Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Hospital Inspection (Unannounced)

Aneurin Bevan University Health Board: Royal Gwent Hospital, St Woolos Hospital

3 and 4 November 2015

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection to areas of the Trauma and Orthopaedic directorate within Aneurin Bevan University Health Board on the 3 and 4 November 2015. The following hospital sites and wards were visited during this inspection:

Royal Gwent Hospital:

- C7 East
- D7 East
- C5 West
- Emergency department

St Woolos Hospital:

- Orthopaedic Surgical Unit (to be referred to as OSU in the body of the report for ease of reading)

These areas included elective orthopaedic surgery, emergency trauma and orthopaedic surgery and specialist orthopaedic care (where surgery is not appropriate). In the emergency department we looked at the system staff follow to care for patients who have a fractured neck of femur.

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2. Methodology

We have a variety of approaches and methodologies available to us when we inspect NHS hospitals, and choose the most appropriate according to the range and spread of services that we plan to inspect. In-depth single ward inspections allow a highly detailed view to be taken on a small aspect of healthcare provision, whilst the increased coverage provided by visiting a larger number of wards and departments enables us to undertake a more robust assessment of themes and issues in relation to the health board concerned. In both cases, feedback is made available to health services in a way which supports learning, development and improvement at both operational and strategic levels.

The new Health and Care Standards (see figure 1) are at the core of HIW's approach to hospital inspections in NHS Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The Standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1

NHS hospital inspections are unannounced and we inspect and report against three themes:

- **Quality of the Patient Experience:**
  We speak with patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to inspection.

- **Delivery of Safe and Effective Care:**
  We consider the extent to which services provide high quality, safe and reliable care centred on individual patients.

- **Quality of Management and Leadership:**
  We consider how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also consider how health boards review and monitor their own performance against the Health and Care Standards.

Our team, for the inspection to the Trauma and Orthopaedic Directorate within Aneurin Bevan University Health Board, comprised of five HIW Inspection Managers (one of whom led and co-ordinated the inspection), three clinical peer reviewers and one lay reviewer.

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

- Information held by HIW
- Conversations with patients, relatives and interviews with staff
- General observation of the environment of care and care practice
- Discussions with senior management within the directorate
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- Consideration of quality improvement processes, activities and programmes
- Responses within completed HIW patient questionnaires
- Responses within completed HIW staff questionnaires.

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the quality, safety and effectiveness of healthcare provided and the way which service delivery upholds essential care and dignity.

3. Context

Aneurin Bevan University Health Board was established on the 1 October 2009 and covers Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. The Health Board as a whole serves a population of more than 600,000.

The health board has two large district general hospitals; the Royal Gwent (in Newport, to be referred to as RGH for ease of reading) and Nevill Hall Hospital (in Abergavenny) and a further two local general hospitals; Ysbyty Aneurin Bevan (in Ebbw Vale) and Ysbyty Ystrad Fawr (in Ystrad Mynach). These are supported by a network of 9 community and mental health hospitals (including St Woolos hospital) and day care premises located throughout the health board.

The RGH has more than 3,400 staff and approximately 774 beds. The hospital provides a comprehensive range of hospital services for inpatients, day cases and outpatients.

St Woolos is a Community and Mental Health Hospital for the people of Newport and surrounding areas. It is also the location of the Orthopaedic Surgical Unit.

Ward C7 East at the RGH is an emergency orthopaedic ward, providing care for up to 30 patients. Some patients receiving elective orthopaedic surgery[1] are also cared for on this ward.

Ward D7 East at the RGH is an elective orthopaedic surgery ward caring for up to 20 patients.

Ward C5 West at the RGH is a trauma ward for up to 30 patients.

The orthopaedic surgical unit at St Woolos is a unit providing elective orthopaedic surgery for up to 36 patients. Patients admitted to this unit have less complex medical care needs than those admitted for orthopaedic surgery at RGH.

[1] Elective surgery is the terms used to describe operations which are scheduled in advance. An example of this in orthopaedic surgery would be joint replacements.

We also visited the A&E department at the RGH to see how the emergency department cares for patients with a suspected fractured neck of femur.

4. Summary

At the time of our inspection, in the ward areas we visited, we saw a kind and compassionate workforce treating their patients. The feedback we received from patients through our questionnaires was extremely positive, particularly in relation to the kind and sensitive manner in which care was provided.

We saw that staff were very busy in all areas visited. Wards at the Royal Gwent were cramped due to the number of patients, staff and range of equipment needed for patient care. Despite this, the areas we visited appeared clean and well maintained.

There were some arrangements in place to enable patients and their families and carers to provide feedback. These systems were better established in some areas than others.

There was written patient information available, in some areas this was via poster displays and in others this was in the form of printed leaflets.

