Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Withybush General Hospital -

Paediatric Ambulatory Care Unit, Puffin Unit

Hywel Dda University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Withybush General Hospital within Hywel Dda University Health Board. The following hospital sites and wards were visited during this inspection:

- Puffin Ward Paediatric Ambulatory Care Unit (PACU)

Our team, for the inspection comprised of one HIW Inspector, two clinical peer reviewers and one lay reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

The paediatric ambulatory care unit was a good setting to provide a rapid assessment and treatment of children and young people in a dedicated paediatric environment.

Staff on the ward were professional and committed to working collaboratively to provide patient care. We found there was strong leadership on the unit.

Patients and their parents/carers reported a positive experience on the ward and were treated with dignity and respect.

However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas. This included a weakness with information governance on the ward.

This is what we found the service did well:

- Patients and their families were positive about the care and treatment provided during their time on the unit
- We saw professional and kind interaction between staff and patients, and care provided in a dignified way
- Arrangements were in place to maintain the safety of patients in the areas we visited
- Audit activity being carried out on the ward.

This is what we recommend the service could improve:

- The paediatric sepsis pathway/guideline should be developed and implemented as a priority and all staff be provided with relevant training
- The door to the controlled drugs room should remain locked at all times and access to all drugs within the stabilisation room should be secured
- Secure storage of information to prevent unauthorised access and to uphold patient confidentiality.

3. What we found

Background of the service

Withybush Hospital is located in Haverfordwest in Pembrokeshire and forms part of the health care services provided by Hywel Dda University Health Board (the health board). The health board provides healthcare services to a total population of around 384,000 throughout Carmarthenshire, Ceredigion and Pembrokeshire.

The Paediatric Ambulatory Care Unit (PACU) or Puffin Ward, is an eight hour a day (10am-6pm), seven day a week service as part of the acute paediatric service within the Women and Children's Directorate.

The 12 bedded unit has been set-up to provide a rapid assessment and treatment of children and young people from 0-16 years in a dedicated paediatric environment. The patient age may go beyond 16 years for those under the care of a paediatric consultant.

The service provides rapid assessment and stabilisation of all general paediatric emergency admissions, plus scheduled elective provision for reviews, outpatient and day cases.

The service works closely with the emergency department for all emergency referrals (including referrals from general practitioners (GPs), health visitors and midwives). There are also various speciality clinics that run including diabetes, epilepsy and allergy clinics, plus visiting consultants, school nurses, children's community nurses and parents of children with long term open access.

Paediatric inpatient or overnight care is not provided at the unit. Children are transferred to the 24 hour paediatric inpatient service at Glangwili Hospital in Carmarthen.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients and their parents/carers were positive about their overall experience of the service and felt they had always been treated with dignity and respect.

We observed polite, friendly and supportive interactions between staff and patients. We saw care was provided in a way that upheld patient dignity.

However, health promotion information should be made readily available throughout the unit.

During the inspection we distributed HIW questionnaires to patients to obtain their views on the services provided. A total of nine questionnaires were completed. Five respondents were under eight years of age, three were aged between 8 and 10 and one patient was aged between 11 and 14. We also spoke to patients and carers during the inspection. Patient comments included the following:

"Staff were lovely and talkative"

"Friendly staff".

Staying healthy

We found there was some health promotion information displayed in the unit. This included how to protect children from flu and 'healthy smile' (to promote cleaning teeth). However, there was little information available on topics such as breastfeeding, mental health and social media awareness. Some health promotion leaflets were located within the seminar room which was inaccessible to patients and their parents/carers.

One patient we spoke to told us a nurse had given them advice on how to look after themselves and offered leaflets on how to help their children look after their own health.

Improvement needed

The health board must ensure that relevant health promotion information is readily available throughout the unit.

Dignified care

During the course of our inspection, we witnessed many examples of staff being compassionate, kind and friendly to patients and their parents/carers. We saw staff treating patients with respect, courtesy and politeness at all times. We also saw staff greeting patients who had previously attended the unit personally by name. We observed a play specialist speak to a young child and their parent kindly in a calm and relaxed manner to help put them at ease for a procedure they were due to undergo.

We observed staff protecting the privacy and dignity of patients as far as possible. Doors to single rooms were closed and curtains were pulled around patient beds in the multi-bedded bay areas whilst staff were providing them with personal care and during personal conversations. We observed staff being respectful to patients in accompanying them into individual rooms to discuss their treatment and care.

During our inspection, we also invited staff to complete a HIW questionnaire to find out what working conditions are like and to obtain their views on the standard of care. We received 13 completed questionnaires from staff. All respondents agreed that the privacy and dignity of patients is always maintained.

We saw that single rooms were available, in the event that staff may need to have sensitive conversations with patients and their parents/carers.

The visiting arrangements on the unit meant that patients were able to maintain contact with their families and friends, according to their wishes.

A playroom was available which contained a wide range of toys, books and games suitable for children of all ages. Staff told us that if young people attend the unit for assessment or treatment, they can have access to an individual room if required. This will ensure their privacy and dignity is maintained during their time on the unit.

The inspection team were told that all patients who attend the unit are weighed upon their admission. We saw the weighing scales were situated in the corridor,

near to the nurses' station. We considered that this could impact on some patients' dignity as they may not wish to be weighed in a public area. We advise the weighing scales should be moved to a location where patients' privacy may be maintained.

