Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Dignity and Essential Care Inspection (unannounced)

Cwm Taf University Health Board: Ysbyty Cwm Cynon, Ward 3 (trauma and orthopedics-rehabilitation)

22 and 23 November 2014

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care Inspection in Ward 3 at Ysbyty Cwm Cynon, part of Cwm Taf University Health Board on the 22 and 23 November 2014.

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
- 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

Cwm Taf University Health Board is situated in South Wales just north of Cardiff, between the Brecon Beacons National Park and the M4 motorway. The Health Board is responsible for providing healthcare services to the population of Merthyr Tydfil and Rhondda Cynon Taf, estimated to be around 289,400 people.

The Health Board area is made up of four localities, three of which are within the Rhondda Cynon Taf area. These are the Cynon Valley, the Rhondda Valley and the Taff Ely area. The fourth locality is Merthyr Tydfil. Cwm Taf is the second most densely populated health board in Wales; many areas being amongst the most deprived in Wales.

Cwm Taf University Health Board currently manages two district general hospitals, five community hospitals and a university health park.

Ysbyty Cwm Cynon was built approximately two years ago to replace the former Aberdare and Mountain Ash Hospitals respectively; the environment having been designed to create a 'non-institutional' feel in order to enhance the psychological well-being of patients and staff. The hospital is situated in Mountain Ash and provides primary care (out of hours GP and dental service) support for the residents of the Cynon Valley and local communities. A minor injuries service is provided during the hours of 9.00am to 4.30pm, Monday to Friday. In addition, the hospital has a mental health unit, an outpatient department, a day care unit and six wards where people are able to receive rehabilitation and palliative care services.

Ward 3 at Ysbyty Cwm Cynon has 25 patient beds which are divided to provide a mixture of four bedded bays and cubicles; nurses' stations having been arranged at three separate points to enable staff to work in close proximity to the patients they are allocated to care for on a day to day basis. The main reception area is located close to the secure entrance of the ward. The ward accepts male and female patients who require trauma and orthopaedic rehabilitation services. At the time of this inspection there were 25 patients aged from 45 years to 90 and above, receiving care and treatment within ward 3.

4. Summary

During the course of this unannounced inspection, patients and relatives provided us with very positive comments about the care provided by Ward 3.

We also gathered evidence which supported the following:

Overall, patients expressed a high level of satisfaction with the care and treatment they had received within the ward. Patients also very much appreciated the cleanliness and presentation of the ward environment.

We found that the ward team had made every effort to get to know their patients (and their needs and wishes), very well; some patients having been in receipt of care and treatment for many weeks. All patients were treated with compassion, patience and respect

It was evident that the ward team took time to listen and actively respond to questions raised by patients and requests for assistance on both days of our inspection

The staff team placed an emphasis on ensuring that patients' information, confidentiality and privacy were respected as far as possible within the ward environment

Visiting hours were organised at two separate times of the day over a period of seven days. However, we were informed that visitors were able to go along to the ward at other times with prior agreement from the ward manager or other person in charge

Conversations with staff in addition to our observation over a two day period revealed that the ward team recognised the importance of maintaining patients' personal hygiene and its association with good physical health

All patients had been assessed by the ward team to identify those who may be malnourished or at risk of becoming malnourished

We found that staff made time to assess and monitor patient's oral health and hygiene

We found that staff approached problems of incontinence and frequent toilet use with compassion and sensitivity

We found that there were suitable arrangements and processes in place to assess patients' risk of developing pressure sores. We also found that there was appropriate equipment available to staff to reduce the risk of damage to patients' skin when providing care and treatment

Overall, we found that the ward team functioned through the use of well established management systems, processes and clinical guidelines in an attempt to ensure that patients received safe and effective care

Patients' safety and welfare was actively promoted and protected. This was achieved through the use of a range of risk assessments, the provision of a safe ward environment and clean well maintained equipment

We also identified a number of areas for improvement as shown below:

The health board is advised to ensure that it provides care and support in accordance with the All-Wales Catering and Nutrition Standards[1]

The health board is advised of the need to ensure that clear and accurate on-going information is available about the type of service to be provided to patients

The health board is advised of the need to demonstrate how it will ensure that nursing staff have sufficient time to promote people's independence in accordance with national policy

The health board is advised of the need to ensure that patients' level of discomfort, pain or distress is regularly assessed and recorded. The health board is also required to describe ways in which it will ensure that improvements are made to the pain assessment process. This is in order to provide all patients with effective and appropriate treatment/medication

The health board is required to demonstrate how it will ensure that patients are able to obtain timely and appropriate support at mealtimes in accordance with their identified needs

The health board is required to describe how it will ensure that patients are encouraged to wash their hands prior to meals

The health board is required to demonstrate how improvements are to be made in respect of the assessment and management of continence

The health board is advised of the need to demonstrate how it will ensure that future staffing levels within the ward are sufficient to meet the needs of patients

[1] Link to All Wales nutritional standards.

http://wales.gov.uk/topics/health/publications/health/guidance/nutrition/?lang=en

The health board is advised of the need to demonstrate how it will ensure that patients' care and treatment is provided in accordance with DoLS legislation

The health board is advised to demonstrate how it will ensure that patients' mental health needs are assessed from the point of admission

The health board is required to describe how it will ensure that medicines are stored safely at all times

The health board is required to provide HIW with a description of how it will ensure that medicines are administered safely at all times

The health board is advised of the need to demonstrate how it will ensure that improvements are made to the recording of all aspects of patients care

5. Findings

Quality of the Patient Experience

Overall, patients expressed a high level of satisfaction with the care and treatment they had received within the ward. Patients also very much appreciated the cleanliness and presentation of the ward environment.