The evidence we found led us to the overall conclusion that there was some variability and inconsistency in the application of standards for providing quality patient care across the trauma and orthopaedic directorate. Specifically, the standards on two wards (C5 West and OSU) were good whilst the standards on two others were not being met as effectively (D7 East and C7 East). We identified two issues on C7 East that required immediate action by the health board.

We found areas where patient needs were being assessed, appropriate care plans created and then clearly evaluated so that improvement or deterioration was evident. We found other areas where this process was not as clear with omissions in parts of it. We felt that overall, the standard of documentation could present a risk that staff less familiar with the patient and clinical area may not be clear from the documentation in place, about the person's current needs and care/treatment to be provided.

We found that there were arrangements in place to make the process of medication administration safe, for example by reducing distractions to the staff carrying out this task. However, we found that the systems in place to ensure safe stocks of medication at ward level were insufficient and we found there was nota standardised approach to medication management at ward level that all clinical areas were required to adhere to.

We found examples of strong, clear ward level leadership which resulted in well run teams and well run wards. However, we also found areas where leadership was weaker and the team and ward structure suffered as a consequence.

We saw that there had been many positive changes and initiatives introduced by senior directorate level nurses, including realigning and increasing the senior nurse structure so that more support could be provided to staff working at the RGH. Some staff told us that they did not feel well connected to senior managers and this needs to be considered and addressed.

There was clear evidence of systems in place to monitor the effectiveness and safety of services but again, we found that at individual ward level, these were more effectively used in some areas compared to others.

Most staff confirmed that they had received training which they felt had helped them to do their job more effectively. An educational package had recently been developed and introduced specifically to help develop the skills of new and existing staff working within the trauma and orthopaedic directorate.

Immediate assurance requested at this inspection

During this inspection, we identified two issues on C7 East which could potentially have led to immediate risks to patient safety. Specifically not all patients were wearing identification wristbands and there was out of date medication in the emergency bag held on the ward. Both issues were raised with representatives of the health board immediately and they took swift corrective action. We were satisfied with their actions and their response.

Previous Inspections by Healthcare Inspectorate Wales

During the year 2014-15 Healthcare Inspectorate Wales carried out seven dignity and essential care inspections in hospitals across Aneurin Bevan University Health Board. From the seven inspections, four of these inspections took place at the RGH (January and March 2015) and St Woolos (December 2014 and March 2015). Detailed reports[2] of our findings are available on the HIW website (www.hiw.org.uk)

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[2] HIW Dignity and Essential Care Inspection (Unannounced), Aneurin Bevan University Health Board, Royal Gwent Hospital, Ward D3 West, 21 and 22 January 2015

HIW Dignity and Essential Care Inspection (Unannounced), Aneurin Bevan University Health Board, Royal Gwent Hospital, Ward C7 West, 17 and 18 March 2015

Whilst this recent inspection considered different clinical areas, we did consider recommendations made during previous inspection activity in 2014 and 2015. This was to establish whether specific improvement action described by the health board in response to previous HIW inspection findings needed to be applied more widely across the hospitals inspected. At the four previous inspections in the Royal Gwent and St Woolos we identified the following improvements were needed:

- Better availability of linen stocks (gowns and blankets),
- Warmer temperature, quantity and choice of patient meals,
- Better secure storage of liquid medication and intravenous fluids,
- Improved cleanliness and maintenance of a ward bathroom
- Identifying and addressing the reason(s) for faults to patient buzzers on one ward (C7 West, RGH).
- Improved quality of recording within written care plans
- Improved staff training in a range of topics including adult safeguarding and dementia. Also overall staffing levels on one ward (Penhow, St Woolos).

At this inspection we found that there was sufficient linen, meals were served promptly from heated trolleys and patients told us they were happy with the food. We saw that ward areas were clean and saw a number of cleaning staff working hard throughout the day to maintain these standards. We did not find any other issues relating to faulty buzzers on the four ward areas we visited. We have therefore concluded that the health board has effectively addressed these issues.

One finding repeatedly reported in our inspections in 2014 / 2015 (three of four inspection visits) concerned the quality of recording in nursing records about patient care. We identified that this issue has still not been resolved and again

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HIW Dignity and Essential Care Inspection (Unannounced), Aneurin Bevan University Health Board, St Woolos, Penhow Ward, 3rd and 4th December 2014

HIW Dignity and Essential Care Follow up Inspection (Announced), Aneurin Bevan University Health Board, St Woolos, Penhow Ward, 24th March 2015.

found variability in the completeness of records. We found that written care plans still did not accurately reflect the patients' needs and there was insufficient planning and evaluation of the effectiveness of care being provided. We have asked the health board to prioritise this issue and have made some specific recommendations in order to clearly identify particular problems.