Patient information

We found that directions to the unit were clearly displayed throughout the hospital, meaning that patients were able to find their way easily. Visiting hours were displayed on the unit which clearly stated the arrangements surrounding the unit's opening and visiting times.

A notice board was located near the reception desk which displayed information regarding the staffing details of those who were on duty. This included staff names and colour coded tunics next to each staff member which reflected their designation. This would assist patients and their parents/carers in identifying the staff involved in their care.

We saw that, upon their arrival at the unit, parents/carers are asked to sign in at reception and are taken with the patients to the play room to wait for their appointments or to be assessed. Toilet facilities are available within the play room area, and we observed staff offer refreshments to patients and their parents/carers.

Communicating effectively

Overall, patients and their parents/carers who completed questionnaires and those that we spoke with were positive about their interactions with staff during their time in the unit. All respondents said staff explained their health with them in a way they could understand.

We spoke to patients who told us that staff had communicated clearly with them what to expect in terms of their treatment, and had also shown them pictures. We also observed staff taking time to speak to patients in line with the patient's stage of development. We heard several telephone conversations between staff members and parents, all of which were polite and respectful. We saw parents/carers being warmly welcomed to the ward and involved in discussions around their child's care.

We observed play specialists spending quality time with patients, encouraging play and actively engaging and listening to parents. Staff told us that play specialists are a vital part of the unit and play an important and positive role in children's experience at the unit. We saw play specialists provide help to children with understanding their care through the use of picture books and iPads which

had widget communication aids and sensory apps. We were told by staff that individual patient passports had been developed and introduced which are an excellent tool for patients who have difficulties in communicating.

Staff we spoke with were aware of the translation services within the health board and how they could access these to support patients whose first language may not be English. Staff told us they ask patients and their parents/carers what their preferred language is. They also said that some Welsh speaking staff are available on the unit. All patients who completed questionnaires said that English was their first language and all said they were able to speak their preferred language with staff.

The inspection team saw that bilingual signs and posters were evident on the unit. This would assist Welsh speaking patients by giving them confidence to use Welsh if it was their preferred language.

A patient safety at a glance board[1] was located opposite the nurses' station within the unit. We found this to be a good tool to communicate with staff across the unit. Patient's initials were used as opposed to their full names to protect patient confidentiality. We spoke to staff who were all aware of the condition of the individual patients, investigations required and their monitoring and review status.

Nearly all staff who completed questionnaires agreed families are always or usually involved in decisions about their child's care.

Timely care

We saw that unscheduled patients who attend the unit for an urgent assessment or treatment are dealt with in a timely manner. Staff are informed by the ward clerk the patient is on their way, and ensure that plans are in place to assess and treat patients in a prompt manner upon their arrival at the unit. We also saw evidence of staff planning in advance for patients who were due to attend pre-arranged appointments the following day by reviewing what treatment they were

[1] The patient safety at a glance board is used in hospital wards for displaying important patient information such as infection risk levels, mobility, and admission and discharge flow amongst others.

due to undergo, and how they will be treated. We spoke to staff who all had good knowledge of patients who were on the unit and the care they required.

Staff told us that the majority of patients attend the unit for pre-booked appointments. When an unscheduled patient requires an urgent assessment or treatment, staff told us that they inform the patients who are pre-booked that there may be a delay in their appointment as another patient has taken priority. However, one parent who completed a questionnaire said that communication on waiting times could be improved. We advise that staff should ensure that all patients are kept updated of any possible delays in their treatment.

We saw that patient observations were recorded on a recognised national chart to identify patients who may become unwell or develop sepsis[2]. However there was no clear paediatric sepsis guideline or pathway in place. We spoke to the practice development nurse who informed us that a working group had been formed in July 2019 to develop a paediatric sepsis pathway/guideline. We were told that this work was behind schedule due to competing demands, and saw evidence that a base line assessment had been undertaken and an action plan developed. We were assured that the sepsis pathway was in the process of being developed, however we recommend that the work is prioritised to assist staff with the recognition, diagnosis and early management of sepsis of patients.

Staff told us that, in the event that paediatric patients attend the emergency department (ED) and require transfer out to a high dependency unit (HDU), staff from within the unit will go and care for them at the ED prior to their transfer. Staff we spoke to highlighted the importance of staff within the unit and ED staff working closely together. Managers told us that they are looking at ways of improving links with the ED and the unit is in the process of identifying two PACU nurse links for the ED to develop relationships and continue dialogue and feedback between the two departments. We were told that links between the ED and the unit are maintained through liaison meetings between an ED sister and staff from the unit.

In the event that a patient requires transfer from the unit to the HDU or paediatric inpatient service at Glangwili hospital, staff told us a dedicated ambulance vehicle

[2] Sepsis is a life-threatening reaction to an infection. It happens when your immune system overreacts to an infection and starts to damage your body's own tissues and organs.

(DAV) is available to provide transfer. The DAV is also used for transfers of maternity, obstetrics and gynaecology patients. We were told that a paediatric consultant would check the patient prior to transfer and a nurse escort from the unit would be provided, should one be required. In the event that the DAV is unavailable and a patient was very unwell, staff told us transfer would be arranged by emergency 999 call to the Welsh Ambulance Service Trust (WAST). We asked managers about the impact upon the unit when staff accompany patients being transferred and were told that cover would be sought from within the team or from the paediatric unit at Glangwili hospital. Managers told us that there had not been any issues to date.

