Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Dignity and Essential Care Inspection (unannounced)

Abertawe Bro Morgannwg University Health Board, Singleton Hospital, Ward 6

14 and 15 January 2015

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care inspection in Ward 6 at Singleton Hospital, part of Abertawe Bro Morgannwg University Health Board on the 14 and 15 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 and relatives and interviews with staff
- Discussions with senior management within the health board
- Completed HIW questionnaires
- 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

Abertawe Bro Morgannwg University Health Board covers a population of approximately 500,000 people and employs around 16,500 members of staff.

The health board has four acute hospitals providing a range of services; these are Singleton and Morriston Hospitals in Swansea, Neath Port Talbot Hospital in Port Talbot and the Princess of Wales Hospital in Bridgend. There are also a number of smaller community hospitals providing clinical services outside of the four main acute hospital settings.

Singleton hospital is a district general hospital with 550 beds situated on Swansea Bay, adjacent to the campus of Swansea University. There are acute general medical, care of the elderly, general surgical, ophthalmology, ENT and radiotherapy departments in addition to a high dependency unit and the obstetric and gynaecological departments.

Ward 6 is a 30 bedded ward which provides care to adult patients with medical care needs. The ward specialises in providing healthcare services to patients with disorders of the endocrine system, for example diabetes.

4. Summary

Overall, patients told us they were satisfied with the care and treatment provided on the ward. We found the ward to be clean and tidy.

Generally, the Fundamentals of Care standards were being met on the ward. However we have made recommendations for improvement in respect of the standards concerned with sleep, rest and activity and eating and drinking. We also recommended that the ward team considers using a more comprehensive pain assessment tool.

Overall, patients told us staff had helped them understand their medical conditions. We saw staff explaining procedures to patients relating to their care.

We saw staff treating patients and their relatives with respect.

Staff were assisting patients to be as independent as their conditions allowed. Other members of the multidisciplinary team visited the ward to assess patients and provide equipment to help them be independent.

We found appropriate arrangements were in place to allow patients to maintain contact with their family and friends.

Comments from patients indicated they sometimes had their sleep disturbed due to general noise and activity within the ward.

The stock of bed linen on the ward appeared low. Staff told us there was sometimes a delay in clean linen being delivered to the ward. We have recommended the health board explore the reasons for this and take corrective action as necessary.

We found a number of bed lights not working. We were told this had resulted in staff having to use the main lights at night when attending to patients, causing others in the bays to be disturbed. We highlighted this to the nurse in charge and repairs to the lights took place during our inspection.

We saw staff had assessed patients' pain and taken action to make them comfortable.

Generally, patients appeared well cared for. However, during our inspection we felt patients would have benefited from more frequent intervention from nursing staff to meet their care needs.

Protected mealtimes were in place and overall these were being adhered to. Some patients told us they had sometimes been served meals that were not as

warm as they would have liked. We made senior staff aware of this so they could explore possible reasons for this and take corrective action as necessary.

The ward had supplies of toothpaste and toothbrushes so patients' oral hygiene needs could be met.

Toilets were clean and appropriately equipped to reduce cross infection. We saw staff responding to patients' requests and helping them as needed.

We saw appropriate pressure relieving equipment in use that was clean and working properly. Assessment and monitoring records indicated staff were providing care to prevent patients developing pressure sores.

At the time of our inspection we felt some patients with complex needs required more frequent intervention from nursing staff. Conversations with staff indicated they felt staffing levels required reviewing.

We saw good leadership from the nurse in charge on both days of our inspection and it was evident senior staff on the ward were committed to supporting and developing the ward team.

Staff told us they had received training relevant to their role. However, audit results demonstrated improvements were needed for the ward to comply with the health board's training target.

The nurse in charge told us staff would try and resolve concerns (complaints) at ward level as far as possible.

The nurse in charge described appropriate arrangements were in place to report, investigate and learn from clinical incidents.

Staff had access to a range of relevant policies.

We saw audits were taking place to check key areas of patient care. We recommended these be supported by the completion and displaying of safety crosses[1] within the ward.