We identified that issues with medicines management were a theme which emerged from our inspections in 2014 and 2015. During this inspection, we found issues with medicines management, specifically a lack of a clear procedure to ensure usable emergency medication stocks were kept on the wards. We have made a specific recommendation asking the health board to address this.

We also identified previously that ensuring the privacy and dignity of patients was important (Penhow, St Woolos and D3 West, RGH). During this inspection we found that this could still be improved further. On ward C7 East there were no privacy signs and on D7 East the lack of private washing facilities sometimes meant that maintaining privacy could be difficult.

5. Findings

Quality of the Patient Experience

At the time of our inspection, in the ward areas we visited, we found a kind and compassionate workforce treating their patients. The feedback we received from patients through our questionnaires was extremely positive, particularly in relation to the kind and sensitive manner in which care was provided.

We observed staff were very busy. At the Royal Gwent hospital staff were working in ward areas which appeared cramped, partially due to the range of equipment needed. Despite this, the areas we visited appeared clean and well maintained.

There were arrangements in place to enable patients and their families and carers to provide feedback. These systems seemed to be better established in some areas than others.

There was written patient information available. In some areas this was via poster displays and in others this was in the form of printed leaflets.

Dignified Care

People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs. (Standard 4.1)

During our inspection we invited patients and/or their visitors to complete a HIW questionnaire to provide us with their views on their current experiences of the services provided. Through our questionnaires we asked for patients' views on the clinical environment, the hospital staff and the care they had received.

In total 24 questionnaires were completed, either via face to face interviews or returned to us separately during the inspection. Without exception, the comments received indicated that staff were polite to patients and their families/friends. We also observed staff being friendly and kind to patients and their visitors.

A small number of respondents (2) told us that staff did not always address them by their preferred name. We did not identify which ward area this related to but saw that on ward C5 West there were boards at each patients bedside

which clearly indicated their preferred name and this may be an initiative which could be considered for use elsewhere.

All patients completing questionnaires indicated that they were able to communicate in the language of their choice.

We asked patients to provide an overall rating, out of ten, of their care and treatment. All patients that chose to do this rated their experience as at least 8 out of 10, with the average score being 9.5 out of 10. This indicated a high level of satisfaction with the service being received.

We did see some instances where patients' privacy could have been more actively protected through the use of signs to indicate when bathrooms were in use or if personal care was taking place.

Improvement needed

The health board should consider introducing dignity signs to further protect patients' privacy and dignity whilst personal care is being provided.

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner. (Standard 4.2)

In general, the comments we received from patients and families indicated that staff had spoken to them about their medical conditions. We did encounter one instance where a relative reported to us that the communication from staff could have been better. We raised this with staff, who provided an explanation as to why this may have happened. The staff took immediate action so that they could meet with the family and offer opportunities for discussion about their relative's care.

We looked at a sample of patients' care plans. These demonstrated nursing and medical staff and other members of the multi-disciplinary team had spoken to patients (and/or their families / carers where appropriate) about their care and treatment.

A variety of patient information leaflets were available for patients and their relatives or carers to read. On one ward we saw a patient information display board with dementia information. This meant there was relevant patient information accessible to patients on the wards we visited.

Individual Care

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation (Standard 6.2).

We found that staff and the health board recognised their responsibilities both to recognise and respect the diversity of their population and to respect the rights of individuals. We found the following evidence:

- We saw next of kin details clearly identified in patient records. Conversations with staff also indicated that they had knowledge of some individual family circumstances that they would need to be mindful of when communicating with families and individuals.
- Visiting arrangements on all wards enabled contact with families and friends according to patient needs and wishes.
- In the notes we looked at for patients in the OSU we saw that staff had considered patients' own decision making capability and highlighted where they had any concerns or where there should be particular consideration given.
- We noted signposting to the hospital chapel and also to a prayer room / mosque which had adjacent washing facilities.

Wards C5 West and C7 East at the RGH were noticeably busy wards, with all beds occupied at the time of our inspection visit. There was little space in these ward areas, other than by the patients' own bedside for people to receive visitors. We also received some comments from staff which indicated that they found the environment in these areas challenging and recognised that additional space to provide care would be beneficial.

Improvement needed

In recognition of the above comments from staff, the health board should consider if there are additional steps they can take to make it easier for patients to receive visitors on these particularly busy wards.

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear

understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback (Standard 6.3).

We were given some good examples of work with relatives and patients which demonstrated that senior management within the trauma and orthopaedic directorate were willing to engage with the public and users of their service, when feedback had been provided. We were told that the wards had introduced an initiative whereby senior ward staff were given 'protected' time during visiting hours so that they were readily available to speak to any visitor.

We also noted that there was information readily available in the RGH which gave details of how to provide feedback, including how to raise a concern or give a compliment.