The unit has a high dependency cubicle for children to be stabilised if necessary. We were told that arrangements for patients who require transfer to a paediatric intensive care unit (PICU) are made with the Wales and West Acute Transport for Children Service (WATCh)[3]. Staff told us that the transfer of each patient is considered individually to identify and arrange the timeliest and most appropriate method of transfer for the child.

We were informed there is a gap in the provision of the DAV between 4pm and 6pm. If a patient requires transfer after 4pm, DAV staff will not carry out the transfer as the turnaround time for patients to Glangwili is two hours which would result in them ending their shift late. Therefore patients are transferred after 6pm when the new shift comes on duty. We were told that this can mean delays in transfer which has an impact on staff within the unit as they have to remain on duty until the patient has been transferred. We were also told that there are instances where staff have to work out of hours when waiting for the DAV or WATCh retrieval team to transfer a patient. Managers told us that, in these instances, they are reliant on the goodwill of staff to work late, or off duty staff are called in. We were told that an incident report is completed documenting the reasons that staff from the unit were late leaving and that all reports are investigated by a manager. We reviewed the late finishers' report which documented the date and time the unit closed, description of the circumstances and the rationale for the late closure.

[3] The Wales and West Acute Transport for Children Service (WATCh) https://www.watch.nhs.uk/ is a jointly commissioned team responsible for the safe transfer of critically ill children across South West England and South Wales.

Improvement needed

The health board must ensure that:

- The paediatric sepsis pathway/guideline is developed and implemented as a priority and all staff are provided with relevant training.
- Consider how all patients can be transferred in a timely way without being reliant on the goodwill of staff to work late when required.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit. We saw the corridors were well lit and clear of trip hazards.

We spoke to a play specialist who was inspirational in the play and preparation work with each individual patient to ensure their needs are met on the ward. This included patients with additional learning needs and autism. They described how patients are prepared for procedures, for example, MRI scans[4] through play, thus reducing the need for sedation.

Within the sample of patient records we reviewed, we saw evidence of a patient who, upon their discharge from hospital, had been given verbal advice and written information to help them understand the administration of the medication they had to take home. This would support, encourage and enable the parent/carer and child to have the knowledge to understand the medications being given and continue with the administration of medication at home, thus promoting their independence.

People's rights

[4] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Most patients and their parents/carers who completed questionnaires and who we spoke to agreed they have the opportunity to ask questions and get involved in their care. Patients explained to us they felt more at ease knowing that their family had involvement. We observed a member of staff positively engage in discussion with a patient to ensure the patient was happy to remain on the unit for a few hours.

Staff told us that patient's individual spiritual and cultural needs are taken into consideration. We spoke to a play specialist who was very aware of addressing the individual needs of children and their parents/carers. They spoke passionately about a child who had needed an interpreter to explain their medical condition. The play specialist told us they had arranged for an interpreter to accompany the child to an appointment at a different hospital which had greatly enhanced their experience. We were told the hospital provides a multi faith room and a chapel is also available.

We saw posters of the United Nations Convention on the Rights of the Child[5] (UNCRC) displayed on the walls around the unit. The posters set out the ten promises that let children and young people know they will be respected, listened to and looked after when receiving treatment within the unit.

A playroom was available for the use of children and young people of all ages. A wide range of toys, puzzles and books were available to assist with the development of children. We also saw gaming stations for older children to make use of whilst waiting to be seen. We were told that older children can have their own room if requested. This will ensure their privacy and dignity is maintained whilst at the unit. All patients who completed questionnaires agreed there was enough entertainment and things to do on the ward suitable for their age.

Listening and learning from feedback

The inspection team saw that patients and their parents/carers were actively encouraged to provide feedback on the service and care received in a variety of ways. We saw that leaflets and posters were displayed around the unit to encourage and explain how to leave feedback. One method was a coloured coin

[5] The United Nations Convention on the Rights of the Child is a human rights treaty which sets out the civil, political, economic, social, health and cultural rights of children.

rate which allowed patients and families to drop a coloured coin into their preferred slot is situated near to the reception area on the unit. The slots have a smiley face, mid smile face and sad face and children are encouraged to place a coin in a slot to provide feedback on their care. We also saw a feedback box for parents/children's comments located within the reception area.

Staff and managers told us they would aim to deal with any complaints at source, with a view to resolving them quickly. We were told that details of any complaints were forwarded to the patient advice and liaison service[6] within the hospital to notify them, in case of a formal complaint being received. Bilingual leaflets were displayed within the unit relating to the NHS Putting Things Right complaints procedure for patients to follow should they have concerns about their care. Information was also available providing details of the Community Health Council (CHC). The CHC can provide advocacy and support to patients raising a concern about their care. Information on raising concerns and advocacy support was also available on the health board's website. Parents/carers we spoke to on the unit said they would know how to make a complaint as they had seen information displayed throughout the unit.

Most of the staff who completed questionnaires agreed that the organisation acts on concerns raised by patients. We were told by managers that staff are encouraged to report any complaints or concerns on the health board's incident reporting system. We were also told that recurring themes or issues are identified and feedback is provided to staff during team meetings. We also saw that feedback is highlighted on notice boards within the staff room. All respondents who completed staff questionnaires told us patient experience feedback (e.g. patient surveys) was collected and two thirds said they received regular updates on the patient experience feedback. Most respondents said feedback is used to make informed decisions within their directorate or department.