During the course of this inspection, we distributed 16 HIW questionnaires to patients and relatives in an attempt to obtain their views on the services provided within ward 3. In addition, a small number of visiting relatives were willing to speak with us over a two day period.

Twelve questionnaires were actually completed during the inspection. Two additional questionnaires were returned to HIW several days after the inspection, by relatives. Each person indicated they 'strongly agreed' the ward was clean and tidy. Patients also provided us with their permission to include their additional comments about cleanliness within this report. For example:

'Very nice ward'

'Excellent on the ward-nothing bad to say'

And

'The ward is very clean and tidy. Girls-all staff are very thorough'

We held conversations with most of the patients and a small number of relatives all of whom expressed a high level of satisfaction with the care and service experienced to date. Some people also specifically indicated that all the staff on the ward provided kind and compassionate care. We did however find that a number of patients receiving care had difficulties with verbal communication associated with short term memory loss and dementia.

Patients and relatives who completed a HIW questionnaire offered additional views in relation to hospital staff as follows:

'Don't go into detail over my medical condition-mainly Doctors'

'Staff are exceptionally good and dedicated to their work'

'They are always on hand to talk about my (relative) and his condition. They have provided me with a better understanding of my (relative's) condition. They listen to what I have to say and advise accordingly in a sensitive manner. Wonderful staff!'

And

'Short staffed and very busy'

Responses within 12 of the 14 completed HIW questionnaires about care received, resulted in a score between eight and 10, (0 representing poor care, 5 indicating that care was average and 10 representing excellent care). The remaining two people chose not to provide a score in relation to the provision of care.

Twelve people either 'agreed' or 'strongly agreed' that staff were kind and sensitive to them when carrying out care and treatment. One person chose to indicate that they neither agreed nor disagreed and the remaining respondent provided us with the following comment *'mostly, not when they are very busy'.*

A question relating to whether staff provided patients with care when they needed it, attracted responses which varied between 'agree' to 'strongly agree. However, two patients provided us with specific comments relating to delays they had experienced in receiving assistance as staff were very busy.

Eight patients indicated that staff helped them to eat if they needed assistance, four people choosing not to agree or disagree with the question. In addition, we observed three mealtime periods (lunch on both days of our inspection and breakfast on the second day). On each occasion, we saw that ward staff were unable to help all those patients who required assistance to eat and drink in a timely way. This meant that the temperature of food served to patients was not maintained and the hotel services staff (during lunchtime on day one of our visit), was not accompanied by a member of the ward team to serve food to patients as all staff were actively engaged in supporting patients with eating and drinking.

The above issues are presented in more detail within page 14 of this report and have resulted in a recommendation for improvement to the health board.

Ten patients suggested that they always had access to a nurse buzzer, water, and had a choice in terms of their toilet/continence needs**.** Two patients neither 'agreed' nor 'disagreed'; the remaining questionnaires having been completed by relatives. However we found that the water jugs given to patients with fresh water in the mornings were not refreshed at any other time during the day.

Recommendation

The health board is advised to ensure that it provides care and support in accordance with the All-Wales Catering and Nutrition Standards.[2]

Patients were treated with dignity and respect. This is because we observed ward staff responding to patients' requests for assistance throughout the inspection and found their approach to be professional and caring at all times.

A further sample of comments that patients gave us their permission to include in this report, is shown below:

'No complaints at all'

'Food is lovely in this hospital'

'Very little choice on the menu'

'Had the best attention on this ward'

'Not always listened to by staff. Can happen in the afternoon'.

And

'More staff on the ward in the week than at weekends'.

Overall, patients were not positively occupied or stimulated. This was because patients told us that there was nothing for them to do during the day and they were only able to leave the ward in the company of relatives on occasions.

Conversation with a small number of patients revealed that they were encouraged to speak up if they had any concerns. They also told us that they felt confident in approaching members of the ward team if they were in any way worried about their care or treatment.

We were also provided with preliminary health board findings in relation to a completed audit regarding patients' experiences of care received and the presentation of the ward environment (14 patients took part in the survey). The

[2] Link to All Wales nutritional standards.
http://wales.gov.uk/topics/health/publications/health/guidance/nutrition/?lang=en

audit, which was undertaken between the 1- 30 October 2014, stated that patients' overall satisfaction with the care provided was 94 per cent.

Delivery of the Fundamentals of Care

We found that the ward team had made every effort to get to know their patients (and their needs and wishes), very well; some patients having been in receipt of care and treatment for many weeks. All patients were treated with compassion, patience and respect.

Communication and information

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

It was evident that the ward team took time to listen and actively respond to questions raised by patients and requests for assistance on both days of our inspection.

We found that the ward team recognised the importance of consulting with patients and their families about care and treatment. This is because we held conversations with staff which revealed the emphasis they placed on providing people with information to enable them to understand and make informed choices. We also found that staff would arrange for patients to speak with staff in Welsh in accordance with their identified preferences.