In the OSU at St Woolos we were told that a patient satisfaction survey was given out to all patients when they were admitted and then collected at discharge or sent in by the patients at a later time. We did not ask to see any results of these surveys. We did not see this initiative in place in other trauma and orthopaedic wards visited.

Improvement needed

The health board should consider what additional methods of gathering patient feedback would be useful. The health board should introduce additional formal opportunities for patients to provide feedback on trauma and orthopaedic wards in the RGH.

Delivery of Safe and Effective Care

The evidence we found led us to the overall conclusion that there was variability and inconsistency in the application of standards for providing quality patient care across the trauma and orthopaedic directorate. Specifically, the standards on two wards (C5 West and OSU) were good whilst the standards on two others were not being met as effectively (D7 East and C7 East). We identified two issues on C7 East that required immediate action by the health board.

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Staying healthy

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities. (Standard 1.1)

We found that there were some good examples of team working to support patient recovery and consider that these provided evidence that staff were trying to empower patients to take as much responsibility for their own health and wellbeing as possible. We saw the following:

- Patients had been referred to and were receiving support from a dietician

- Occupational therapists were seen busy working with patients and staff on the wards
- There were a number of physiotherapy staff on the wards, working hard to improve patient mobility during recovery
- The tissue viability nurse had been involved by ward staff and we could see these assessments and recommendations for treatment in the relevant patient records.

All this input was with the aim of providing the most appropriate, patient care to enable patients to be as independent as possible.

We saw an active hospital volunteer service undertaking their daily round to offer newspapers, enabling patients to continue to read local and national news, plus snacks and drinks to inpatients.

Safe care

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented. (Standard 2.1)

We found considerable variability in the quality of the nursing risk assessments we saw. Our observations indicated that where the prescribed care was being given, it was not always written down. We also found some instances where the prescribed care did not appear to have been given despite the documentation in place. In one of the areas inspected, we had particular concerns around incomplete risk assessments. There were also certain cases where risk assessments had been completed and issues identified, but a care plan had not been developed setting out nursing actions to mitigate the risks.

We also found some risks around storage of medication that we felt were not being adequately managed, specifically:

- Fridge temperatures were not being recorded. This is necessary to ensure that medication is being stored at correct temperatures which do not lessen their effectiveness or shelf life.
- We found in one clinical area that controlled drug stock had not been checked for two weeks.
- We found out of date emergency medication in one clinical area (please refer to the medication section later in the report for further details).

Improvement needed

Senior staff must take action to review patient risk assessments to ensure that the documentation is fit for purpose. The need for these to be completed must be urgently communicated to all staff.

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage. (Standard 2.2).

We saw documentation which confirmed that staff were assessing and paying attention to maintaining patient skin integrity, for example through the use of pressure relieving equipment. However we found that this documentation was inconsistently completed, meaning that in some cases the individual plan of care was unclear. One patient complained to us about a sore area of skin but we found no documentation to support that this was being managed to prevent any further deterioration. We raised this with relevant nursing staff immediately and senior nursing staff took swift action to address the issue.

We found that generally, the staff we spoke with at ward level were unaware of national[3] guidance about reporting pressure damage.

We discussed the current health board system for formal reporting of pressure sores and found that the team could confidently describe how they met their obligations to report serious pressure sores to the Welsh Government. The same level of skin damage was also recorded formally on the health board's own risk management system (known as Datix[4]), which enables them to record and monitor trends. The health board did not currently use Datix to record all instances of pressure damage unless it reached the severity which must be reported to Welsh Government. We discussed this with senior directorate nurses and were pleased to note that they had already been discussing this

[3] All Wales Guidelines for Pressure Ulcer Reporting and Investigation were published in 2014 and endorsed for use across Wales.

[4] DATIX software is a tool used within the NHS used to record, investigate, analyse causes of adverse events and near misses.

with a view to changing their system and recording all instances of pressure damage in future. This would improve the ability of the directorate (and health board) to identify any trends that may be apparent.

Improvement needed

Once a decision on pressure sore reporting is reached, senior staff must ensure there is clear communication to all staff involved of the changes so that changes can be fully implemented.

People are assessed for risk of falling and every effort is made to prevent falls and reduce avoidable harm and disability. (Standard 2.3)

Across all the clinical areas we visited, the evidence we found led to the conclusion that the assessment of patient's risk of falling was a particular area of weakness within the documentation.

We found some different ways being used to alert staff to patients who were at risk of falls. For example in one area we saw a board in the nurse's office used and in another area we saw that individual patient records identified whether or not there was a risk of falling. The use of an alert strategy was seen in use across all areas we visited.

We found there were many cases where falls risk assessments had not been completed for patients. Where we did find them, there was some duplication of information and badly organised documentation meaning that it was confusing and not easy to follow. This meant that it was often unclear what strategies would be put in place to manage a risk of falling.