[6] The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall, arrangements were in place to maintain the safety of patients in the unit.

Arrangements were in place for the safe management of medicines. However, we identified improvements needed to ensure the door to the controlled drugs room was locked.

Information was not always being managed or stored securely, to prevent unauthorised access and to uphold patient confidentiality.

Safe care

Managing risk and promoting health and safety

The inspection team saw that the environment was clean and tidy, appropriately lit and well-maintained. The unit felt calm and relaxed throughout the inspection and the environment was safe for patients with no blocked corridors, clutter or tripping hazards present. We also saw that the unit was accessible for people with mobility difficulties. All patients who completed questionnaires agreed they liked the environment on the ward and that the ward was clean.

We saw excellent processes in place to manage risk which included regular audits, effective ordering and well planned staff rotas. We also observed excellent multi-disciplinary team work with play staff co-ordinating patient bookings and liaising with ward staff in preparation for appointments.

The inspection team also saw an incubator being stored in a sluice room located off the main corridor near the entrance to the unit. We spoke to staff who told us the incubator needed to be serviced and assured us the room is not in use as another sluice room is available within the unit. We advise the incubator should be moved from this room and stored appropriately.

We saw that arrangements were in place to maintain the safety of patients within the unit. Entry to the unit was gained via an intercom system. We observed staff asking for patient's details and the reason for their visit prior to being allowed entry to the unit. Anyone wishing to leave the unit had to ask the receptionist to

enable the door to be opened, or seek assistance from a member of staff to use their swipe card.

Staff told us that when patients attend pre-booked appointments which require sedation such as botox or MRI scans, two or three beds are available within a designated bay area. Patients in this area are under constant supervision from an additional nurse who is based within the bay area throughout the patient recovery process.

Infection prevention and control

We noted that all areas of the unit appeared visibly clean and uncluttered. This was supported by patients and their parents/carers who told us the unit, including the play room, was always nice and clean and they felt comfortable within the environment. However, we saw that half of the ward area where the designated bay area for pre-booked appointments was located was used as a storage area for cots/beds. This was an unpleasant outlook for children and we advised they are moved and stored in another location.

We saw that personal protective equipment (PPE) such as disposable gloves and aprons were available and being used by healthcare professionals to reduce the risk of cross infection. We observed staff upholding the standards of bare below the elbow which was assisted by the staff uniform.[7] Also appropriate facilities were in place for the safe disposal of clinical waste.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure. This would help encourage children to wash their hands and maintain good hygiene. We saw hand wipes and hand sanitising gel was available throughout the unit, including the play room. We also observed staff washing their hands appropriately and using hand sanitiser gel when needed. We also saw evidence of regular hand hygiene audits being completed which demonstrated high compliance rate.

[7] Best practice is for staff involved in direct patient care to be bare below the elbow. This includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), or wrist watches, nail polishes or false nails.

We were assured that a process is in place for ensuring that children's toys, books and other play equipment was regularly cleaned. This means they are as clean and safe as possible for children to use.

We noted the unit to be spotlessly clean and tidy. We were told that the unit has two housekeepers who share the role and work opposite each other. They complete a communication book to pass messages to each other to highlight what work had been cleaned, and any areas that required completing. We also saw excellent communication between the housekeeper and nursing staff within the unit. The housekeeper we spoke to had excellent knowledge of her role and told us that any room or environment where an infective or barrier nursed patient has been located is deep-cleaned. We also saw evidence of regular cleaning audits being completed with high compliance rates.

The unit had a separate en-suite room available for patients with a requirement for barrier nursing, prior to their transfer to another hospital. This meant the risk of infection being transferred to other patients was reduced.

Infection prevention and control training was mandatory for all staff. Nearly all staff indicated in their questionnaires that they had undertaken learning and development in infection control in the last 12 months.

We spoke to the unit's infection control link nurse. Their role is to act as a link between their own clinical area and the hospital infection control team, raise awareness of infection prevention and control and educate colleagues and motivate staff to improve practice. We also saw evidence of hand hygiene audits with high compliance rates. The results of the audits were displayed on the noticeboard within the staff room.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met during their time at the unit. We saw that patients who have been referred to the unit are continually assessed by nurses to monitor their nutrition and hydration status.

We observed children had access to jugs of water within easy reach which were topped up when required. We were also told by staff that alternative cold drink options were readily available to children on the ward or in the playroom area.

There was a dedicated kitchen area within the unit where staff could prepare healthy snacks for children. Staff told us patients who were on the unit for a longer period of time are provided with hot meals from the canteen. Staff advised us that they will provide more than one portion of food to patients if they are hungry and

if food supplies are low they can request additional food from the canteen. This will ensure patients nutritional needs are met by providing access to a good choice of healthy, nutritious food. We observed a patient being served a snack and drink which was pleasantly served on a tray. We were also told a healthcare support worker will assist children to eat their meals if required.

In the selection of patient records we reviewed, we saw that patients who had been referred to the unit were continually being assessed by staff to monitor their nutrition and hydration status. Staff also informed us that dietitians are contacted by telephone if necessary to provide advice on a patient.