We found arrangements were in place to ensure the care provided to patients was safe. However, the care records we saw did not always contain evidence

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[1] The Safety Cross has been adapted from industry to make highly visible the incidence of avoidable adverse events. In doing so it ensures that the whole team is aware of avoidable events and thus instils a sense of purpose in working to avoid future events.

that mental capacity issues had been assessed or considered when providing care. We have recommended the health board takes suitable action to ensure staff are aware of their responsibilities under the Mental Capacity Act (2005).

We saw safe practice in respect of the management of medication being used on the ward.

We saw written care plans in place for patients and that these were being evaluated regularly. Whilst written care plans were in place, these were standardised and would benefit from being further individualised to each patient. Some risk assessment documentation being used had been photocopied and was of a poor print quality. This made it difficult to read and we have recommended the health board addresses this.

Some entries within care plans were not legible and we have recommended the health board takes appropriate action to ensure staff adhere to professional standards for record keeping.

Ministerial Unannounced Spot Check Visits

On 28 July 2014 ministerial unannounced spot check visits were made to the hospital and Welsh Government published the findings within a report[2]. We used the findings from these visits to inform our dignity and essential care inspection. Whilst our inspection focussed on ward 6, we did visit two of the wards visited by the spot check review team to look at the wider practice within wards at the hospital. The wards we visited were ward 3 and ward 4.

We found improvements had been made in some of the areas identified by the spot check visits. Specifically these related to the provision of toileting aids and medication storage. However, we did recommend that the medication cupboard on ward 3, whilst located in a lockable room, had a new lock fitted. This was for additional medication security. Senior hospital managers agreed to arrange for this work to be completed.

We were disappointed to find that poorly photocopied documentation was still in use on ward 3 and highlighted this to senior hospital managers. We have also

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[2] A copy of the report *Learning from Trusted to Care, Ministerial Unannounced Spot Check Visits to Singleton Hospital, Swansea* is available from the Welsh Government website at http://wales.gov.uk/topics/health/nhswales/spot-checks/abertawe1/?lang=en

identified the same issue within ward 6 and have made a specific recommendation within this report regarding this. We expect action to be taken to address this, not just on ward 6, but across other areas of the health board as necessary.

We were told the skill mix on ward 3 and 4 had not been reviewed but were assured that since the time of the spot checks, the situation had improved. We were told this was a result of staff who had previously been on sick leave returning to work and the introduction of a twilight shift to ensure adequate staffing at busier times on the night shift.

We found water jugs were not being replenished three times per day as was recommended. This was discussed with senior hospital managers. They told us they were aware of this issue and had met with a representative from the office of the Chief Nursing Officer for Wales and were working towards a suitable way forward.

5. Findings

Quality of the Patient Experience

Overall, patients told us they were satisfied with the care and treatment provided on the ward. We found the ward to be clean and tidy.

During our inspection we invited patients and relatives to complete our questionnaires to tell us about their experience on the ward. We asked for their views about the ward environment, the hospital staff and the care received. Patients and visitors also provided us with comments through ad hoc conversations.

In total, 10 questionnaires were completed either via face to face interviews or completed and returned to us during the inspection.

Overall, those who provided comments within questionnaires indicated the ward had been clean and tidy during their stay. This was confirmed through our observations on the days we visited.

In general, those who completed questionnaires told us staff were polite to them and their friends and family.

Comments we received included:

'All staff are friendly.'

'They are amazing.'

'Some are better than others.'

We saw staff being polite and treating patients with courtesy. We also saw staff protecting the privacy and dignity of patients when helping them with their care needs.

When asked to provide their views on the care they had received, patients who provided comments within completed questionnaires told us staff were kind and helped them when needed. We invited patients to rate the care and treatment provided to them on the ward. The majority of patients rated this as between 8 to 10, out of 10.

Other comments made within completed questionnaires included:

'As a visitor I was happy to see that my relative was cared for and clean.'

‘The staff have been wonderful to me. The nurses, doctors, [healthcare support workers].They are amazing.’

‘Food absolutely tasteless.’

‘Care ….. is first class.’