Improvement needed

Senior staff should review the use of methods for alerting staff to patients who have been assessed as at risk of having a fall. Current strategies for alerts were found to be inconsistently used and the introduction of a clear method would be beneficial.

Falls risk assessment was a particularly weak area within the nursing documentation and the health board should address this as a matter of urgency.

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available

evidence so that people are protected from preventable healthcare associated infections (Standard 2.4).

The clinical areas we visited all appeared visibly clean. We noted that they were busy areas, with high numbers of patients. In two of the four areas we found they were cluttered with essential equipment. In the small ward station areas there were a number of different professionals all needing to use the space to review records, write up findings, use the telephone and liaise with each other.

We noted that there were hand sanitising gel points at the entrance to all wards visited and also at other points elsewhere in the ward. On ward C7 East the hand gel dispenser at the entrance of the ward was empty. On ward D7 East we saw instances of staff moving from patient to patient without always sanitising their hands in between. We did however, see many appropriate instances where staff either washed their hands or used sanitising gel.

In each area visited there were plentiful stocks of personal protective equipment in the form of gloves and aprons and we saw these being appropriately used. There were also facilities available to nurse patients in isolation if this was necessary for infection control purposes.

We saw information about the incidence of Clostridium difficile[5] infection displayed in each particular ward area. The information was displayed in a place that both visitors and staff could read, which represented a willingness to be open and transparent. We did find however that this information was not up to date in all clinical areas and also felt that it could be presented more clearly so that visitors would be able to understand it more easily.

Improvement needed

The health board should ensure that key performance data (such as Clostridium difficile infection rates) is kept up to date and the display format as clear as possible.

People are supported to meet their nutritional and hydration needs, to maximise

[5] A Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The bacteria can spread very easily and whilst the condition usually responds well to treatment, it can also lead to life-threatening complications.

recovery from illness or injury (Standard 2.5).

During our inspection visit, we did not formally observe any mealtimes but we were present over lunchtime on some of the wards. We saw that the food looked appetising, hot and seemed to be served promptly to patients.

In addition to the hospital meals served, there was a trolley taken around to the wards during both mornings of our visit offering an abundance of snacks to buy.

At RGH there was also a hospital shop, restaurant and café, all of which had long opening hours and we saw all three being used by visitors and patients at varying times.

Again we found variability in whether or not nutritional risk assessments had been completed and where they had we found they did not clearly seem to support the subsequent care planning that had been done. We spoke in depth to the senior team, including nurse director, about one particular patient case we identified. It transpired that whilst the documentation was poor and gave limited and confusing evidence, the care required had indeed been provided and the patient's nutritional status had actually improved as a result of the interventions of the nursing staff and multidisciplinary team.

We saw water jugs being replenished and replaced during our visit, enabling patients to have fresh, constant supplies of water.

We found that fluid charts used to monitor the liquid input and output of individual patients were not always being kept up to date.

Improvement needed

Careful regard must be given to the completion of nutritional risk assessments by ward staff. Senior staff should explore the current deficit in the standard of patient specific nutritional documentation completed by nursing staff and work alongside ward staff to champion proper and effective use of the assessment and care planning tools.

People receive medication for the correct reason, the right medication at the right dose and at the right time (Standard 2.6).

We looked at medication procedures, ranging from storage to administration in each of the four clinical areas we visited.

We saw staff wearing bright red tabards or being left undisturbed in all areas, whilst administering medication. This indicated that staff were aware of the need to concentrate fully on this important task.

We noted that medicine charts were used appropriately and those we saw had been completed correctly.

On ward C7 East we found that a small number of patients present on the ward had no identification wristbands. As part of local and national nursing policy, it is set out that patient identification must be checked prior to administering any medication and the wearing of identity bands can be an important part of the checking process. We raised this as an immediate action (HIW call this the 'Immediate Assurance' process) and it was resolved for these particular patients before we left site. A wider check to ensure that patients across the health board were wearing wristbands was also conducted.

We noted that the environment on the wards we visited at the Royal Gwent posed some challenges in terms of the storage of medication and potentially also in the preparation (at ward level) of certain medication types. There were dedicated medication storage areas but these were open areas and not separate rooms with doors. There were however locked cupboards within the medication areas and we found that all of these were diligently being kept locked.

In St Woolos OSU, (a newly refurbished unit) there was a separate medication room. However the door to this room did not have a lock and we found some packs of medication ready for patients to take home were potentially accessible to anyone who may enter the room. We raised this and it was resolved immediately by ward staff who also requested a lock for the door to prevent any future risk.

As previously mentioned, during this inspection we identified that medication fridge temperatures were not being monitored, we found out of date emergency medications in one ward emergency kit (C7 East) and we found that a stock check on the controlled drugs had not been undertaken for a period of almost two weeks on another ward (D7 East). The immediate risks associated with these findings were dealt with at the time of our inspection.