Conversations with staff revealed that no information was usually produced in large print or braille to assist patients with visual difficulties. There were however, large clocks in all areas occupied by patients to help with orientation. We saw a sign displayed at the ward reception desk to indicate that people were able to access loop hearing facilities if they had difficulties with hearing; however we were told that the ward did not have current access to that type of equipment.

We discovered that there were a number of patients within the ward who had difficulties with verbal communication due to short term memory loss and/or conditions such as dementia. During the course of our two day inspection, we saw that staff took time to listen and actively respond to such individuals at various times in a warm and patient manner.

Conversations with staff indicated that a weekly multi-disciplinary meeting took place to enable all health professional involved in patients' care to plan priorities and goals for the coming week and future discharge. We could not however, find any clear reference to the agreed goals and actions from those meetings within nursing care plans, daily records or forms intended for the purpose of describing discharge arrangements (known as the Expected Date of Discharge (EDD) forms).

Recommendation

The health board is advised of the need to ensure that clear, accurate and on-going information is available within the ward about the service to be provided to patients.

Discussion with a senior manager indicated that patients' views were obtained on an annual basis via a structured survey. We also saw that there was a poster displayed in a prominent position near the ward reception desk containing details about the current NHS complaints arrangements called 'Putting Things Right' [3]as a reminder for patients and visitors.

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.

The staff team placed an emphasis on ensuring that patients' information, confidentiality and privacy were respected as far as possible within the ward environment.

We observed that staff were respectful to patients, treating them with courtesy and compassion at all times. Patients who spoke with us also confirmed that staff were polite and addressed them using their preferred name. In addition, we found that a number of patients receiving care and treatment within the ward had difficulties with verbal communication. Nursing and medical staff approached such individuals with kindness and respect, holding conversations in soft tones at patients' bedside. In addition, where patients presented with any degree of distress, staff demonstrated patience and understanding in their repeated attempts to reassure the individuals concerned.

[3] In April 2011 the Welsh Government introduced new arrangements for the management of concerns: *Putting Things Right.* It aimed to make it easier for patients and carers to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

Staff protected the privacy of patients by closing curtains around their beds when providing support with personal care and at times when people were being examined by medical staff. Doors to toilets and shower/bathing areas were also noted to be closed when patients were using those facilities, providing privacy and protecting their dignity. Further measures, e.g. privacy signs were also used to clearly indicate that toilets and washing areas were in use.

The ward provided treatment and support to male and female patients. Toilets and washing areas were found to be segregated and male patients were being cared for in an area which was distinctly separate from the female patients. We were told that this arrangement was intended to ensure that patients' dignity was maintained.

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 found that there were ongoing assessments within patients' records in relation to their ability to mobilise, eat and wash independently. However staff had limited time available to encourage individuals to make the most of their abilities and wishes to do as much for themselves as possible.

Corridors, patient bays and single rooms were generally free of equipment allowing individuals to mobilise independently. The clutter free ward environment also enabled staff to provide patients with assistance as required. We further observed that equipment such as (Zimmer) walking frames and handling belts were kept close to patients so that they were readily available for use.

However, conversations we held with staff demonstrated that they had limited time available to encourage people to do things for themselves or with their support. We also observed that staff were constantly moving from one patient to another in an attempt to respond promptly to their needs and requests. Additionally we were told that the ward team did not have the support of other professionals such as physiotherapists and occupational therapists at weekends to prompt and support patients to make the most of their abilities to care for themselves.

We did observe a small number of patients being assisted and supervised by staff to walk safely from their bed area to the toilet at various intervals on day two of our inspection, but staff clearly had no additional time to encourage elderly frail patients to mobilise outside of those times of need.

Recommendation

The health board is advised of the need to demonstrate how it will ensure that nursing staff have sufficient time to promote people's independence in accordance with national policy.

Patients did have access to a small day room/dining room at one end of the ward, however we were told that the room was not used. This was because the room was being used to store large boxes of incontinence pads and so many chairs that it would not have been possible for patients or staff to negotiate their way safely or easily around the area. We were told though that an unused toilet would shortly be converted to a store room, releasing the day room for patient use once again, as the ward manager had already identified the matter as an area for improvement.

Relationships

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

Visiting hours were organised at two separate times of the day over a period of seven days. However, we were informed that visitors were able to go along to the ward at other times with prior agreement from the ward manager or other person in charge.

Conversation with staff and a senior manager revealed that visiting times to the ward had been altered recently. Specifically, the afternoon visiting hours had been increased every day; the evening period having been slightly reduced. This was in acknowledgement of the difficulties some relatives faced in returning home in the hours of darkness. The change had also resulted in the creation of more time for discussion between relatives and staff during the afternoon visiting period.

We observed that the ward had a designated area for visitors to use if they needed to be present at the hospital at such times when their relative was particularly unwell. The room was also used to hold private conversations with relatives as and when needed. The area was welcoming, decorated in a homely style, comfortably furnished and contained tea and coffee making facilities as well as a television.

The ward team had also been successful in ensuring that a patient with communication difficulties was able to receive daily visits from a team of carers who usually supported them in their own home in the community. Such visits took place over and above the established times for visitors and were evidently of benefit to the person concerned.

Rest, sleep and activity

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

On this occasion, rest, sleep and activity was not inspected.

Ensuring comfort, alleviating pain

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

Patients' level of discomfort or pain was assessed at various points during the time they had spent on the ward. However, the approach to assessment and subsequent care planning was not consistent. In addition, there was no evidence of written evaluation to confirm that prescribed medication had been effective, or that it remained necessary.