We saw evidence with the patient records we reviewed of the use Paediatric Yorkhill Malnutrition Score (PYMS). This was developed to assist nursing staff and other health professionals to identify children in hospital, between the ages of 1-16 years, who are at risk of malnutrition and offer them appropriate care. We were told by managers that this tool was introduced by dieticians within the health board as their preference. We also saw evidence of regular PYMS audits being undertaken. The results of the audits were displayed on the notice board within the staff room and we were told were also fed back at monthly staff meetings.

Medicines management

The health board policy on medicines management was easily accessible to all staff electronically on the intranet. The policy included information on the safe administration of medication and safe storage, prescription and dispensing of drugs. We observed staff following the health board's policy on medicines management including the use of quiet time to calculate medication dosage. We saw documentation to show that medicine management quality assurance audits were undertaken to help ensure standards were maintained.

Controlled drugs were secured within locked cupboards and a locked refrigerator in a drugs room, however the drugs room was not locked. We spoke to staff who told us that the room is not locked during the day to allow easy access to the room but is locked overnight. We saw that there was access within the drugs room to sodium chloride vials, sucrose and water vials which were not locked away. We also saw sodium chloride vials stored within an unlocked drawer in a Hickman and Port trolley within the stabilisation room and saline solution vials accessible within unlocked drawers in the room. We recommended that the door to the controlled drugs room should be locked at all times and access to all items within the stabilisation room should be secured.

We saw that controlled drugs checks were consistently completed daily, however they were done as a whole. We recommend that each drug should be checked and signed for individually within the drugs register.

We saw evidence of regular temperature checks of the medication fridges being completed and recorded. This ensured refrigerated medication was stored at the manufacturer's advised temperature.

The inspection team observed good practice in all areas of medical administration. We reviewed the completion of the All Wales Drug Charts and noted consistent accurate recording to include patient names and when drugs had been prescribed and administered. All records reviewed were being recorded contemporaneously and appropriately signed and dated.

Staff told us the unit has a dedicated paediatric pharmacist who provides advice and guidance. We saw evidence of the pharmacist undertaking regular checks of the controlled drugs within the unit. Staff said access to a stock of medication was available within their drugs room and they are able to dispense medication from within the unit. A two person check system was operating against the prescribed medication requested by clinicians. In the event that medication is not available on the unit out of hours, staff told us the hospital duty nurse is contacted to access medication via the ED.

Whilst we did not have an opportunity to observe this during our inspection, we were told that a play specialist uses play to encourage children to take medication and uses a puppet to help with the children taking medication for sedation.

Improvement needed

The health board must ensure that:

- The door to the controlled drugs room remains locked at all times and access to all drugs within the stabilisation room should be secured
- Controlled drugs checks are signed for individually within the drugs register.

Safeguarding children and adults at risk

We saw that the health board had policies and procedures in place to identify, promote and protect the welfare of children who were vulnerable or at risk.

We were told that safeguarding training was mandatory for staff on the unit. All staff who completed questionnaires said they had received recent safeguarding training. We also were also assured that compliance figures for safeguarding training for staff on the unit was high.

Managers told us that safeguarding processes are discussed at team meetings, training days and any relevant safeguarding updates are displayed on the notice board within the staff room. We were also told the unit has a named safeguarding lead who is contactable for advice.

Staff we spoke to were aware of the procedures to follow in the event of a safeguarding concern and reported good links with social services staff and the police.

Blood management

Staff told us that patients who require blood transfusions or blood products will generally be treated at Glangwili hospital. This included oncology patients. However, staff within the unit receive annual training in blood management in case a need should arise. We saw evidence of this within the training records we reviewed.

Medical devices, equipment and diagnostic systems

We saw the unit had equipment and medical devices to meet the needs of patients. Nearly all staff who completed questionnaires said they 'always' or 'usually' have adequate materials, supplies and equipment to do their work. We found processes in place to ensure that equipment is cleaned and maintained to ensure they are appropriate for their intended use. All equipment checked by the inspection team had been recently checked/serviced.

Effective care

Safe and clinically effective care

We saw that patients were well cared for and appeared comfortable on the unit. Under half of staff who completed questionnaires agreed the care of patients is the organisation's top priority, and nearly a third said it never is. Most respondents said they were always or usually satisfied with the quality of care they are able to give to patients. A majority agreed they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.

We were provided with evidence to show the clinical audits that take place on the unit each month. This included a PEWS[8] document audit, hand hygiene, infection control, bare below the elbow compliance and medicine management audit. We saw evidence on the notice board within the staff room of high compliance in all areas.

We were told that the PEWS document audit had been undertaken monthly as issues had been identified around the accurate completion of documentation. However, it was noted within the Health Board Paediatric Newsletter that the compliance figures were now consistently high and had been referred to the quality assurance meeting where it had been agreed that they would be reduced to quarterly for the remainder of the year.

We saw that one of the cubicles within the unit was used for speciality clinics, such as children with diabetes. We were also informed that additional speciality clinics were planned for the future.

The unit also undertakes daily unplanned work when children are referred to the unit by either their General Practitioner (GP), health visitor, midwife or community nurse.

Quality improvement, research and innovation

Staff told us that the unit holds nurse led blood clinics. Referrals are made from GP practices and patients are able to immediately access the clinics as there are no waiting lists. We were told that the unit has received good positive feedback from patients and their parents/carers.