Improvement needed

The health board must ensure that roles and responsibilities in relation to medication held at ward level are reviewed. This is to ensure that the delineation between nursing and pharmacy staff roles is clear, appropriate and ensures that all necessary tasks for ensuring safe stocks of ward medication are undertaken.

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. (Standard 2.7)

The conversations we had with ward staff across the four areas indicated that there was an awareness of safeguarding considerations and obligations. We also had conversations with divisional level senior nursing staff who told us there was a strong level of support available to ward staff should it be needed. We were also told that there were dedicated safeguarding and learning disability lead professionals working within the health board who could be used for advice and guidance.

On one ward we saw a dementia information board which was informative and easy to read. We also noted that on the same ward (C7 East) there was dementia friendly patient documentation available for staff to use. This could have been used to benefit one particular patient but it had not been.

Improvement needed

Ensure that dementia friendly initiatives are used if these could benefit patient care.

We looked at some staff training information and found that a number of staff had not had recent training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was also confirmed by a proportion of staff who responded to the staff questionnaires we distributed during our visit.

Confidence in these legal frameworks will help staff in their role of promoting and protecting the welfare of patients in their care. It would be advisable for the directorate to consider how they ensure ward level knowledge of safeguarding and the legal frameworks outlined above remains sufficient and up to date.

Improvement needed

The health board should undertake a review of the number of staff within the trauma and orthopaedic directorate who need refresher training in mental capacity and deprivation of liberty safeguards, ensuring that this is provided as a priority.

Effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their

individual needs. (Standard 3.1)

There were many staff working across the trauma and orthopaedic directorate wards who had a wealth of experience and expertise in this particular specialty. We found that this was more evident in some of the clinical areas compared to others. In wards D7 East and C7 East for example we found that quality of care planning documentation was variable; where there were specialist orthopaedic care pathways (documentation which guides care interventions according to evidence based best practice) these were generally well used, however these were available for a limited number of orthopaedic procedures only.

We saw some instances where patients were receiving particular orthopaedic treatment, for example particular neck collars or spinal care yet they did not have care plans in place to reflect the care that staff should give. We felt that this specific knowledge and care planning should be a core part of orthopaedic care which should be evidenced clearly in patient notes.

We also found in one ward area (C7 East) that staff did not have a confident knowledge of general policies and procedures. We were told that for a short time some weeks previously the electronic system had failed completely, meaning that staff were unable to access any of the policies and procedures which they may need to safely undertake their work. It seemed that at this point there were no clear contingency plans in place to enable staff to access key policies via any other means.

Improvement needed

Although it is acknowledged that a total failure in Information Technology (IT) systems is unprecedented, there should be a contingency written into business continuity plans so that staff can still have access to key policies and procedures at any time when these are needed.

In communicating with people, health services proactively meet individual language and communication needs. (Standard 3.2)

We found that the hospital overall was relatively well signposted and we were able to find our way to the trauma and orthopaedic wards quite easily. When we asked for directions to parts of the hospital we were also able to find people who could explain or show us the way.

On the trauma and orthopaedic wards, there was various information on display, or available as leaflets for patients and ward visitors to read. We noted that information was not displayed in any languages other than English but, on

this inspection, we did not explore the availability of information in other languages with any staff.

Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services. (Standard 3.3)

We had discussions with senior divisional level nurses and heard about the new learning pathway being introduced into the trauma and orthopaedic directorate for the development of new and existing staff. These discussions indicated that learning opportunities and development of the staff in this directorate was given a high priority. The lead divisional nurse had been instrumental in setting up this programme and securing a member of staff to implement it having found it a positive and effective system in a previous role.

Senior nursing managers informed us that the division received consistently strong feedback from nursing students who had undertaken placements on ward C7 East and the senior nurses acknowledged that there were some individuals with strong mentorship skills working on that ward.

The training records we saw showed various levels of compliance with mandatory and basic training. Some staff had their own paper copies of training logs, whereas for other staff everything was held electronically. Divisional management had recognised this and were working to give more control back to the ward sisters to enable them to monitor their staff training levels more accurately. We were told that additional training was necessary to enable them to manage the electronic system in this way and that this training was in the process of being arranged.

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance (Standard 3.5)

We considered a sample of patient records currently being used within the clinical areas we visited.

Multi disciplinary (team) patient records were in use in all areas. We found regular written entries had been made within patients' notes, which demonstrated that there was a multi disciplinary approach to patient care. We did identify some areas for improvement. Specifically this was in respect of the nursing care plans and risk assessments. Overall, these were found to be disorganised, with a number of incomplete documents, duplication of some information and omission of other information. In general the care necessary for each individual patient was often unclear from the records we looked at, although the nursing staff we spoke with were able to provide further verbal explanation of the care that was being given.

