Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Unannounced Dignity and Essential Care Inspection

Aneurin Bevan Health Board

Royal Gwent Hospital

D4 West (Winter Pressures)

Date of inspection: 18 March 2014

Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced Dignity and Essential Care Inspection to the D4 West (Winter Pressures) ward at The Royal Gwent Hospital, part of the Aneurin Bevan University Health Board (ABUHB) on Tuesday 18th March 2014. During the inspection we observed and reviewed the following areas:

- Patient Experience
- The Delivery of the Fundamentals of Care
- Management and Leadership
- Quality and Safety.

The Aneurin Bevan University Health Board (ABUHB) as a whole serves a population of more than 600,000 and many of the inpatient and specialist services at the Royal Gwent Hospital support the entire catchment area.

The Royal Gwent is a District General Hospital, with more than 3400 staff and approximately 774 beds. It provides a comprehensive range of hospital services for inpatients, day cases and outpatients.

Outpatient services are utilised primarily by those in Newport and the surrounding area. In recent years a massive redevelopment has been undertaken to provide a new Cardiology Unit, Medical Day Case Unit, Medical Admissions Unit, and Paediatric A&E, complete refurbishment of the outpatient facilities and a £5m Ophthalmology and Otolaryngology Unit. Work has now been completed on an expansion to the Main Delivery Unit, with two new obstetric operating theatres, high dependency beds, extra delivery rooms and a six bed post operative support ward.

A new trauma and orthopaedic unit has been opened at St Woolos Hospital (situated close to the Royal Gwent Hospital). This unit has a state of the art operating theatre suite with clean air flow systems throughout and voice activated surgical equipment.

A proposal is under discussion that would make the hospital a sub-Deanery of the University of Wales College of Medicine. This proposition builds on the substantial links that already exist between the Royal Gwent Hospital and the University Hospital of Wales, with a number of joint appointments in many clinical departments.

D4 West (Winter Pressures) is a temporary unit opened in January 2014 to facilitate early discharge from acute wards within the Royal Gwent Hospital. It has a total of 30 beds, four bays with seven beds and two individual cubicles. There are segregated female and male bays. It is envisaged that the unit will close at the end of March 2014.

2. Methodology of Inspection

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[1]. We review documentation and information from a number of sources including:

- Information held to date by Healthcare Inspectorate Wales (HIW)
- Conversations with patients, relatives and interviews with staff
- Discussions with senior management within the Health Board
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- General observation of the environment of care and care practice.

These HIW inspections capture a *'snapshot'* of the standards of care patients receive on hospital wards/units/ Departments, which may point to wider issues about the quality and safety of essential care and dignity.

At the outset of the inspection we briefed the clinical team and requested to be informed at all times should clinical activity increase and whereby the inspection team may require additional caution to ensure balance between inspection and patient need.

We provided an overview of our main findings and requirements to representatives of the Health Board at the feedback meeting held at the end of our inspection. We found no urgent concerns emerging from the inspection and our findings are detailed within Appendix A of this report.

[1] *The Fundamentals of Care*, Welsh Assembly Government 2003

3. Summary

Overall, we were met by a friendly, approachable and organised staff team working within a busy ward environment, striving at all times to try and ensure that the patient experience was as positive as possible.

Generally, patients can be confident that the service, at the time of the inspection, was noted to be well run, with attention to maintaining professional standards of care. We witnessed that patients received information about their care in a language and manner which was sensitive to their needs because medical and nursing staff were talking with patients in a sensitive manner, with nurses returning later to answer any further questions.

Several areas of noteworthy practice were observed, particularly the efforts of the Ward Manager, who explained that the ward had only been open for a short period of time and that staff were either on loan from other areas of the hospital or from nursing agencies. Despite the short term nature of the ward, the nursing staff appeared to work well as a team and were led by enthusiastic ward managers. All worked together to ensure the seamless provision of care.

There was evidence that patients views were being listened to. For example we read on the ward's comments board that patients would appreciate more clocks and noted that this had been actioned with clocks now positioned above each bay door.

Notwithstanding the good practise observed above, we identified a number of areas for improvement within the four domains. The areas for improvement included completion of documentation and risk assessment, ensuring safe and effective medicines management, application of Infection Prevention and Control procedures and staff training and knowledge in relation to Dementia and the mental health capacity act. Details of the areas for improvement and our requirements are set out within Appendix A.