Examination of a sample of five patient records demonstrated that the ward team had periodically recorded pain scores for patients who were receiving prescribed medication for pain relief. The records of those patients however provided little or no evidence of their current level of pain, although they were still receiving medication for pain relief.

We found that there was no evidence of the assessment/evaluation of patients' level of pain after prescribed pain relief medication had been administered. We were therefore unable to find any written evidence to confirm that such medication had been effective, or that it remained necessary.

We found that a number of patients being cared for within the ward had complex difficulties regarding verbal communication. Given that some of those people were not able to express pain, it may be that the approach and pain assessment tool used by the ward team to record pain scores for those patients was not suitable. We did however note that such patients had been prescribed regular pain relief which is considered to be appropriate practice for people who live with conditions such as dementia.

Recommendation

The health board is advised of the need to ensure that patients' level of discomfort, pain or distress is regularly assessed and recorded. The health board is also required to describe ways in which it will ensure that improvements are made to the pain assessment process. This is in order to provide all patients with effective and appropriate treatment/medication.

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.

Conversations with staff in addition to our observation over a two day period revealed that the ward team recognised the importance of maintaining patients' personal hygiene and its association with good physical health.

On day one of our inspection visit (at 9.00am) some patients had washed, or were being helped to wash; others being able to continue to rest. On day two, we arrived at the ward by 7.00am and found that all patients were resting or asleep within a peaceful ward environment.

We saw patients wearing their own clothes or nightwear, on both days of our inspection. In addition, we observed that all patients appeared well cared with the exception of one, whose finger nails were long and jagged. We did not explore the arrangements in place with regard to patients' foot care.

We looked at five patient's nursing notes and found that staff were recording how individuals' personal hygiene was maintained on a daily basis. There appeared to be a tendency for patients to have, or be supported with a 'full wash' as opposed to a shower or bath. We also saw that the washing area which contained assisted bathing equipment was crowded with moving and handling equipment and appeared to be unused on the Saturday and Sunday. Conversations with patients did not however indicate that they were not able to shower or bath at any time.

Patients' individual rooms were fitted with en-suite facilities. All toilets, washing/bathing areas were observed to be clean and hygienic.

We found that nursing staff made every attempt to wash and style patients' hair and shave male patients in accordance with their preferences, within the limited time they had available. One patient had benefitted from support to wash their hair on the day prior to our unannounced inspection. The person concerned told us that she was pleased that her hair looked nice.

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 had been assessed by the ward team to identify those who may be malnourished or at risk of becoming malnourished.

We found that there were protected mealtime[4] arrangements in place within the ward to minimise disruption to patients when they were eating their meals. We also found that food being served over a period of two days was offered to patients in accordance with their identified individual requirements and preferences.

We saw that patients had been assessed by the ward team to identify those who may be at risk of becoming malnourished. Individuals who were considered to be at risk were identified within the ward through the use of certain symbols which were placed on a white board for all staff to see. We also observed how information was exchanged between night and day staff and found that sufficient detail was given to enable 'in-coming' staff to understand the needs and requirements of patients within the ward.

However, we observed the lunchtime meal being served on the two days of our inspection as well as breakfast on day two. On each occasion it was evident that there were insufficient numbers of staff present to assist people with eating and drinking in accordance with their presenting needs. Staff were seen helping one patient at a time in a non-hurried way, ensuring that they had something to drink during and after their meal. They also ensured that patients were comfortable before leaving them to assist someone else. However, despite the efforts of the staff to assist all patients who were unable to eat independently, some individuals had no alternative other than to wait until a member of staff was available. The temperature of the food served was also affected by the above situation.

We found that there were no family members present to assist patients and conversations with staff revealed that limited opportunities had been offered to families to visit during mealtimes ((which may prove to be a welcome event for elderly frail people). Conversation with staff and a senior manager demonstrated that the ward did not have access to volunteers or additional staff during mealtimes. This may mean that some patients' needs are not being met.

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

In addition, the lunchtime meal served by hotel services staff was constrained by the lack of staff available to assist with distributing food to patients when it had been served. The hotel services staff did have a patient list which specified patients' requirements. However, one patient's food was left on a bedside table out of reach of the person concerned and a member of the inspection team needed to intervene in order to ensure that the patient was able to eat their meal before it become cold. All ward staff were in the process of helping others at that time.

The hotel services staff further provided another patient with a plastic packaged meal with a lid that could not easily be removed. The plastic tray was hot and no attempt had been made to remove the meal from the packaging and place the food onto a plate. This was brought to the immediate attention of the staff concerned.

We saw that some patients eating in their bed did not appear to have been positioned as upright as they could have been, to (comfortably and safely) eat their meal. We also found that patients' bedside tables were not cleared and cleaned prior to meals being served.

Recommendation

The health board is required to demonstrate how it will ensure that patients are able to obtain timely and appropriate support at mealtimes in accordance with their identified needs.

We noted that patients had a jug of water and a glass within easy reach at all times. Additionally, we found that staff had accurately recorded the amount of food and fluid consumed by patients immediately after they had finished assisting them to eat and drink. Discussion with a member of the hotel services staff on day two of our inspection also revealed that staff did approach them to confirm the amounts of food patients have eaten (if for some reason they have not had the opportunity themselves to remove food trays from patients' bedsides). This demonstrated that the team had an effective process in place to monitor patient's food intake.