Delivery of the Fundamentals of Care

Generally, the Fundamentals of Care standards were being met on the ward. However we have made recommendations for improvement in respect of the standards concerned with sleep, rest and activity and eating and drinking. We also recommended that the ward team considers using a more comprehensive pain assessment tool.

Communication and information

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

Overall, patients told us staff had helped them understand their medical conditions. We saw staff explaining procedures to patients relating to their care.

In general, patients who completed questionnaires told us staff had talked to them about their medical conditions which helped them to have a better understanding.

We saw nursing staff explaining procedures to patients and gaining their consent before providing care. Doctors were conducting rounds at the time of our inspection and we found they were being as discreet as possible when seeing patients.

We found advice was provided to patients on their care and treatment by physiotherapists and occupational therapists. This meant patients had access to specialist advice from the wider hospital team.

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.

We saw staff treating patients and their relatives with respect.

We saw staff being polite to patients and treating patients with respect. As far as possible staff were protecting the privacy of patients when helping them with their personal hygiene needs.

Promoting independence

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

Staff were assisting patients to be as independent as their conditions allowed. Other members of the multidisciplinary team visited the ward to assess patients and provide equipment to help them be independent.

We saw staff helping patients to be as independent as their condition allowed. Toilets and washing rooms were clearly signposted to assist patients to find these areas independently.

Patients had their personal belongings nearby so they could reach these without needing help from staff.

Occupational therapists and physiotherapists visited the ward to assess patients and provide advice and equipment to promote their independence. This meant patients were being supported to be as independent as their condition allowed whilst on the ward and to prepare them for a safe discharge home.

Relationships

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

We found appropriate arrangements were in place to allow patients to maintain contact with their family and friends.

We were told the ward had structured visiting hours. However, staff confirmed these could be flexible with the agreement from the nurse in charge. This meant patients could maintain contact with their relatives and friends whilst in hospital.

We were told the ward encouraged relatives and friends to be involved in care according to their and the patient's wishes. There were also facilities for relatives and carers to stay overnight if necessary, to be with patients who were very ill.

There was a dayroom on the ward for patients to use and to spend time with their relatives and friends. However, we did not see this area being used during our inspection.

Rest, sleep and activity

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

Comments from patients indicated they sometimes had their sleep disturbed due to general noise and activity within the ward.

The stock of bed linen on the ward appeared low. Staff told us there was sometimes a delay in clean linen being delivered to the ward. We have recommended the health board explore the reasons for this and take corrective action as necessary.

We found a number of bed lights not working. We were told this had resulted in staff having to use the main lights at night when attending to patients, causing others in the bays to be disturbed. We highlighted this to the nurse in charge and repairs to the lights took place during our inspection.

We saw patients retiring to bed to rest at different times of the day during our inspection.

All the beds on the ward were made up and patients appeared to have adequate pillows and blankets for their comfort. We checked the stock of bed linen available. Whilst there appeared to be sufficient blankets available, the stock of clean sheets was low. Staff agreed with our view and explained whilst they could request more sheets there was sometimes a delay in them being delivered to the ward. This could result in delays in patients returning to bed to rest should their bed need changing.

Recommendation

The health board should explore the reasons for the delays in the availability of clean linen and take appropriate action to ensure sufficient supplies are available to the ward in a timely manner.

We received comments from patients who told us they had experienced difficulty with sleeping. This appeared to be due to general noise and activity within the ward. In addition, a number of the bed lights were not working. Patients told us this had resulted in the main light having to be used when night staff attended to patients, causing others in the bay having their sleep disturbed. We raised this with the nurse in charge who arranged for the bed lights to be checked and repaired during our inspection.

Ensuring comfort, alleviating pain

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

We saw staff had assessed patients' pain and taken action to make them comfortable.

During our inspection patients appeared comfortable. Where staff had assessed patients as having pain, action was taken to make them comfortable. Patients who spoke to us confirmed staff provided their pain relief promptly.

We saw staff had assessed patients' pain when completing the National Early Warning Score[3] (NEWS) charts. This recorded a (numerical) measure of pain, however, it did not identify the type or location of a patient's pain, which may be useful for some patients, in order to better assess and manage their pain. The ward team may therefore wish to explore using a more comprehensive pain assessment tool to support existing pain assessment methods.