4. Findings

4a. Patient Experience

During the inspection we identified three areas which require improvement in the area of patient experience. Our requirements in this respect are detailed within Appendix A.

Overall, we were met by a friendly, approachable and organised staff team working within a busy ward environment, striving at all times to try and ensure that patients' experience was as positive as possible.

Although the ward did not use privacy signage, we observed that curtains were always drawn around the bed when care was being given. We heard patients being spoken to discreetly, with staff ensuring that conversations regarding personal care and medical conditions could not be overheard. We witnessed doctors raising voices appropriately, to speak with patients who had difficulty with hearing, but discreetly sharing information at the foot of the bed when discussing on going treatment with colleagues.

We also observed that, on the whole, staff spoke with patients and other members of the ward team in a calm, professional and courteous manner, with patients being called by their preferred name, which was clearly documented in the care files and on the information board in the nurses office. On occasions we did hear some staff calling patients "darling" although no patients indicated that they were uncomfortable with this.

There was no evidence that the ward had communication aids for people with additional needs (i.e. picture cards, loop hearing system, information in large print). Patients stated, however, that their care had been discussed with them and we saw staff taking their time speaking with patients who had more complex needs. We read on the ward's comments board that patients would appreciate more clocks and noted that this had been actioned, with clocks now positioned above each bay door.

Patient's stated that staff were "respectful, helpful, friendly and dedicated". These attitudes were confirmed when we observed staff being patient and considerate with one confused patient who was purposefully wandering around the ward. Staff also offered to collect newspapers for the patients during their break times, although we were told that the Royal Voluntary Service (RVS) had commenced a ward service in the hospital that week, which offers people with the opportunity to buy newsagents goods by the bedside.

Patients stated that responses to nurse call bells varied and sometimes there was a wait for staff to respond. This, patients suggested, was due to staff shortages and that the ward was busy. However, they indicated that the response for assistance to use the toilet was good, especially at night. We observed on the day of inspection that there was some delay in answering the call bells in the afternoon. This means that patient's needs are not always being met in a timely way.

Conversations with patients indicated that food was generally good although a number or patients told us that there was very little choice for breakfast. Staff confirmed this, stating that there was only toast or cereal available. We observed a mealtime and found that it was busy with some areas of the ward having more staff support than others. We saw that all staff, irrespective of their grade, assisted with ensuring food was given to patients in a timely manner. Patients ate their meals sitting in or by their beds, which did not provide an environment of rehabilitation or preparation for discharge home. It was noted that there was a day room available which was not used by the patients, but as a storage / staff room / office facility. Discussion was therefore held with the Ward Manager as to whether the room would be better used as a functional day room where television, radio or an opportunity to socialise could be provided, to improve the experience for the patient.

We observed that all staff wore uniforms in accordance with the All-Wales dress code, however not all staff wore clear identification badges to assist patients with names and in understanding the different roles of staff.

Notwithstanding the good practise observed above, we identified three areas for improvement in relation to the Fundamentals of Care. These are detailed in appendix A:

- Limited activities available for patients and the patient day room used as a storage / staff room / office facility.
- We observed delays answering buzzer calls during the afternoon. This means that patient's needs are not always being met in a timely way.
- Patients not being addressed by their preferred name

4b. Fundamentals of Care

During the inspection we identified eight areas which require improvement concerning the delivery of the Fundamentals of Care. Our requirements in this respect are detailed within Appendix A.

Communication and Information

We observed interaction between staff and patients/relatives in accordance with the standard required by the 'Fundamentals of Care'. The majority of patients and relatives we spoke with during the inspection confirmed that they felt adequately informed about their care management and treatment.

We witnessed that patients received information about their care in a language and manner which was sensitive to their needs because medical and nursing staff were talking with patients in a sensitive manner, with nurses returning later to answer any further questions. Information was recorded in patients' care files which were stored at the foot of individual beds. The care files contained the relevant personal information, although they were not easy to navigate and documents were not filed in a systematic format.