We found that patients were not routinely offered the opportunity to wash their hands prior to eating their meals in accordance with the health board's dignity pledge.

Recommendation

The health board is required to describe how it will ensure that patients are encouraged to wash their hands prior to meals.

We looked at a sample of five patient records and found that individuals with swallowing difficulties were referred to speech and language therapists in a timely way for specialist advice about the consistency of food and fluid required by the patients concerned.

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.

We found that staff made time to assess and monitor patient's oral health and hygiene

We found that patients' records contained an assessment and care plan regarding mouth care, action being taken to help them to keep their mouth clean and moist.

We also saw registered nurses and health care support workers offering drinks to patients between meals.

We held a conversation with a registered nurse and saw a notice displayed within the ward which confirmed that patients were offered the opportunity to obtain a dental check-up in accordance with their needs.

Toilet needs

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

We found that staff approached problems of incontinence and frequent toilet use with compassion and sensitivity.

We found that staff responded to patients' requests to use the toilet in a sensitive and calm way. We also saw that toilet doors were closed when those facilities were in use.

We held conversations with patients and found that there was sometimes a delay in staff responses because other patients needed their help at the same time. We also noted that nurse call buzzers continued to sound for up to five minutes on a few occasions during the two days of inspection.

Toilet areas and commodes were found to be clean throughout our visit and there were sufficient supplies of hand soap, toilet paper and non-touch paper hand towel dispensers available for use.

Examination of five patient records revealed that some did not contain continence assessments. We therefore found no evidence of how decisions had been made to determine what type of continence aid was required by patients. Given that the ward has a key role to play in patients' rehabilitation and support in preparation for discharge from hospital, this matter needs to be addressed.

Recommendation

The health board is required to demonstrate how improvements are to be made in respect of the assessment and management of continence.

Preventing pressure sores

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

We found that there were suitable arrangements and processes in place to assess patients' risk of developing pressure sores. We also found that there was appropriate equipment available to staff to reduce the risk of damage to patients' skin when providing care and treatment.

We viewed a sample of five patient's records and found that appropriate and regular assessments were undertaken to determine their risk of developing pressure ulcers. The risk was reviewed daily by a registered nurse as required by current clinical guidelines.

We saw staff undertaking regular 'rounds' of patients on the ward to make them comfortable and relieve any pressure associated with staying in bed for long periods of time. Where patients required help to alter their position in bed, the change was recorded, together with the time of day.

We noted that there was a range of equipment in place to help relieve pressure (such as air mattresses, moving and handling hoists, handling belts and heel protection aids).

We saw evidence that initiatives/targets were in place to reduce the amount of pressure sores on the ward. Information about the incidence of pressure sores was also available for members of the public to see on the wall at the entrance of the ward.

Quality of Staffing, Management and Leadership

Overall, we found that the ward team functioned through the use of well established management systems, processes and clinical guidelines in an attempt to ensure that patients received safe and effective care.

Staffing levels and skill mix and professional accountability

During the course of our two day inspection we were informed that several members of the ward team had been unable to work due to short term sickness. This meant that the registered nurse in charge had needed to request and secure additional health care assistants (HCA's) from the established 'nurse bank' to support the ward team. Two requests were fulfilled via the 'nurse bank' on the first day of our visit, the third being arranged via a bed manager based at one of the other local hospitals as the nurse bank was unable to provide all three HCA's.

On day two, we found that the registered nurse in charge experienced greater difficulty in obtaining sufficient staff to compensate for staff sickness as the nurse bank was unable to fulfil any more requests for staff. As a result of the efforts of the registered nurse (who secured staff assistance from other local ward areas in addition to gaining agreement from other members of the team within ward 3 to work extra hours), patient care and support overall was provided in a safe and timely way. However, we still found that the presenting needs of the patients, particularly at mealtimes meant that some individuals had to wait for assistance to eat their meals. That issue has already been described on page 16 of this report.

We were told that the ward had recently benefitted from an additional HCA (over and above the usual numbers employed). The increase had enabled the ward to use a HCA to provide support and supervision exclusively to a group of patients (by day and night) that had been identified as being at a high risk of falls.

Conversations with staff who were working on the ward during the two days of inspection though, revealed that they often felt rushed in their attempts to fully meet the changing/complex needs of patients. Specifically, they described the difficulties they sometimes faced when supporting people with their personal

hygiene, responding to 'wander alarms'[5] and responding to patients' requests to use the toilet facilities within the limited time available to them.

Recommendation

The health board is advised of the need to demonstrate how it will ensure that future staffing levels within the ward are sufficient to meet the needs of patients.

We found that the ward was regularly required to provide staff support to other wards (from among their established team members-registered nurses and HCA's). Conversation with a senior manager resulted in a description of how the hospital has benefitted overall from rotating staff across all wards. Specifically, we were told that the arrangement had helped to increase staff skills across the hospital workforce thereby creating more flexibility in providing care and services to patients.

The culture evident in the ward area

The entire ward team appeared motivated, kind and compassionate during the course of their work, on both days of our inspection. Conversations with staff revealed that they felt supported by the ward manager. We were also told that they were able to raise any issues or concerns about aspects of service delivery and the ward manager was actively involved in providing care and support to patients.

Effective systems for the organisation of clinical care

The ward had 25 patient beds in total which were divided into a combination of four bedded bay areas and single rooms. There were 25 patients on the ward on both days of our inspection.