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.

Generally, patients appeared well cared for. However, during our inspection we felt patients would have benefited from more frequent intervention from nursing staff to meet their care needs.

During our inspection, staff were assisting patients with their personal hygiene needs. Patients we spoke to and who provided comments within completed questionnaires confirmed staff helped them as needed in a kind and sensitive manner.

Whist we saw patients were generally well cared for, it was evident from our observations that some patients would have benefited from more frequent intervention from staff. Our findings in respect of staffing can be found under the *Quality of staffing, management and leadership* section of this report.

[3] The National Early Warning Score (NEWS) is a simple system that hospital staff can use to assess whether patients are developing potentially life-threatening illnesses

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.

Protected mealtimes were in place and overall these were being adhered to. Some patients told us they had sometimes been served meals that were not as warm as they would have liked. We made senior staff aware of this so they could explore possible reasons for this and take corrective action as necessary.

The ward had protected mealtimes in place for lunch and teatime with the intention of allowing patients to eat their meals without being disturbed. We observed lunch being served on both days of our inspection and overall the arrangements were being adhered to. No concerns were raised by patients regarding having time to eat their meals.

Meals were served by a hostess, with ward staff assisting by taking meals to patients and helping them to eat their meals. Snacks and drinks were available in between meals for patients who wanted them. We were also informed about appropriate arrangements to obtain meals for patients who, for some reason, were absent from the ward at mealtimes.

We were told the ward used the red tray system[4] but this was not always possible due to a lack of red coloured trays. However, we were told that where patients required monitoring or assistance this would be communicated to staff verbally via the staff shift handover.

Most of the patients we saw were sitting up in their beds or chairs prior to the meal being served. However, where required we saw staff helping patients to sit up to have their meals and clearing bed tables to make room for plates and drinks. Patients were being offered the opportunity to wash their hands prior to meals and we saw staff clearing and cleaning tables in preparation for tables to be used for lunch.

We identified a dignity issue regarding the way in which one patient was being assisted to eat a meal. This was brought to the attention of the staff member at

[4] The Red Tray system is a simple way of alerting staff to the fact that a person requires monitoring and/or help with eating.

the time who took immediate action to ensure the patient's dignity was then maintained. We also highlighted this matter to the nurse in charge so any further follow up action could be considered as necessary.

Some patients told us they had been served meals which were not as warm as they would have liked. This appeared to be due to the system in place to serve meals, with those patients receiving their meals last making this comment. We made senior staff aware of this so they could explore this further and take corrective action as appropriate.

Recommendation

The health board should make suitable arrangements to determine whether food served on the ward is suitably warm and take appropriate action as necessary.

Staff also told us patients' water jugs were routinely replenished twice per day. The recommended frequency is three times per day. However, we were told if patients requested this to be done more frequently, or required more water, ward staff would arrange this.

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.

The ward had supplies of toothpaste and toothbrushes so patients' oral hygiene needs could be met.

We saw the ward had supplies of toothbrushes and toothpaste for patients to use. Individual denture pots were also available to keep patients' dentures safe when not being worn.

We did not identify any concerns regarding patients' oral hygiene needs.

Toilet needs

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

Toilets were clean and appropriately equipped to reduce cross infection. We saw staff responding to patients' requests and helping them as needed.

We saw patients' continence needs had been assessed when they were admitted to the ward. Staff told us the outcome of this initial assessment may

lead to a more detailed assessment being conducted to identify specific assistance and aids required.

We saw staff assisting patients with their toilet needs, encouraging and promoting their independence as their condition allowed. Patients who provided comments within completed questionnaires confirmed staff helped them as needed in a sensitive way.

Toilets were very clean and equipped with suitable hand washing facilities, and paper, to reduce cross infection and maintain patients' dignity. Commodes were visibly well maintained and labelled to indicate they had been cleaned and were ready for use.

Different types of continence pads were available on the ward for patients' use. From our observations and conversations with staff, these appeared to be used appropriately and only for patients who needed 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 that was clean and working properly. Assessment and monitoring records indicated staff were providing care to prevent patients developing pressure sores.