We could not however, be assured that patients health, personal and social care needs were always assessed and set out in a regularly reviewed plan of care. We saw in the inspected care files that there were a limited number of initial assessments undertaken on admission to the ward, and of the six care files examined at least four had no care plans and the remaining files had some care plans but not for all identified needs. Subsequently, there was no evidence of planned care, its implementation or the evaluation of any interventions to ensure care given was effective. This also means that neither permanent or agency staff were provided with a clear guide as to how to provide care and support to each patient in accordance with their needs, wishes and preferences. We did however see appropriate referrals to wound care specialists and wound charts to monitor the efficacy of treatment.

We saw that patients had signed for consent to procedures, with one patient consenting to a surgical procedure even thought the doctor had written "that he had not taken the details on board". Another had undergone an invasive procedure even though his care file indicated that he may not have had capacity. There was no evidence of communication or discussion with relatives in either file. These contravene the guidance in the Mental Capacity Act 2005 and the 'fundamentals of care' clearly require healthcare staff to help patients comprehend what is being said to them in the decision making process including their carer or next of kin if needed.

There was some evidence of discharge planning in one care file, with adaptations ordered in readiness for the patient to go home. However we saw that another patient was recorded as medically fit for discharge on the 26th February 2014 although a best interest meeting was arranged for the 28th March 2014 and there was an outstanding Occupational Therapist assessment from February 2014. Another care file indicated that there had been no multidisciplinary team meeting with regard to discharge planning and two of the examined care files were classified as delayed transfer of care (DTOC). It was not in the best interests of the patients to remain in the hospital longer than was necessary.

Respecting People

During the inspection we observed the efforts being made by staff to protect patient's basic human rights to dignity, privacy and choice. We also found that the care provided on the ward took into account individual's needs, abilities and wishes in this regard. This is because there was evidence of good signage on bathroom doors and staff preserved privacy and dignity by closing doors and curtains before undertaking any personal care. We did not see the use of privacy signage on the curtains around the beds, however we did not observe any staff entering, other than to assist with care, when the curtains were closed. Staff stated that confidentiality was maintained by discussing any personal matters at quieter times or by speaking discreetly behind bed curtains.

We noted that people were called by their preferred name and were encouraged to make decisions i.e. what they would like to eat or drink, whether they wanted to go back in to bed or if they wanted a shower or bath. Staff were seen to demonstrate patience and understanding towards the patients in their care throughout the unannounced inspection.

Ensuring safety

The Ward Manager stated that staffing levels were appropriate to meet the needs of the patient's currently on the ward, although she acknowledged that it was very busy due to the nature of admissions from other wards and planned discharges. She had identified that there were risks to continuity of care due to not having a full compliment of permanent staff, however she did not feel that it was affecting the quality of care being given. Patients stated that staff were always very busy.

We spoke with the domestic staff working on the ward who confirmed that there were appropriate cleaning schedules available and that they had up to date training for the work expected of them. We noted that the environment was clean and well maintained for its age, although there was only one nurse

call bell in bay C. This may limit some patient's ability to request assistance as and when required. Fire exits were clearly signed and uncluttered.

There was limited room for storage in the ward; the day room being utilised to house larger equipment. Storage cupboards were inspected and although tidy, we saw intravenous administration equipment, continence products and nutritional supplements stored on the floor. This is not in-keeping with accepted infection, prevention and control practice. Sorting items in this way, also increases the risk of staff trips and falls.

Promoting independence

To a limited extent we witnessed patients being supported to be as physically independent as they were able, because we saw two patients receiving therapy from the Physiotherapist and another had been to Audiology to have a hearing aid repaired. However there was no evidence of any encouragement for patients with cognitive deficits (such as confusion or dementia) through the use of specific initiatives.

Relationships

Staff stated that patients were encouraged to maintain involvement with their family, although there was no private area for them to speak confidentially with relatives. We noted that it was difficult to develop new relationships with others patients because they were either sitting in or by their beds throughout the day. The day room was being utilised as a storage /staff room and office space. There was no area for patients to socialise, watch television or listen to the radio to maintain contact with the outside community.

Rest, Sleep and Activity.

We saw that consideration was given to the patients environment and comfort so that they could rest and sleep. There were adequate amounts of pillows and blankets available, however staff stated that this was not always the case. Weekends were usually a problem with clean laundry not being delivered until Sunday afternoon. This may result in patient's discomfort.