We observed what seemed to be a very well established daily approach to the provision of care and support to patients. For example we saw that each of the three registered nurses were allocated patients in separate areas of the ward along the length of the main corridor. They were each accompanied by a HCA and so worked in partnership except at times such as medication administration. The registered nurses also undertook 'rounds' of their respective

[5] Wander alarms are devices which are used to alert hospital staff to patients' movements in instances where they have been assessed as at a high risk of falls.

patients at least every two hours and more frequently than this when it was required.

There were clear levels of accountability and good communication between the registered nurses and health care assistants.

Training and development

We were provided with information which confirmed that there were suitable arrangements in place to provide staff with an annual appraisal. During such times, staff personal development was discussed and future training identified. Conversations with staff demonstrated that future training on specific relevant topics had been discussed with them.

Handling of complaints and concerns

Conversations with staff indicated that they were aware of the NHS complaints arrangements known as 'Putting Things Right'.

We were also provided with the details of a complaint that had been resolved in the past six months and found that the health board had provided the persons concerned with a comprehensive and detailed response in relation to all points raised. We also saw the action plan which had been produced and shared with relevant professionals working in Ward 3 and other wards at the hospital.

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.

Patients' safety and welfare was actively promoted and protected. This was achieved through the use of a range of risk assessments, the provision of a safe ward environment and clean well maintained equipment.

Risk management, Safeguarding and Deprivation of Liberty Safeguards (DoLS)

Overall, there was an emphasis on ensuring that the health, safety and welfare of patients was maintained.

We looked at a sample of five patient records. This clearly demonstrated that staff placed an emphasis on identifying safety risks associated with patients.

We saw that clinical incidents were reported via the Datix system,[6] copies of such incidents being attached to patient records that we examined during the inspection.

Conversation with a senior manager revealed that staff were always required to consider whether issues reported via Datix, may also relate to adult safeguarding. We were further told that (in instances where any form of abuse is suspected), such concerns were reported by staff to relevant health and social care professionals. This was to make sure that the current adult safeguarding process in Wales was followed.

We were provided with two written examples when the adult safeguarding process had been initiated by the ward in relation to allegations of patient neglect in the past eighteen months. Appropriate action had been taken with regard to use of the safeguarding process and the recommendations which followed on conclusion of both cases. Neither patient had been subject to any form of neglect.

We found that the ward staff had identified 'triggers' for the use of legislation known as DoLS[7]. Specifically, the team, having assessed patients' needs had

[6] Datix is an incident and adverse event reporting system used within the NHS.

started the correct process to ensure that patients were protected and were not being unlawfully deprived of their liberty whilst receiving care. The records of two such patients were examined in depth. One record provided extremely comprehensive information about the process that was being followed, whilst the other patient record demonstrated that the initial request form had been completed very well, however, the patient had not been assessed by a Best Interests Assessor (BIA) at the time of our inspection. We therefore held discussions with a registered nurse and senior manager about that issue and were told that there were delays in obtaining BIA assessments in accordance with legislative requirements. This was due to the increase in the number of assessments required across health and social care services within the Cwm Taf area in recent months.

The registered nurse told us that she would contact the DoLS co-ordinator based in the local authority after the weekend period in an attempt to address the situation for the patient concerned. However, the delay in obtaining best interest assessments in general however, may mean that some patients may be unlawfully detained within the ward and they will not receive the additional support they require with regard to future care provision.

Recommendation

The health board is advised of the need to demonstrate how it will ensure that patients care and treatment is provided in accordance with DoLS legislation.

We did find however that there were arrangements in place to provide one patient with an Independent Mental Health Advocate. This meant that the person concerned was receiving the additional and appropriate support they needed with regard to decisions about their future care and treatment.

Policies, procedures and clinical guidelines

Staff demonstrated their awareness of how to access relevant information to assist them in providing care to patients.

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[7] When a person lacks the mental capacity to make decisions about the care or treatment they need, legislation called The Deprivation of Liberty Safeguards (DoLS) has to be followed to ensure that people are not unlawfully deprived of their liberty.

We held conversations with staff on the two days of our inspection and found that they were aware of how to access current policy information and guidelines on the hospital intranet. We also saw a variety of folders on a shelf within the ward to help staff in providing care to patients, although some of the information seen required updating.

Effective systems for audit and clinical effectiveness

The services provided to patients within ward 3 were based on clear aims objectives, standards and organisational values.

We found that the ward recorded regular information (quality indicators) to help the team to check whether they were providing care to patients as efficiently and effectively as possible.

Discussion with registered nurses and a senior manager revealed that executive members of the health board complete a 'walkabout' every two to three months with a view to identifying areas for improvement as far as possible. We were also informed that the senior nurse based at the hospital was pro-active during weekly meetings where patients' needs and on-going care requirements were discussed with a variety of health care professionals. This was in addition to ward visits completed by the senior nurse commonly known within the health board as 'deep dives' whereby patients' current and future needs were explored in depth. Whilst we were assured that the 'deep dive' visits took place on a regular basis, we found very limited evidence of the outcome of those visits and the weekly multidisciplinary meetings. The above matter has already been discussed in the Fundamental of Care section of this report (under the sub-heading of communication and information- page ten) and resulted in a recommendation for improvement.