We saw a recognised tool was being used by staff to assess patients' risk of developing pressure sores. SKIN Bundle[5] (monitoring) records showed staff had assessed patients' skin regularly for signs of pressure sores. These records also showed patients had been assisted or encouraged to move position to prevent pressure sores developing. Written entries on assessment and monitoring records indicated these were up to date.

Specialist pressure relieving air mattresses were in use on the ward to help prevent patients developing pressure sores. These appeared clean and to be working properly.

[5] SKIN Bundle - A simple holistic approach ensuring that all patients receive the appropriate care to prevent pressure damage

Quality of Staffing, Management and Leadership

At the time of our inspection we felt some patients with complex needs required more frequent intervention from nursing staff. Conversations with staff indicated they felt staffing levels required reviewing.

We saw good leadership from the nurse in charge on both days of our inspection and it was evident senior staff on the ward were committed to supporting and developing the ward team.

Staff told us they had received training relevant to their role. However, audit results demonstrated improvements were needed for the ward to comply with the health board's training target.

The nurse in charge told us staff would try and resolve concerns (complaints) at ward level as far as possible.

Staffing levels and skill mix and professional accountability

Senior staff told us staffing levels had been arranged to ensure seven staff were on duty during the morning shift, six during the afternoon and four during the night. At the time of our inspection the ward was full, with 30 patients being cared for. The number of registered nurses working was in accordance with the guiding principles for nurse staffing as set out by the Chief Nursing Officer for Wales. These recommend the number of patients per registered nurse should not exceed seven during the day.

We were told agency staff could be requested to provide additional support to the ward team should this be necessary. This was evident during our inspection as an additional member of staff had been arranged to provide 1:1 supervision for a patient requiring close observation.

Whilst an additional staff member had been arranged, we felt some patients with complex needs required more frequent intervention. This is because the inspection team needed to ask staff to provide patients with assistance on a number of occasions. Some patients were requesting assistance to get into bed. Other patients needed help to change position in bed to maintain their dignity and safety, at times when there were no members of the ward team in the areas occupied by the patients concerned. Conversations with staff also indicated they felt routine staffing levels on the ward required reviewing.

Recommendation

The health board should make suitable arrangements to review routine staffing on the ward to ensure it is sufficient to meet the care needs of patients at all times.

It was evident that senior staff on the ward were committed to supporting and developing the ward team as far as possible. Ward meetings were being held monthly and minutes were available for all staff to read. A range of topics relevant to the team's work had been discussed including updates from the health board and areas for improvement on the ward, such as documentation.

The ward was a clinical learning area for student nurses and comments we received indicated the ward provided an effective environment for student nurses to learn.

We saw clear leadership on the ward. Over the two days of our inspection, the nurse in charge demonstrated a thorough understanding of the needs of the patients and the ward routine. Other staff also appeared to be aware of their respective roles and responsibilities. We saw registered nurses supervising and supporting healthcare support workers and student nurses appropriately.

Effective systems for the organisation of clinical care

Patient care was organised using a team nursing approach. This meant the ward was divided into two sections with registered nurses responsible for a smaller group of patients on the ward. The senior registered nurse for each section then supervised and directed junior staff and students. Whilst this system seemed appropriate given the layout of the ward, our findings in respect of staffing indicated some patients required more frequent intervention to meet their needs.

A senior registered nurse was in charge on both days of our inspection. She demonstrated a very good understanding of the needs of the patients and the routine of the ward. She told us that her shift pattern would be arranged to ensure that either she or the ward manager was on duty each morning and the other during the afternoon/evening, as far as possible. This meant senior staff were available to offer support and guidance to junior staff and be available to talk to relatives and carers on a regular basis.

Training and development

The nurse in charge told us the number of staff whose mandatory training was up to date was monitored monthly as part of the health board's regular auditing process. The audit records were up to date and considered a number of areas/topics relevant to patient care. From the records reviewed, we concluded

that improvements were required in a number of areas to achieve compliance with the health board targets.

Recommendation

The health board should make suitable arrangements to assist the ward team to achieve compliance with health board targets for mandatory training.