We heard patients (who had been sitting by the side of their beds) asking to go back into bed after lunch and they were assisted to make themselves comfortable.

Ensuring Comfort, Alleviating Pain

Patients were helped to be as comfortable and pain-free as their condition and circumstances allowed and we noted that the patients we spoke with did not display any signs of discomfort. However when we looked at the documentation, although there were pain score charts available, they were not completed in line with the administration of medication and therefore there was no evaluation of the effectiveness of any prescribed analgesia.

Personal Hygiene and Appearance

Patients told us that they were encouraged to be as independent as possible with washing and dressing. Assistance was given if required, especially for the male patients with shaving. Patients were generally clean and well groomed. However we did notice that some male patients had long nails that needed attention. Staff spoken with stated that there were no nail brushes available to undertake nail care. Staff also stated that there was sometimes a shortage of clean gowns or nightwear on the weekend, again because the laundry was not delivered until Sunday afternoon. This may cause patients some distress and undermine individual's dignity.

Eating and Drinking

We observed that patients were offered a choice of food and drink that met their nutritional and personal requirements and saw that they were provided with assistance to eat when required. All staff regardless of their grade assisted with distributing and ensuring that food was eaten in a timely manner. However the female bays seemed to have higher needs and less help. We saw one patient's food being removed although she was confused and had not eaten any. Other patients who required pureed food were assisted to eat in an unhurried, patient and respectful manner.

We also found that fluids were offered on occasion, but if the patient was asleep we did not see them being offered later when they woke and cups were sometimes placed out of reach of patients who were in bed.

The ward team were using a recognised nutritional tool to assess patient's needs. However, examination of a number of patient's records revealed that such risk assessments had not been updated and reviewed appropriately and the All Wales food and fluid charts were not always completed, even though evaluation notes stated that a nutritional drink had been given.

There was a small sign on the ward door to indicate that mealtimes were protected, however we observed a considerable amount of medical staff and therapists on the Ward undertaking procedures during lunchtime.

The ward did not utilise the red jug / tray system to identify who required assistance however the staff were familiar with the needs of the patients and no one was seen to be without food or assistance to eat.

Patients did not have a dining room to eat their meals and therefore meals were brought to their bedsides. We noted that tables were not cleared of clutter before lunches were served.

The above matters were brought to the attention of the health board at the inspection as patients who experience difficulties with eating and drinking independently should receive prompt assistance, encouragement and appropriate aids or support to ensure that they are well nourished.

Oral Health and Hygiene

It was evident that patients were supported to maintain healthy, comfortable mouths and pain-free teeth and gums, enabling them to eat well and prevent related problems. Although the All Wales Oral Health and Hygiene bundle was not seen in the notes, we did not observe any issues of concern in relation to oral health and hygiene. One patient, whose nursing and medical notes were scrutinised was 'Nil By Mouth' (NBM). On speaking with the

person concerned, we were able to confirm that their mouth was moist, clean and fresh.

Toilet Needs

On the whole we observed appropriate, discreet and prompt assistance being provided to patients when accessing toilets or commodes. Call bells were mostly being answered in a timely manner, and no patients indicated that they were distressed as a result of having to wait.

There was evidence of continence pads in the store room, however we did not see any continence assessments recorded in care files, even though changes of pads were recorded. Discussion with staff indicated that there were two sizes of pads available on the ward and they either asked patients which one they wanted or chose for them. There was no record viewed of any referrals to the continence nurse specialist. The above findings may mean that some patient's continence needs are not being fully met.

Preventing Pressure Sores

Patients were helped to look after their skin and every effort made to prevent the development of pressure sores with the ward using the Waterlow tool as part of an initial assessment on admission. Where necessary SKIN bundles and charts were also adopted. However updates and reviews of these assessments were variable in the care files we examined. We also found that planned intervention was not always clearly written.

Staff stated that access to pressure relieving mattresses was not a problem and this was evident by the mattresses seen on the patients' beds however, we did not see any pressure relieving cushions and staff stated they were more difficult to access. This may mean that patient's are at unnecessary risk of developing damage to their skin. Discussion with the ward manager however revealed that there were currently no patients with pressure damage at this time.