We found that the poor standard of nursing documentation could pose a risk to patients in the event that new, bank or agency nursing staff were required to provide care on the wards visited. As a result we have recommended that the health board take prompt action to review the paperwork that nursing staff are required to complete. Concerns around the quality of nursing record keeping were highlighted in some of the HIW hospital inspections last year and progress now needs to be demonstrated.

Improvement needed

The health board must undertake a full review of nursing documentation, streamlining the risk assessment and care planning process in accordance with best practice guidance and professional standards for record keeping. The outcome of this should be to replace the current arrangements which appear to be leading to omissions, duplication and an overall poor standard of recording.

Senior staff told us that reviews of nursing documentation have been ongoing in recent times but have not yet resulted in a change to the range and type of documents in use. Our findings suggest that taking action to improve nursing documentation, perhaps initially on a smaller scale within trauma and orthopaedic wards must now be a key priority.

We found patient records were being stored securely when not in use to prevent access by unauthorised persons.

Timely care

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff (Standard 5.1).

In terms of receiving timely care, we found evidence to suggest that there were some positive initiatives to avoid delays to patients' scheduled orthopaedic

surgery. We saw that the health board were proactively working to address delays in transfer of patients with confirmed neck of femur fractures from the emergency department into a ward bed.

We saw that beds intended for patients requiring elective orthopaedic surgery were being actively ring fenced to prevent patient operations being cancelled. We also saw that frequent bed management meetings were held throughout the day where senior staff from across the hospital directorates came together to address the demand for beds. We were present for two of these meetings and observed that senior staff were proactively working to discharge patients and using the network of community hospitals within the health board in order to free up beds within the Royal Gwent Hospital for those patients waiting in the emergency department or requiring elective surgery.

We noted a considerable pressure for acute beds in the Royal Gwent hospital at the time of our inspection and saw that senior staff were working effectively together to manage this as best as they could.

We visited the emergency department solely to gather information on how the care of patients with a fractured neck of femur was managed. We found that there was a clear care pathway in place for diagnosing this fracture and arranging a theatre slot and ward bed. We were told that there can sometimes be a delay in getting a senior orthopaedic doctor's opinion to confirm the fracture (as per local policy and national guidelines). We discussed this with senior staff and found that they had already been actively discussing some solutions for the medium to longer term which they believe will help to address this. However, the health board should still look to implement some solutions for the immediate term until longer term plans can be put into action.

Quality of Management and Leadership

We found some examples of strong, clear ward level leadership which resulted in well run teams and well run wards. However, we also found areas where leadership was weaker and the team and ward structure suffered as a consequence.

We saw that there had been many positive changes and initiatives introduced by senior directorate level nurses, including realigning and increasing the senior nurse structure so that more support could be provided to staff working at the RGH. Some staff told us that they did not feel well connected to senior managers and this needs to be considered and addressed.

There was clear evidence of systems in place to monitor the effectiveness and safety of services but again, we found that at individual ward level, these were more effectively used in some areas compared to others.

Most staff confirmed that they had received training which they felt had helped them to do their job more effectively. An educational package had recently been developed and introduced specifically to help develop the skills of new and existing staff working within the trauma and orthopaedic directorate.

Staff and resources

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need (Standard 7.1).

The staff we saw at work were busy and focussed on caring for their patients. We saw behaviours that demonstrated compassion and care.

The staff numbers and skill mix seen across the directorate at the time of our inspection appeared to be appropriate. We saw a number of new staff working on ward D7 East and were told that this was causing some pressure in finding staff able to mentor and support them in developing into their new role. We were not clear about the size and impact of this issue, therefore suggest that the health board explore this further.

There was a newly established role as practice development nurse for trauma, orthopaedic and surgical nursing staff. A specific learning programme had been created and was just being implemented with the intention of further developing the knowledge and expertise of nurses within the directorate. We were told that early response to this had been very positive and as a result the plan was for it

to be rolled out more widely. Whilst this was extremely positive, the staff resource to deliver and support this programme needs to be sufficient to deliver the potential benefit of offering this to as many staff as possible.

Some responses from staff indicated that they felt some disconnect from senior managers. We were unsure from our conversations and enquiries as to how effectively the transfer of information about updates and changes was between senior staff and ward staff. We advised the directorate lead team to explore this further to see what they could improve and they were willing to take this on board.

Improvement needed

The health board should review the availability of staff who can mentor new nurses and ensure that there is sufficient resource available for an adequate induction.