We were told staff were not routinely receiving an appraisal of their work to identify training and development needs. This was attributed to the fact that many staff had not been in post very long as a result of service changes within the health board's hospitals over the last year.

Recommendation

The health board should make suitable arrangements to ensure staff on the ward receive a regular appraisal of their work and in accordance with health board policy.

Handling of complaints and concerns

The nurse in charge told us staff would try and resolve concerns (complaints) at ward level wherever possible. She was aware of the process to follow should it be necessary to escalate concerns (complaints) further.

Literature was clearly displayed within the ward providing information to patients, visitors and staff on how to report concerns about care. This meant people had easy access to information on how to raise concerns.

We were told that whilst staff identified in concerns (complaints) would be involved and provided with feedback from investigations, identified learning was not always shared with the wider staff team. This meant opportunities to learn from concerns (complaints) and make improvements as a result were not always available to staff.

Recommendation

The health board should make suitable arrangements to ensure learning from concerns (complaints) is routinely shared with ward staff so service improvements can be made as appropriate.

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.

The nurse in charge described appropriate arrangements in place to report, investigate and learn from clinical incidents.

Staff had access to a range of relevant policies.

We saw audits were taking place to check key areas of patient care. We recommended these be supported by the completion and displaying of safety crosses within the ward.

We found arrangements were in place to ensure the care provided to patients was safe. However, the care records we saw did not always contain evidence that mental capacity issues had been assessed or considered when providing care. We have recommended the health board takes suitable action to ensure staff are aware of their responsibilities under the Mental Capacity Act (2005).

We saw safe practice in respect of the management of medication used on the ward.

We saw written care plans in place for patients and that these were being evaluated regularly. Whilst written care plans were in place, these were standardised and would benefit from being further individualised to each patient. Some risk assessment documentation being used had been photocopied and was of a poor print quality. This made it difficult to read and we have recommended the health board addresses this.

Some entries within care plans were not legible and we have recommended the health board takes appropriate action to ensure staff adhere to professional standards for record keeping.

Risk management

The nurse in charge told us clinical incidents were reported via the health board's electronic reporting system. We were told incidents were investigated in in timely manner and involved relevant staff.

The nurse in charge described an example where learning from patient falls had been shared with ward staff. This was with the intention to avoid further patient falls as far as possible. Monthly audit records indicated the number of

serious incidents reported as happening on the ward had decreased over the previous six months. This could be reflective of improved risk assessment processes and learning.

Policies, procedures and clinical guidelines

The nurse in charge told us copies of relevant health board policies were available to staff on the ward.

Interviews with staff indicated they were aware of the policies and guidelines associated with the ward.

Effective systems for audit and clinical effectiveness

We saw a number of areas associated with patient care were being audited monthly. These included the incidence of pressure sores, clinical incidents and infections, compliance with hand hygiene and infection control procedures, as well as timely completion of patient risk assessments.

Safety crosses[6] were not displayed. We were told this was because they had been temporarily removed during the reorganisation of the ward environment. We recommended these be reintroduced to complement the existing monthly audits. These should ensure the ward team can see, via a simple system, the incidence of relevant clinical incidents such as pressure sores, falls and infections with the intention of taking timely action to prevent re-occurrence.

Patient safety

The ward was very clean and free from trip hazards. The patients we saw had access to a working buzzer to summon assistance from staff if required. Buzzers were also available within toilets and wash rooms for patients to use. Overall, we saw staff answering buzzers in a timely manner and patients who provided comments within questionnaires generally confirmed this to be the case. However, as mentioned earlier we found it necessary to seek assistance from staff to attend to patients on a number of occasions during our inspection

[6] The Safety Cross has been adapted from industry to make highly visible the incidence of avoidable adverse events. In doing so it ensures that the whole team is aware of avoidable events and thus instils a sense of purpose in working to avoid future events.

suggesting additional staff may have been required to fully meet the needs of patients on the ward at the time.

During our inspection, one patient required close supervision and an additional member of staff had been arranged to provide this.

Staff we spoke to confirmed they had received training in relation to the protection of vulnerable adults.