We found that patients' and relatives' views about care and treatment received were not regularly formally obtained within the ward. Instead, that type of information was gathered once a year to help inform the health board's audit (check) undertaken in relation to the delivery of the fundamentals of care to patients.

Conversations held with staff, clearly indicated the efforts they make to obtain patients' and relatives' informal views on services provided on a day to day basis. In addition, we were provided with the preliminary findings of the health board fundamentals of care audit which was completed during 1-30 October 2014. The results showed that ward 3 was over 85 per cent compliant with current fundamentals of care guidelines.

Quality and safety Information was readily available to staff, patients and relatives, via noticeboards in the corridor leading to the bed areas.

Patient safety

Overall, we found that there was an emphasis on ensuring that patients were provided with safe, effective treatment and care.

Examination of a sample of patient records showed that individuals had not received any form of mental health assessment at the point of admission to the ward, or thereafter. Staff also confirmed that there were often a number of patients within the ward who had difficulties with verbal communication/short term memory loss. This matter should be addressed to ensure that people's needs are fully met in the future.

Recommendation

The health board is advised to demonstrate how it will ensure that patients' mental health needs are assessed from the point of admission.

We observed the overall presentation of the ward and found the patient environment to be extremely clean and well maintained. Domestic staff were seen to be cleaning toilet and washing areas and those occupied by patients at various times during Saturday and Sunday.

Medicines management

Ward routine and approach

Overall, we found that there was an appropriate standard of care in relation to the administration of all forms of prescribed medication.

Discussion with registered nurses indicated that a dedicated pharmacist usually visited the ward every day between Monday to Friday to provide the ward team with support and advice.

Storage of drugs

We found that the majority of medication was either stored inside a dedicated room or at patients' bedsides in a locked cabinet, although we did discover that a small amount of prescribed medicines (which needed to be returned to the hospital pharmacy) were being held in a container which was not secured. We also saw that a small number of pharmacy items associated with the treatment of low blood sugar (within the 'hypo box') were found to be out of date. Those matters were brought to the attention of the nurse in charge who took immediate and appropriate action.

The dedicated medicines room and fridge were found to be unlocked during our inspection. Conversation with the registered nurse revealed that the room was

left unlocked at all times so that staff could gain easy access to emergency/resuscitation equipment if and when required. We therefore advised that consideration should be given to re-locating the emergency equipment in order that the medicines room could be locked to prevent access from unauthorised persons.

Recommendation

The health board is required to describe how it will ensure that medicines are stored safely at all times.

We saw that controlled drugs were stored in a locked cupboard and administered correctly. We also found that there were suitable arrangements in place to check and record ward stock levels of controlled drugs.

Preparation of patients

Observation of the administration of medication to patients indicated that they had access to a drink to help them swallow their tablets. We also observed registered nurses helping patients to sit in an upright position before they were provided with their medication.

We found that the registered nurses checked medicines and attempted to confirm patient's identity before administering drugs by asking them to confirm their name, address and date of birth. However we also saw that nurses did not check patients' wristbands prior to offering drugs and a number of patients within the ward had difficulties with verbal communication. We spoke with registered nurses about the above and were told that they had got to know the patients and their names well enough to administer medication without needing to refer to their wristbands. However patient wristbands need to be checked in accordance with the health board policy.

We saw each of the registered nurses signing medication charts prior to ensuring that patients had taken their tablets or medicines. We further observed one instance whereby a registered nurse had placed medication near to a patient but had not waited to observe the drugs actually being taken. The above practices are not in-keeping with current health board policy or relevant professional guidelines.

Recommendation

The health board is required to provide HIW with a description of how it will ensure that medicines are administered safely at all times

On occasions when drugs had not been administered, the medication administration records showed evidence that the correct written code had been

applied as required. We also observed that two registered nurses worked together when patients were prescribed insulin, in accordance with health board policy.

Documentation

Patient Assessment

We scrutinised the content of five patient's records, spoke with the patients concerned and staff who were familiar with their care and treatment.

As a result, we found that the records contained a combination of risk assessments associated with, patients' falls, pressure ulcers, infection and mouth care. However, we found that risk assessments tended to be followed by a pre-printed plan of care which was not in any way individualised. Where care plans existed, the recorded entries which related to evaluation of the care given provided very little useful information. Conversations with members of the ward team demonstrated that they had made every effort to get to know patients well. However there were a small number of examples whereby the information they shared with us was not reflected in patients' nursing notes. This meant that bank or agency staff may not have a clear guide as to how to meet patients' identified and changing needs.

The ward team were using National Early Warning System charts (NEWS) to record patient observations (which included their pulse, blood pressure and temperature) which enabled them to seek help from medical staff in direct response to the deterioration in people's clinical presentation.

All-Wales food charts were being used to record the daily intake of the patient with a view to monitoring whether they were eating adequate amounts of food.

We held discussions with the nurse in charge and a senior manager who confirmed that the health board is seeking to improve patient documentation.

Recommendation

The health board is advised of the need to demonstrate how it will ensure that improvements are made to the recording of all aspects of patients care.

Conversations with registered nurses confirmed that the ward has access to advice from diabetic specialist nurses based in another of the local hospitals. We were also told that they had received training on the ward regarding the use of the new insulin administration charts and they were also aware of the correct treatment for low blood sugar.

We selected and looked at the records of two patients who had been diagnosed with diabetes. One record provided evidence of a suitable care plan and evaluation of the care provided but the second contained limited care planning information. This meant that the staff team may not always be provided with a clear guide as to how to meet the patient's needs.