Notwithstanding the good practise observed above, we identified eight areas for improvement in relation to the Fundamentals of Care. These are detailed in appendix A:

- Limited care plans with very little evidence of evaluation / outcomes and Limited risk assessments.
- Lack of consistence in Mental Capacity Act assessment.
- Limited evidence of promoting independence.
- Lack of evidence of recording of effectiveness of pain relief.
- Poor evidence of nutritional assessments.
- No continence assessments.
- Poor nail care.

4c. Management and Leadership

During the inspection we identified one area for improvement concerning management and leadership. Our requirement in this respect is detailed within Appendix A.

Overall, patients can be confident that the service, at the time of the inspection, was noted to be well run, with attention to maintaining professional standards of care we did identify areas of improvement.

There were two Ward Managers who shared the management responsibilities. On the day of the visit one was working clinically, whilst the other undertook the management role, including assisting with the inspection process.

Both Ward Managers were visible on the ward and were approachable and supportive to the patients, relatives and staff. It was evident that they had worked hard to promote a cohesive and well engaged staff team in a very short period of time. The number of medical teams referring to this ward makes the co-ordination of care challenging, however both Ward Managers seemed to work well together to ensure the provision of seamless care. The

Ward Manager involved in the inspection process remained fully aware of the needs of the patients on the ward, and was able to advise when necessary.

The Ward Manager explained that the ward had only been open for a short period of time and that staff were either on loan from other areas of the hospital or from nursing agencies. She stated that to maintain consistency and continuity for both staff and patients they tried to contract with the same agency staff. Due to this staffing situation it was difficult to inspect the training schedule, however the Ward Manager indicated that the ward may become a permanent part of the hospital and that would give her the opportunity to ensure that staff were appropriately trained to undertake the more specialised work required of them, such as dementia care. Staff spoken with indicated that they have access to all mandatory training across the Health Board.

At this point the ward does not take Student Nurses although the Ward Manager suggested it would be something she would consider if the ward became a permanent site.

Notwithstanding the good practise observed above, we identified one area for improvement in relation to the Management and Leadership. These are detailed in appendix A:

- Lack of evidence of staff having received recent Dementia training.

4d. Quality and Safety

During this inspection we identified seven areas for improvement concerning Quality and safety. At the time of writing, six had already been dealt with via an Immediate Response Management letter, the remaining finding is detailed within Appendix A.

Overall, the ward environment appeared clean and pleasant and conversations with patients indicated that they were satisfied with the

cleanliness. The ward was generally free from clutter which enabled patients and staff to move around safely and freely.

We saw that there were dedicated hand-washing facilities with appropriate signage for hand washing in critical areas of the ward environment. Bedpans and commodes were clean and stored appropriately. Toilet and bathroom facilities were clean with foot operated pedal bins for waste. However we did notice that personal toiletries were left in one bathroom.

We observed that the door to the treatment room where drugs were stored had a key pad lock system but the door did not always close securely. Cupboards within this room were locked, however the medicine fridge was not locked and we found two bottles of medication which had exceeded the recommended expiry date.

We observed nurses' practice in administering medication to patients in accordance with recognised professional standards. The ward did not use the red tabard system to ensure staff were not disturbed when administering medication, although nurses were not interrupted and were able to offer assistance to patients in an unhurried and calm manner. There was incorrect completion of the 'Controlled Drugs Book' where we found administration signatures for two medication doses had been omitted. Subsequently we found these had been entered retrospectively. We also found unclear authorisation to dispense in the Controlled Drugs Book with an instance whereby medication from the ward stock had been approved for dispensing as take home medication (page 12). It was not clear however, if the authorising signatory had the authority to dispense this medication.

The above findings present a potential risk of unauthorised access to prescribed medicines and the administration of medication that is no longer in date. These matters were brought to the attention of senior representatives of the health board during the inspection and by means of an Immediate Action Management letter.

We noted that there were two cubicles which we had been advised posed a risk of cross infection. As a result, the patients accommodated in these two rooms were being barrier nursed. However, there was no signage on the doors to alert all staff or visitors. Neither was the issue documented in the care files of the persons concerned and we observed staff entering to undertake care practices and serving food without appropriate protection wear.