At the time of our inspection some patients were presenting with confusion. Whilst this had been identified, the care records we saw did not always contain evidence that mental capacity issues had been assessed or considered when providing care. This meant we could not be assured staff were always following the principles of the Mental Capacity Act (2005) when providing care. We have recommended the health board takes suitable action to ensure staff are aware of their responsibilities under the Mental Capacity Act (2005) legislation.

Recommendation

The health board should take suitable action to ensure staff are aware of their responsibilities under the Mental Capacity Act (2005). The health board should also make suitable arrangements to demonstrate patient mental capacity issues have been considered when planning and delivering care.

Medicines management

Ward routine and approach

Staff told us the health board's policy on the safe management of medicines was available to them on the ward. A pharmacist visited the ward regularly to provide advice on the medicines used on the ward. We saw a pharmacist visiting during both days of our inspection.

We saw medication, oxygen therapy and intravenous fluids were being prescribed and using the correct form. One prescription for oxygen therapy was not fully completed. We highlighted this to the nurse in charge and this was corrected immediately.

Storage of drugs

We saw suitable arrangements in place for the storage of drugs.

Preparation of patients and administration of drugs

We accompanied a member of staff during the medication round. The nurse conducted required identification checks and provided the necessary help to patients so they could take their medication safely.

The All Wales Drug Charts were being used to record the prescription and administration of medicines. The sample we saw had been completed correctly apart from one as referred to above and which was then corrected immediately.

Controlled Drugs

We saw Controlled Drugs were being stored securely and stock levels being checked regularly in accordance with expected control measures.

Take Home drugs

We saw suitable arrangements were in place for the safe storage of patients' take home medication. Staff told us patients' medication is explained to them prior to them going home to advise them on what medication they are taking and how to take it correctly.

Documentation

Patient assessment and care planning/evaluation

We looked at a sample of four patient care records. We saw patients had a written assessment of their care needs performed on admission to the ward. Relevant risk assessments had also been completed using recognised nursing assessment tools and were regularly updated. However, some of the risk assessment documentation being used had been photocopied and was of a poor print quality, making it difficult to read. We have recommended the health board takes suitable action to ensure documentation used on the ward is clear and easy to read.

Recommendation

The health board should make suitable arrangements to ensure the print quality of documentation used on the ward is clear.

The written care plans contained evidence that patients' care needs were being evaluated regularly. Standardised (printed) core plans were being used on the ward, setting out the patient's identified care needs, the anticipated outcome (or goal) for the patients and the main nursing care interventions needed. Whilst these provided detail of the patient's care needs and care interventions, these

plans would benefit from being more personalised to take into account patients' individual care needs and wishes.

We saw care plans had been evaluated regularly and contained details of the patient's progress.

We saw one example where we could not be assured of the amount of prescribed intravenous fluids a patient had received due to the chart not being completed fully. This appeared to be due to an inconsistent approach to the use of fluid balance monitoring records being used on the ward. This issue had already been identified by senior ward staff prior to our inspection and we were satisfied they were taking action to resolve it.

Whilst entries within medical care records were legible and included dates and times, some of the nursing notes were illegible and did not fully meet professional standards for record keeping.

Recommendation

The heath board should make suitable arrangements to ensure nursing care records are maintained in accordance with professional standards for record keeping.

Staff told us they received a verbal handover from staff working the previous shift. This meant staff should have been made aware of up to date and relevant information regarding patients' care needs which ensured important information was passed on so appropriate action could be taken by the oncoming shift.

Other members of the multidisciplinary team had recorded notes detailing their contribution to the patient's care. This meant patients had received specialist care input according to their needs and staff had access to written information when required.

Diabetes care

The ward specialised in the care of patients with disorders of the endocrine system, which would include those with diabetes. We were told the diabetes specialist team visited the ward regularly and were available to advise and support staff with any queries relating to diabetes care.

Two of the patient records we selected related to patients who had a diagnosis of diabetes. There were standardised (core) care plans in place for how the patients' diabetes was being managed whilst on the ward. As mentioned previously these would benefit from being more individualised for each patient.