We were told that in order to progress their career, a Band 6 nurse had completed an advanced nurse practitioner course. Due to this success, plans are in place for two other nurses from each paediatric unit to attend the course.

In addition, we were told that a Band 5 nurse had introduced a baby immunisation course at the unit.

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[8] The paediatric early warning score (PEWS) is a tool which improves the detection and response to clinical deterioration in paediatric patients and is a key element of patient safety and improving patient outcomes.

Information governance and communications technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations (2018) within the unit. Overall, we found that patient information was being managed or stored securely to prevent unauthorised access and to uphold patient confidentiality.

However, we saw some patient records located on a table within an unlocked seminar room along the main corridor leading to the reception desk. There were times when staff were not present within the room. This meant there was a risk that patient information could be accessed by patients or visitors on the unit. We recommended that patient records are securely stored within the room to prevent unauthorised access.

The internal intranet was informative for staff, with a wide range of accessible paediatric and medical clinical policies and procedures. Staff we spoke to told us that they could be easily accessed on the intranet. This meant that staff were able to retrieve, review and use all policies.

Improvement needed

The health board should ensure that patient records are stored securely to prevent unauthorised access and to uphold patient confidentiality.

Record keeping

As referred to earlier in this report, the unit had been completing monthly audits of patient records, however, this had been reduced to quarterly audits following improvements to their quality.

We considered a sample of patient records within the unit. Overall, we found patient records were of a good standard, easy to navigate and informative. We saw that all nursing documents were appropriately signed and dated. However we observed inconsistencies in the completion of doctors names, GMC registration number and the signature was illegible. We also observed a lack of completion of an assessment date and time and admission and discharge date amongst another doctor entry. We also noted a lack of completion of a fluid monitoring chart for a child who had been admitted with vomiting. We spoke to a manager who told us a fluid monitoring chart would usually be used in such instances but they were unable to account for it on this occasion.

Improvement needed

The health board must ensure that all patient records are in line with standards of professional record keeping.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

We found the service had in place a number of regular meetings to improve services and strengthen governance arrangements.

There was evidence of good leadership and management within the unit and good multidisciplinary team working.

However, we recommended a review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication.

Governance, leadership and accountability

The health board's childrens services group had in place a number of regular meetings to improve services and strengthen governance arrangements. These included an operational monthly children's services meeting and operational delivery and performance management review meeting. We also saw that monthly quality assurance meetings take place where discussions include fundamentals of care, health care standards audits and monthly compliance with paediatric care indicators. Monthly PACU ward meetings also take place.

We were told that on alternate months datix meetings are held where reported incidents, investigations and their findings are discussed in a multidisciplinary format. We saw that minutes of the meetings were produced and information/learning shared across paediatric services across the health board to support changes to practice and learning. Themes and trends were identified with the view of highlighting any areas of practice, which were in need of addressing across the heath board.

It was also positive to note that a monthly paediatric newsletter has been introduced and circulated amongst staff. The newsletter included feedback from incidents, highlighting where areas of good practice had been identified, training

information, and other team related news. Information relating to learning from incidents was also displayed on the notice board within the staff room.

The health board demonstrated a clear and robust process to managing clinical incidents. A senior nurse quality assurance manager was in place, who held responsibility for reviewing, investigating and managing clinical incidents for acute paediatrics across the health board,with overarching responsibility lying with the directorate nurse. We were unable to speak to thesenior nurse quality assurance manager during this inspection. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were never dealt with in a punitive manner. Staff advised us that they had all received Datix (electronic incident management system) training and were aware of when to escalate concerns.

Most respondents who completed questionnaires agreed that staff who are involved in errors, near misses or incidents are treated fairly and none disagreed. A majority of respondents said they were informed of incidents and given feedback about changes made in response to reported errors, near misses and incidents and none disagreed. One member of staff commented:

> *"Staff have no problems sharing errors and concerns and all freely use Datix".*

We spoke to the service delivery manager who informed us that a paediatric dashboard was in the process of being developed by the senior nurse quality assurance manager. This would include information in relation to the whole health board, but broken down to each hospital and would provide information on clinical activities including clinical indicators and incidents.

We were assured that the internal risk register was monitored and acted upon when required.

We considered the noticeboard located in the staff area as an excellent tool for communication. It displays a wide range of up-to-date and active information, to include opportunities for staff training, audit compliance rates, clinical updates and advice, safeguarding, and student information. The inspection team considered this to be of significant importance given that the unit has the potential to feel isolated given its geographical position and location away from Glangwili and its main paediatric units.

We considered the audit activity being carried out on the ward, to ensure that essential activities were being undertaken. We were assured that there was sufficient oversight by the management of wards to be confident that there was a robust process in place for audit activity, to help demonstrate a safe and

effective service. We were told by managers that all staff have a designated role and responsibility for audits which has a positive effect on staff as it encourages ownership and responsibility. We saw the Health and Care Standards Fundamentals of Care Audit were completed with all areas achieving consistently high compliance rates. The results of the audits were displayed on the notice board within the staff room and we were told were also fed back at monthly staff meetings.

Staff and resources

Workforce

The unit is managed on a day-to-day basis by one of four Band 6 nurses. Through observation and staff discussions we established that they showed excellent leadership skills and were very experienced and capable of managing the unit. We also observed evidence of the Band 5 nursing staff displaying excellent experience and skills in managing their own caseloads. It was evident to the inspection team that the wider staffing team is equally as experienced and all staff work cohesively together within the unit which supported the provision of safe and effective care. We were also told there is a low turnover of staff.