The above issues place patients and staff at unnecessary risk of hospital acquired infection. These matters were brought to the attention of senior members of the health board during the inspection.

Notwithstanding the good practise observed above, we identified the following seven areas for improvement in relation to Quality and Safety. This is detailed in appendix A:

- staff not observed wearing aprons for distributing meals.
- Potential access to medication by unauthorised persons.
- Out of date medication stored on the ward.
- Incorrect completion of the ‘Controlled Drugs Book’.
- Unclear authorisation to dispense in the ‘Controlled Drugs Book’.
- Unclear implementation of All Wales Infection Prevention and Control procedures.
- Limited risk assessment undertaken of a confused patient.

5. Next Steps

Aneurin Bevan University 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 D4 West (Winter Pressures) at The Royal Gwent 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 Boards Improvement Plan, once agreed, will be published on Healthcare Inspectorate Wales website and will be evaluated as part of the on-going Dignity and Essential Care inspection process.

Dignity and Essential Care: Improvement Plan — Appendix A

Royal Gwent Hospital

Ward D4(west): Winter Pressures

19 March 2014

Ref.	Finding	Requirement	Health Board Action	Responsible Officer	Timescale
4a. Patient Experience					
	Limited activities: There was a day room available which was not used by the patients but as a storage / staff room / office facility. Discussion was therefore held with the Ward Manager as to whether the room would be better used as a functional day room where television, radio or an opportunity to socialise could be provided, to improve the experience for the patient.	The Health Board should consider the availability of a day room and / activities for patients to assist their preparation for discharge.			
	Delays answering buzzer calls: Patients stated that responses to nurse call bells varied and sometimes there	The Health Board should ensure buzzer calls for assistance are answered			

	was a wait for staff to respond. We observed on the day of inspection that there was some delay in answering the call bells in the afternoon. This means that patient's needs are not always being met in a timely way.	promptly and that patients do not become distressed by any undue delays.			
4b. Fundamentals of Care					
4b.1	Limited care plans with very little evidence of evaluation / outcomes and Limited risk assessments when undertaken no care plans to mitigate the risks.	The Health Board should ensure care plans are fully completed with evidence of care undertaken and all relevant risk assessments completed including any subsequent actions.			
4b.2	Lack of consistency in assessment of Mental Health Capacity: We saw one patient had undergone an invasive procedure even though his care file indicated that he may not have had capacity contravening the guidance in	The Health Board should ensure a consistent assessment of Mental Health Capacity in accordance with the Mental Health Act 2005.			

	the Mental Capacity Act 2005 and the 'fundamentals of care'				
4b.3	Limited evidence of promoting independence: There was no evidence of any encouragement for patients with cognitive deficits, such as dementia initiatives.	The Health Board should consider implementing initiatives to encourage independence of patients particularly those who are preparing for discharge.			
4b.4	Lack of evidence of recording of effectiveness of pain relief: Pain score charts were not completed in line with the administration of medication and therefore there was no evaluation of the effectiveness of any prescribed analgesia.	The Health Board must ensure pain score charts are completed in line with the administration of medication and the effectiveness of any prescribed analgesia is evaluated.			
4b.5	Nutritional assessments poor: Examination of a number of patient's records revealed that such risk assessments had not been updated and reviewed appropriately and the All	The Health Board must ensure Nutritional assessments are completed and updated where required.			

	Wales food and fluid charts were not always completed.				
4b.6	No continence assessments: We did not see any continence assessments recorded in care files, even though changes of pads were recorded.	The Health Board must ensure continence assessments are undertaken where required.			
4b.7	Poor nail care: We observed that some male patients had long nails that needed attention. Staff spoken with stated that there were no nail brushes available to undertake nail care.	The Health Board should undertaken appropriate nail care is undertaken and nail brushes are available.			
4c. Management and Leadership					
4c.1	Lack of evidence of staff having received recent Dementia training: Staff we spoke to had not received recent Dementia training.	The Health Board should ensure an adequate number of staff receive up to date Dementia training to reflect the needs of the patients on the ward.			
4d. Quality and Safety					