We held discussions with the two patients concerned. One patient told us that he administered his own insulin whilst in hospital and that snacks were available at any time. Both indicated that they were well informed about their health care condition as a result of information provided during diabetic clinic appointments and within the ward. In addition, the patients told us that they had been provided with snacks at times when their blood glucose levels had been found to be low. We also found that staff did work with patients to negotiate future care and treatment, appropriate referrals being made to the hospital's specialist diabetes team and the dietetic department.

We found that the ward staff had access to 'hypo-boxes' on the ward to enable them to address patients' low blood glucose levels in a prompt way.

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 3 at Ysbyty Cwm Cynon 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.

Dignity and Essential Care: **Improvement Plan**

Hospital: **Ysbyty Cwm Cynon**

Ward/ Department: **Ward 3**

Date of inspection: **22nd & 23rd November 2014**

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Quality of the Patient Experience				
Page 9 Page 17 Page 18	The Health Board is advised to ensure that it provides care and support in accordance with the All Wales Catering and Nutrition Standards. The health board is required to demonstrate how it will ensure that patients are able to obtain timely and appropriate support at meal times in accordance with their identified needs. The health board is required to describe how it will ensure that patients are encouraged to was their hands prior to meals.	• To ensure water jugs will be replenished at a minimum of 3 times per day and on patient request. • To explore the feasibility to purchase chilled water jugs • To ensure meal service does not begin until a member of the ward nursing team is available to accompany the meal trolley. • To ensure the principles of the Protected Meal time procedure are adhered to • To explore the option for catering staff who collect the plates to record food eaten on All Wales Food chart.	Ward Sister / Senior Nurse / Catering Manager	2nd February 2015
Delivery of the Fundamentals of Care				
Page 11	The Health Board is advised of the need to ensure that clear and accurate on-going information is available about the type of service to be provided to patients.	• To review the review MDM documentation and meetings, to ensure patient centred goals are set and evaluated	Ward Sister / Senior Nurse / Discharge Liaison Nurse	2nd March 2015

Page 12	The Health Board is advised of the need to demonstrate how it will ensure the nursing staff have sufficient time to promote peoples independence in accordance with national policy	• To ensure there are mobility plans in place for patients to maintain therapy input out of hours • To ensure nursing team are considering how to promote therapy and independence when providing patient care. • To explore the option of therapy resource out of hours to support the nursing team in promoting patient independence and recovery.	Ward Sister / Senior Nurse / therapists	2nd March 2015
Page 14	The Health board is advised of the need to ensure the patients level of discomfort comfort, pain or distress is regularly assessed and recorded. The Health Board is also required to describe ways in which it will ensure that improvements are made to the pain assessment process. This is in order to provide all patients with effective and appropriate treatment and medication.	• To Implement Abbey Pain score to assist with the monitoring and evaluation of pain for patients who cannot verbalise pain • To ensure patients have individualised prescribed nursing action plans to monitor and evaluate pain – to be used in conjunction with NEWS pain assessment	Ward Sister / Senior Nurse	2nd February 2015
Page 19	The health board is required to demonstrate how improvements are to be made in respect of the assessment and management of continence..	• To monitor compliance to the All Wales Continence pathway	Ward Sister / Senior Nurse	Ongoing
Quality of Staffing, Management and Leadership				
Page 22.	The health board is advised of the need to demonstrate how future staffing levels within the ward are sufficient to meet the needs of patients.	• To support the nurse in charge to use clinical judgement to manage risk and to request / approve additional staff in response to ward acuity levels. • To implement and monitor ward acuity via nursing dashboard. • Improvement plan and report to be shared with nursing team for them to provide solutions to manage workload • To implement transforming Safe and effective model of care.	Ward Sister/Senior Nurse/Head of Nursing	Ongoing

Delivery of Safe and Effective Care				
Page 25.	The health board is advised of the need to demonstrate how it will ensure that patients care and treatment is provided in accordance with Dols legislation.	• To release staff who are able to undertake Best Interests assessments • To train more Best Interest assessors • To access further training for nursing staff to understand and feel confident with Dols legislation	Senior Nurse and Safeguarding team	4th May 2015
Page 27	The health board is advised to demonstrate how it will ensure that patients mental health needs are assessed from the point of admission	• A Mental Health Discharge liaison nurse has been appointed to work with ward teams to identify patient individual needs • The Nurse practitioners are being trained to undertake mental capacity assessments as part of the admission assessments. • To Promote the use of the “This is me “ leaflet	Ward Sister/Senior Nurse	2nd March 2015
Page 28	The health board is required to provide HIW with a description of how it will ensure that medicines are administered safely at all times	• A key pad lock will be installed to secure drug preparation and storage area. • All staff will be reminded of their accountability in the safe management and storage of medicines in line with CTUHB policy • Senior nurse will undertake spot check audits to ensure compliance	Ward Sister/Senior Nurse	Immediate Effect
Page 29	The health board is advised of the need to demonstrate how it will ensure that improvements are made to the recording of all aspects of patients care.	• Ward Sister and Senior nurse will undertake spot check audits of patient documentation • Care metrics will be used as monthly reporting and monitoring tool • CTUHB are in process of reviewing patient records and nursing documentation.	Ward Sister/Senior Nurse/Head of Nursing	Ongoing