The majority of staff who completed questionnaires said the organisation always or usually encourages teamwork and a majority felt the organisation was always or usually supportive.

The unit is overseen by a recently appointed Band 7 nurse, who is based at Glangwili hospital. Staff told us that the Band 7 nurse tries to be at the unit two days a week but their presence had been inconsistent, however they were very approachable and always available by telephone or email. Overall, staff we spoke to said that senior managers would be at the end of the telephone if needed and communicated well with staff, however there was little visibility of them on the unit. Managers we spoke to reported that the senior management team were very supportive.

All staff and managers we spoke to told us that the unit was well staffed. We were told the unit has two registered nurses on duty which included the Band 6 nurse. Staffing levels increase to three registered nurses on days when patients are booked in for theatre appointments or when sedation cases are listed. There is also a healthcare assistant, play specialist and ward clerk on duty every day. We were told there are two consultant paediatricians based at the unit and staff reported excellent multi disciplinary working and good relationships with them.

Staff told us that there were previously two ward clerks within the unit; however there was now only one. We were told they work between 9am and 5pm Monday

to Friday. Staff told us that in the absence of the ward clerk, there is no cover which causes a backlog of work upon their return. However, managers told us that all health care support workers have been trained to manage the majority of the work of the ward clerk to ensure continuity of service and that backfill is put in place to cover the clinical gap of the health care support worker.

Managers told us that an acuity tool is being considered at present by the all Wales paediatrics nurse staffing group for introduction in ambulatory care. We were told that there is capacity to obtain cover where necessary from Glangwili hospital, however this was not routinely required. Managers said that, in instances where additional staff are required, duty staff will try and organise extra cover themselves, or the Band 7 nurse will cover. Staff also have access to bank staff if needed. We reviewed the staff rota and were satisfied that staffing levels were appropriate.

Around half of staff who completed questionnaires said there were always or usually enough staff at the organisation to enable them to do their job properly, though a few answered never to this question. Most respondents said they were always or usually satisfied with the quality of care they are able to give to patients.

We spoke to the practice development nurse who was enthusiastic and knowledgeable in her role and the training requirements of staff. They are based in Glangwili hospital but have responsibillity to co-ordinate training for paediatric staff across the three main hospitals within the health board. We saw a wide range of educational support available for both registered and unregistered staff and a clear engagement in ensuring ward safety and competency of staff who deliver care.

We saw that all new staff are provided with an individual induction and knowledge and skill development pathway pack. This includes a portfolio of competencies and development opportunities available.

We reviewed staff compliance with statutory and mandatory training. We saw evidence that overall mandatory training compliance was high. This included infection prevention level control and paediatric basic life support. We also noted that there was a number of upcoming paediatric training sessions for staff which included simulation training, medication error prevention training, resuscitation training and emergency paediatric life support (EPLS). We were told that all Band 6 nurses at the unit are trained in advanced paediatric life support (APLS) and paediatric nurses are trained in the European Paediatric Life Support (EPLS). This will be in line with the advice given in the Interim Paediatrics Inpatients Nurse

Staffing Principles (Wales)[9] that at least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS.

We reviewed a risk assessment document relating to the health board's paediatric resuscitation training provision. The document highlighted that there was an inability to provide a consistent and continuous high quality resuscitation service by ensuring that staff are trained and updated regularly. This risk assessment document had not been updated since 2016/2017. Whilst we were assured that staff in the unit have undergone relevant training, we recommended that an up-to-date risk assessment is carried out to ensure adequate provision of paediatric resuscitation training throughout the health board.

We saw that compliance with mandatory level 2 fire safety was 40%. We spoke to the practice development nurse who told us that this was as a result of the fire officer cancelling 3 training sessions at the end of 2019. We were also told that there were difficulties in securing further training.

We were told that regular practice development days take place. A Band 6 paediatric training day had taken place which included incident reporting, team building, leadership and discussions on how to improve the service. This had resulted in improved communication with staff within the other hospital paediatric units.

The practice development nurse told us that, whilst they do not have responsibility for paediatric training for ED paediatric link staff, they provide them with support and inform them of updates on any changes in paediatric notes, for example PEWS charts.

Most staff who completed questionnaires said training or learning and development always or usually helps them to do their job more effectively. Nearly all respondents said it helps them to stay up to date with professional requirements and most said it helps them deliver a better experience for patients. Staff told us that there had been occasions when they were unable to access some training opportunities, for a number of reasons which included staff

[9] A set of interim guiding principles to support the planning of nurse staffing levels in paediatric inpatients services issued from the Chief Nursing Officer/Nurse Director NHS Wales to all Health Boards in Wales in June 2019. It is not expected for Health Boards to become fully compliant immediately, but to work towards achieving the principles.

sickness. The training referred to included cannulation training, level 3 safeguarding and PALS.

All staff who completed a questionnaire said that they always or usually know who the senior managers were in the organisation. Around a third of respondents said there is always or usually effective communication between senior management and staff, though a few said there never is. Staff we spoke to expressed to us that there was limited communication from senior management on important decisions which affected them.