4d.1	Staff not observed wearing aprons for distributing meals.	The Health Board should ensure staff wear appropriate aprons when distributing meals.			
4d.2	Potential access to medication by unauthorised persons: We identified access to the medication room was possible by unauthorised persons due to a slow closing door which staff did not ensure had fully closed and locked when leaving the medication room	The Health Board must ensure safe medicines management and prevent unauthorised access to medication	Door reported to works and estates for any remedial work to be carried out. Clear signage placed on the door to remind staff to ensure door is closed at all times.	Deputy Sister's D4W, Senior Nurse, Divisional Lead Nurse	March 2014
4d.3	Potential access to medication by unauthorised persons: We identified that the drugs fridge was not locked and access to the medication room was possible by unauthorised persons due to a slow closing door (identified within the finding above).	The Health Board must ensure safe medicines management and prevent unauthorised access to medication	As above Fridge door to be locked at all times.	Deputy Sister's D4W, Senior Nurse, Divisional Lead Nurse	March 2014
4d.4	Out of date medication stored on the ward:	The Health Board must ensure safe medicines	Medication discarded immediately. All medication in the drugs fridge to	Deputy Sister's D4W, Senior	March 2014

	We found medication within the drugs fridge in the medication room which had passed its use by date.	management and ensure out of date medications are disposed of correctly.	be weekly checked for medication out of date.	Nurse, Divisional Lead Nurse	
4d.5	Incorrect completion of the 'Controlled Drugs Book': We found administration signatures for two medication doses had been omitted from the controlled drugs book (page 16). Subsequently we found these had been entered retrospectively.	The Health Board must report the incident via the Datix system and investigate it appropriately. Furthermore the Health board must ensure safe medicines management with particular reference to the procedure of checking medication administration.	Datix completed investigated by Senior Nurse. Senior Nurse for the area reinforce the importance of ensuring safe medicine management.	Deputy Sister's D4W, Senior Nurse, Divisional Lead Nurse	March 2014
4d.6	Unclear authorisation to dispense in the 'Controlled Drugs Book': We found an instance whereby medication from the ward stock - used for take home medications had been approved for dispensing. It was not clear however, from the 'Controlled Drugs Book' (page 12) if the authorising	The Health Board must provide detail of who the authorising signatories are, and confirm their authority to dispense TTH from ward stock. The health board must ensure safe systems for	Controlled drug book changed to two books. One for medication at ward level. One for patients own medication and TTH. Ward pharmacist involved and will change the system at ward level.	Deputy Sister's D4W, Senior Nurse, Divisional Lead Nurse	March 2014

	signatory had the authority to dispense this medication.	dispensation of take home medication.			
q	Unclear implementation of All Wales Infection Prevention and Control procedures: We were informed two patients were subject to barrier nursing as there may have been infection control issues. There was no signage or information contained within patient documentation to alert staff or visitors. Also, we did not observe nurses undertaking barrier nursing techniques	The Health Board must ensure the All Wales Infection Prevention and Control procedures are adhered to and implemented consistently.	The particular patients identified were not being barrier nursed. The patients were identified in the emergency department as potentially having infections therefore moved in to cubicles as a precaution. A two hour target for the isolation of patients with diarrhoea of unknown origin is being implemented and monitored. An audit and subsequent education will be instigated as soon as possible to ensure such patients are being barrier nursed with appropriate signage.	Deputy Sister's D4W, Senior Nurse, Divisional Lead Nurse	March 2014
	Limited risk assessment undertaken of a confused patient: We observed that a patient who was	The Health Board must ensure appropriate risk assessments are	Risk Assessment had been completed for the patient identifying his confusion and wandering nature.	Deputy Sister's D4W, Senior Nurse,	March 2014

	confused had absconded from the ward and had returned with the assistance of another staff member within the hospital. The patient was found not to be wearing a patient identification band and the patients records contained limited evidence of assessment of potential risks relating to their confused state.	undertaken and required actions implemented to assure the safety of potentially confused patients.	Appropriate observation was put in place. Whilst appropriate action taken when patient left the ward (patient found removing his arm band so bands placed around his ankle to ensure that identification was achieved). The ward sister has reviewed recommendation by HIW and auctioned appropriately. All immediate action undertaken.	Divisional Lead Nurse	