Governance, leadership and accountability

Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care. (Health & Care Standards, Part 2 Page 8)

Senior management structures within the trauma and orthopaedic directorate were relatively new but seemed to have been put in place with careful regard to improving and developing the quality, resilience and skills within the trauma and orthopaedic directorate. There had been a recent change so that senior nurses were now site specific senior nurses and therefore able to provide a higher level of support then when the role required them to cover both acute hospital sites (Nevill Hall and the Royal Gwent).

We discussed the use of the Datix reporting system and found that staff had an awareness of when reporting should be done. In the staff questionnaire responses we received staff also consistently told us that they felt they worked in an open culture.

Quality audits were done across the directorate and a senior nurse from another area completed these with the aim of providing an objective viewpoint. Ward level audits were also being undertaken and we saw evidence of these displayed on the walls of ward corridors. These provided information such as when there had last been a patient fall and when there had last been a case of the infection clostridium difficile.

There were daily ward manager meetings across the directorate, including all surgical wards and these were used to assess and compare the workload

across all of the wards, redeploying staff should it be deemed necessary at this point.

During our inspection, we invited staff working within all the clinical areas we visited to complete a HIW questionnaire. Through our questionnaires we asked staff to provide their comments on a range of topics related to their work. In total, 26 completed questionnaires were returned. Overall, staff who completed and returned questionnaires indicated their immediate managers were supportive and provided clear feedback on their work. All staff indicated that their managers encouraged team work. Comments were more mixed regarding senior managers acting on staff feedback and involving staff in important decisions, with seven responses indicating that senior managers 'never' acted on staff feedback and 'never' try to involve staff in important decisions. The health board may wish to explore the reasons for this for the purpose of establishing how improvements can be made.

Improvement needed

The health board should consider the feedback received from staff about the visibility of senior staff and explore what strategies could be used to help overcome this.

6. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit this 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 will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/units within the wider organisation.

The actions taken by the health board in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the health board's improvement plan remain outstanding and/or in progress, the health board should provide HIW with updates, to confirm when these have been addressed.

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

Appendix A

Hospital Inspection: Improvement Plan

Hospital: Royal Gwent Hospital / St Woolos

Ward/ Department: C5 West, C7 East, D7 East, Orthopaedic Surgical Unit

Date of inspection: 3 and 4 November 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
14	***Consider introducing privacy and dignity signs to further protect patients whilst personal care is being provided.***			
15	***The health board should consider what additional methods of gathering patient feedback would be useful. The health board should introduce additional formal opportunities for patients to provide***			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	feedback on trauma and orthopaedic wards in the RGH.			
	Delivery of Safe and Effective Care			
18	***Senior staff must take action to review patient risk assessments to ensure that the documentation is fit for purpose. The need for these to be completed must be urgently communicated to all staff.***			
19	***Once a decision on pressure sore reporting is reached, senior staff must ensure there is clear communication to all staff involved of the changes.***			
19	***Senior staff should review the use of methods for alerting staff to patients who have been assessed as at risk of having a fall. Current strategies for alerts were found to be inconsistently used and the introduction of a clear method would be***			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	beneficial.			
19	***Falls risk assessment was a particularly weak area within the nursing documentation and this should be addressed as a matter of urgency.***			
20	***Ensure that key performance data (such as clostridium difficile infection rates) is kept up to date and the display format as useful as possible.***			
21	***Careful regard must be given to the completion of nutritional risk assessments by ward staff. Senior staff should explore the current deficit in the standard of patient specific nutritional documentation completed by nursing staff and work alongside ward staff to champion proper and effective use of the assessment and care planning tools.***			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
22	***The roles and responsibilities in relation to medication held at ward level should be reviewed to ensure that the delineation between nursing and pharmacy staff roles is clear, appropriate and ensures that all necessary tasks for ensuring safe stocks of ward medication are undertaken.***			
23	***Ensure that dementia friendly initiatives are used if these could benefit patient care.***			
23	***Undertake a review of the number of staff within the trauma and orthopaedic directorate who need refresher training in mental capacity and deprivation of liberty safeguards, ensuring that this is provided as a priority.***			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
24	***Although it is acknowledged that a total failure in Information Technology (IT) systems is unprecedented, there should be a contingency written into business continuity plans so that staff can still have access to key policies and procedures at any time when these are needed.***			
26	***The health board must undertake a full review of nursing documentation, streamlining the risk assessment and care planning process in accordance with best practice guidance and professional standards for record keeping. The outcome of this should be to replace the current arrangements which appear to be leading to omissions, duplication and an overall poor standard of recording.***			
	Quality of Management and Leadership			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
29	***The health board should review the availability of staff who can mentor new nurses and ensure that there is sufficient resource available for an adequate induction.***			
30	***The health board should consider the feedback received from staff about the visibility of senior staff and explore what strategies could be used to help overcome this.***			

Health Board Representative:

Name (print): .....

Title: .....

Date: .....