Discussions with managers revealed that there was an established system in place for the completion of staff personal appraisal development reviews (PADR). That meant there was a formal mechanism in place to consider whether previous training had been effective. We saw the compliance rate at the unit was 100%. Appraisals were also considered to be a useful forum for identifying future staff training needs. We were told that as a result of additional training requested at appraisals, two staff had attended a critical care course and another four members of staff were due to attend.

We considered staff well-being and whether staff were able to access to occupational health if the need arose. Staff who we spoke to told us they were aware of the occupational health support available within the health board and how to access it. Around half of staff who completed questionnaires agreed that their immediate manager takes a positive interest in their health and well-being and a majority agreed their organisation takes positive action on health and well-being.

Improvement needed

The health board should ensure that:

- An up-to-date risk assessment is carried out to ensure adequate provision of paediatric resuscitation training throughout the health board
- Required staff are provided with up-to-date level two fire safety training
- A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards[10]. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

[10] https://gov.wales/health-and-care-standards

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Hospital: Withybush General Hospital

Ward/department: Puffin ward, PACU

Date of inspection: 12 & 13 February 2020

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate assurances were identified during this inspection				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Withybush general hospital

Ward/department: Puffin unit/PACU

Date of inspection: 12 & 13 February 2020

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that relevant health promotion information is readily available throughout the unit.	1.1 Health promotion, protection and improvement	Information Leaflets are readily available on Puffin and easily accessed. This material will be displayed in the play room / waiting room for easy access to children, parents and families	Senior Sister - PACU	Due to COVID 19 Puffin unit has been relocated to Glangwili General Hospital, all actions will be implemented when paediatrics returns to

Improvement needed	Standard	Service action	Responsible officer	Timescale
				Withybush General Hospital. However this will be reviewed on a quarterly basis and reported into the Women and Children's Quality and Safety meeting
The health board must ensure that: • The paediatric sepsis pathway/guideline is developed and implemented as a priority and all staff are provided with relevant training. • Consider how all patients can be transferred in a timely way without	5.1 Timely access	Paediatric Sepsis Pathway is ongoing and awaiting input from the medical team. Once implemented a comprehensive plan on training and information sharing will be rolled out We were in discussions with the DAV crew with reference to transfer times,	Paediatric Clinical Lead/Paediatric Practice and Professional Development Nurse Senior Sister - PACU	November 2020 Due to COVID-19 Puffin Unit

Improvement needed	Standard	Service action	Responsible officer	Timescale
being reliant on the goodwill of staff to work late when required.		their handover times and working hours, this would help support transfers' in a timelier manner and reduce the need for working late.		has been relocated to GGH, all actions will be implemented when paediatrics returns to WGH. However this will be reviewed on a quarterly basis and reported into the Women and Children's Quality and Safety meeting
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • The door to the controlled drugs room remains locked at all times and access to all drugs within the stabilisation room should be secured • Controlled drugs checks are signed for individually within the drugs register.	2.6 Medicines Management	A new digital lock has been actioned and the room is only opened using the digital lock entry to ensure safe keeping of medication. All medications within the stabilisation room are kept in locked medication cabinets. The controlled drugs checks are undertaken as per health board policy, where daily CD checks are undertaken and documented as an overall stock check and signed all present and correct. The health board policy does not ask staff to sign a check for each medication individually.	Senior Sister - PACU	Completed March 2020 Completed March 2020
The health board should ensure that patient records are stored securely to prevent unauthorised access and to uphold patient confidentiality.	3.4 Information Governance and Communications Technology	All patients' records were removed from the conference room immediately. A notice was erected alerting all staff that notes were not be left unattended at any time. A lockable cupboard was ordered for notes to be stored to enable the conference room to be utilised as an area for medical staff to complete admin	Senior Sister - PACU	Completed March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		duties and discharges. Notes were to be tracked to the lockable cupboard when it was in situ.		
The health board must ensure that all patient records are in line with standards of professional record keeping.	3.5 Record keeping	Memo has been circulate to remind staff on professional aspect of documentation /record keeping policy .Documentation audits are undertaken quarterly with feedback given to staff in unit meetings. Themes are identified and individual staff given feedback if required to improve practice	Senior Sister - PACU	Completed March 2020
Quality of management and leadership				
The health board should ensure that: • An up-to-date risk assessment is carried out to ensure adequate provision of paediatric resuscitation training throughout the health board • Required staff are provided with up-to-date level two fire safety training	7.1 Workforce	Risk assessments has been completed and staff training is on a rolling programme. However due to COVID 19 there are delays and reduced numbers in face to face training. The PPPDN will maintain the booking processes as well as looking at alternative electronic frameworks which can be considered for training purposes	Paediatric Practice and Professional Development Nurse / Senior Sister – PACU	This has been delayed due to COVID 19, Staff from Puffin Unit have been relocated to GGH and training will be allocated

Improvement needed	Standard	Service action	Responsible officer	Timescale
• A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication.		The Senior Directorate Team will ensure that communications are provide and maintained with the operational team	Head of Nursing for Paediatrics and Neonates	within the paediatric ward training plan Due to COVID 19 Puffin unit has been relocated to GGH, all actions will be implemented when paediatrics return to WGH., However this will be reviewed on a quarterly basis and reported into the Women and Children's

Improvement needed	Standard	Service action	Responsible officer	Timescale
				Quality and Safety meeting

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Paula Evans

Job role: Head of Nursing

Date: 15 July 2020