We looked at monitoring and medication records for the two patients with diabetes and found that they were having their blood glucose checked and had received medication as prescribed to control their diabetes.

Equipment to monitor patients' blood glucose levels and safely dispose of sharps (needles) was available to staff on the ward. Suitable arrangements were in place to treat patients identified with severe hypoglycaemia (a low blood glucose level requiring prompt treatment) and staff confirmed they were aware of the correct action to take.

Arrangements were in place for patients to self manage their diabetes when able to do so.

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 6 at Singleton Hospital 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: Singleton Hospital

Ward/ Department: Ward 6

Date of Inspection: 14 and 15 January 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
	-			
	Delivery of the Fundamentals of Care			
12	The health board should explore the reasons for the delays in the availability of clean linen and take appropriate action to ensure sufficient supplies are available to the ward in a timely manner.	Spot checks to be undertaken to monitor the supply of linen. Linen delivery times to be reviewed to ensure linen is supplied in a timely manner.	Facilities manager	28/2/15
15	The health board should make suitable arrangements to determine whether food served on the ward is suitably warm and take	The food is regenerated in the ward kitchen and has to reach 82° before service. Liaison between the ward based catering staff and nursing staff	Facilities Manager & Lead Nurse	28/2/15

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	appropriate action as necessary.	will have to take place to ensure the food is served in a timely manner. The trolley alternates between ends on the ward. There have been no complaints regarding the temperature of food. If a patient raises a concern then an alternative would be offered.		
	Quality of Staffing Management and Leadership			
18	The health board should make suitable arrangements to review routine staffing on the ward to ensure it is sufficient to meet the care needs of patients at all times.	A full review of ward staffing to be undertaken using the All Wales Acuity Tool. The ward is part of an e-rostering pilot to ensure efficient and effective rostering. An additional HCSW has been allocated to the night shift.	Head of Nursing	31/3/15 31/3/15 Immediate effect
19	The health board should make suitable arrangements to assist the ward team to achieve compliance with health board targets for mandatory training.	Each month the percentage compliance with Mandatory training on the ward to increase. 95% compliance with all mandatory & statutory training to be achieved. Compliance with mandatory & statutory training to be monitored in the monthly ward sisters meetings.	Head of Nursing / Lead Nurse / Ward Sister Lead Nurse	31/8/2015 Immediate effect
19	The health board should make suitable arrangements to ensure staff on the ward receive a regular appraisal of their work and	All staff to have an appraisal within the Health Boards agreed timescales and they are to be maintained annually.	Lead Nurse/ Ward Sister	31/6/2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	in accordance with health board policy.	Compliance with appraisals to be monitored in the monthly ward sisters meetings	Lead Nurse	Immediate effect
19	The health board should make suitable arrangements to ensure learning from concerns (complaints) is routinely shared with ward staff so service improvements can be made as appropriate.	A review of how learning from complaints is shared with ward staff & how staff are involved in the decision making in respect of improvement work on the ward.	Senior Nurse	31/3/2015
	Delivery of a Safe and Effective Service			
22	The health board should take suitable action to ensure staff are aware of their responsibilities under the Mental Capacity Act (2005). The health board should also make suitable arrangements to demonstrate patient mental capacity issues have been considered when planning and delivering care.	100% of staff to have received POVA and MCA training.	Head of Nursing / Lead Nurse / Ward Sister	31/8/2015
23	The health board should make suitable arrangements to ensure the print quality of documentation used on the ward is clear.	The Health Board has discussed this with each ward manager and master copies have been circulated. Documentation to be audited during assurance visits by the senior Nurse at least monthly.	Senior Nurse	To commence by 28/2/2015
24	The heath board should make suitable arrangements to ensure nursing care records are maintained in accordance with professional standards for record keeping.	The ward manager has been asked to remind all staff of the standards of record keeping. Monthly audits of standards of record keeping to be undertaken.	Senior Nurse	To commence by 28/2/2015

Health Board Representative:

Name (print): **Nicola Williams.....**

Title: **Assistant Director of Nursing.....**

Signature: **[submitted electronically].....**

Date: **16/2/2015.....**