The health board should consider how to make the documentation easier to follow in terms of understanding the care management and care pathway of the patient.

Generally, we found appropriate care plans had been initiated and were evaluated by staff. However we found two examples where care plans had not been completed fully. For example, one patient's arrhythmia[6] care plan consisted of a date, signature and 'chb' (indicating the patient had a 'complete heart block') only. This meant that care plans did not always have the level of detail required to ensure there were clear care and treatment guidelines.

[6] **Arrhythmia** is a condition in which the heart beats with an irregular or abnormal rhythm.

Recommendation

Patient care plans should be fully completed and have the level of detail required to ensure staff have clear guidelines to follow in treating the patient.

Relevant risk assessments had been completed on admission using an admission pack. We found that mainly, these had been updated and where risks reached certain levels, All Wales bundles were implemented and recognised pathways followed to manage the risk. However, we found three MUST tools[7] which had not been been completed accurately or followed up appropriately. In one case the tool had been appropriately completed but the appropriate action had not been carried out to re-screen the patient in 2-3days. In another case, the risk assessment scores had not been calculated accurately so the patient's level of risk had come out as lower than it should, resulting in a nine day delay to staff taking action. In a third case the tool had not been filled in meaningfully and consisted of a comment that the patient was known to the community dietician. This meant we could not be assured that documentation relating to patients risks around weight management was being used appropriately.

Recommendation

The health board should ensure MUST tools are completed accurately and that actions leading from them are followed through, ensuring appropriate risk management for patients.

Nursing notes were updated contemporaneously in line with best practice guidelines to ensure any issues were captured and dealt with in real time. We saw evidence that care provided was being evaluated to ensure any changes could be identified.

We saw that where patients were assessed as requiring input from a specialist, appropriate referrals were made. We also saw multidisciplinary entries in patients' notes which indicated the involvement of a range of professionals to ensure patients' holistic health needs were being addressed.

[7] 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Diabetes Care

The ward had access to diabetic specialist nurses to act as a local point of contact and share best practice on diabetes care. Staff told us they had received training on diabetes management and staff training statistics confirmed that 96% of staff had undertaken blood glucose monitoring treatment.

We looked at two (type two) diabetic patient records and found that their diabetic needs were being managed appropriately, although documentation was inconsistent. In both cases we found diabetes care plans in patient files but they had not been completed. We found that staff were monitoring both patients' blood glucose levels but did not have clear guidelines to follow in terms of a formalised care plan. This meant the treatment staff were providing in terms of diabetes care was not being formalised or evaluated. In the case of one patient we found their blood glucose levels were being monitored on an insulin dependent diabetic chart even though the patient was a diet controlled diabetic. This had been changed to a ward diabetic chart several days later. However, we could therefore not be assured that documentation for diabetes care was consistently implemented and monitored.

Recommendation

The health board should ensure all diabetic patients have clear care plans and risk assessments in place for staff to follow and to ensure care can be evaluated and is appropriate.

In both cases, patients told us they experienced delays in receiving meals and snacks. The reasons for this have been explained under the 'Fundamentals of Care' section above and a recommendation has been made.

Hypo-boxes[8] containing equipment and medication to treat a diabetic emergency were available on the ward and clearly visible.

[8] A **hypo box** provides staff with all the relevant equipment to treat a diabetic emergency as well as guidelines for the effective management of that emergency.

6. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit their improvement plan to HIW within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified within Ward D3 West at the Royal Gwent will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/ units of the health board.

The health board's improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing dignity and essential care inspection process.

Appendix A

Dignity and Essential Care: Improvement Plan

Hospital: Royal Gwent

Ward/ Department: D3 West

Date of Inspection: 21 and 22 January 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
	None – facilities recommendation below.			
	Delivery of the Fundamentals of Care			
Page 8	The health board should ensure staff have the appropriate tools to enable them to communicate with patients with hearing loss in a discreet way.			
Page 9	The health board should consider how staff can ensure patients' dignity is upheld when using toilet facilities, e.g. through the use of 'in use' signs.			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Page 10	The health board should consider how to make the ward environment as accessible as possible to patients with confusion/dementia and complex or sensory needs.			
Page 11	The health board should review the impact the lack of washing and toilet facilities is having on patient care in regards to the ward routine and disturbed sleep.			
Page 12	The health board should consider the impact of the limited washing facilities on patient care in regards to patients' access to timely personal care.			
Page 12	The health board should ensure the ward receives sufficient numbers of gowns to assist patients' comfort and ensure their dignity is maintained.			
Page 13	The health board should ensure that sufficient numbers of patient meals are provided from the kitchen in line with patients' menu choices. Patient meals should be served warm.			
Page 14	The health board should ensure staff are able to easily access meals and snacks outside of			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	meal times.			
Page 15	The health board should consider the impact the lack of toilet facilities has on patient care in regards to patients' toilet needs, dignity and choice.			
Page 15	The health board should ensure that toilet facilities can be cleaned and maintained to an appropriate standard.			
Page 17	The health board should identify the reason(s) for staff having difficulty obtaining pressure relieving mattresses and take suitable action to prevent delays from happening.			
	Quality of Staffing Management and Leadership			
Page 18	The health board is advised to use the outcome of the acuity tool exercise to inform ongoing staffing levels and to ensure there is sufficient staffing for the ward sister to access supernumerary time.			
Page 20	The health board should ensure staff are supported to keep up to date with mandatory training to ensure they maintain their skills and can work safely and effectively with			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	patients. The health board should ensure staff receive the training they require to support vulnerable patients (e.g. POVA, Mental Capacity Act and dementia/confusion).			
	Delivery of a Safe and Effective Service			
Page 21	The health board should ensure staff have access to an up to date discharge policy to inform practice.			
Page 23	Staff should ensure the trolley containing medicines is secure at all times to avoid access by unauthorised patients.			
Page 23	The newly fitted lock to the treatment room door should be used by all staff to ensure this area is secure at all times.			
Page 24	The health board should ensure suitable storage for IV drugs on an ongoing basis.			
Page 24	The health board should consider how to make the documentation easier to follow in terms of understanding the care management and care pathway of the patient.			
Page 25	Patient care plans should be fully completed			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	and have the level of detail required to ensure staff have clear guidelines to follow in treating the patient.			
Page 25	The health board should ensure MUST tools are completed accurately and that actions leading from them are followed through, ensuring appropriate risk management for patients.			
Page 26	The health board should ensure all diabetic patients have clear care plans and risk assessments in place for staff to follow and to ensure care can be evaluated and is appropriate.			

Health Board Representative:

Name (print): .....

Title: .....

Signature: .....

Date: .....