Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Ward 11, Ysbyty Glan Clwyd

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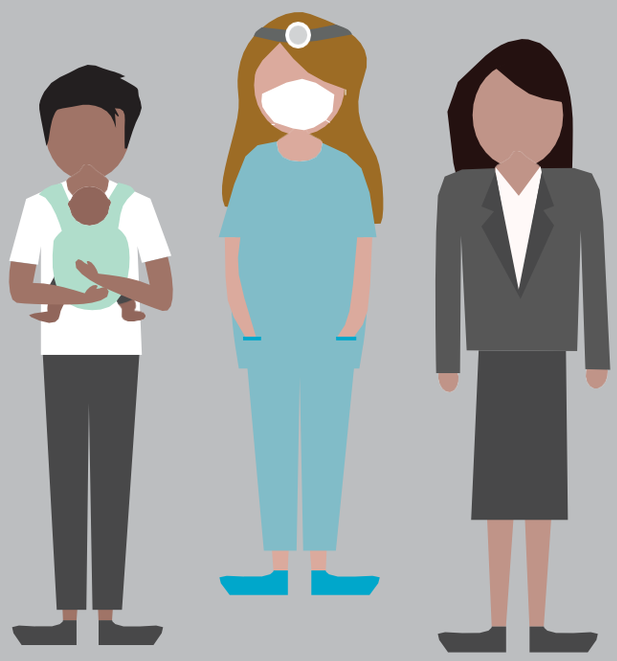

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ward 11, Ysbyty Glan Clwyd as part of its programme of assurance work.

Ward 11 is a 24 bed respiratory ward, which has been designated for patients with COVID-19 throughout the pandemic. The ward comprises of four non-invasive ventilation (NIV) restricted rooms[1] and two negative pressure isolation rooms[2].

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the Ward Manager and Matron on 26th August 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of

[1]Non-invasive ventilation (NIV) refers to the provision of ventilatory support through the patient's upper airway using a mask or similar device.
[2] Negative pressure isolation rooms help prevent airborne diseases from escaping the room and infecting other people.

personal protective equipment (PPE).

The following positive evidence was received:

We noted that a COVID-19 based environmental risk assessment had been completed at a health board level which included input from the ward management. The risk assessment had recently been recently conducted and contained clear actions and timescales.

The ward environment had been designated into red and green zones dependent upon the COVID-19 status of the patient cohort, which enables staff to further limit the risk of transmission. Same sex bays were also still in operation on the ward.

We found that standard patient visiting arrangements to the ward had been suspended during the pandemic, in line with public health guidelines. However, a process for visiting had been introduced for end of life patients.

We were told that tablets were provided for patients who were unable to receive face-to-face visitors due to the suspended visiting arrangements, and that staff had taken the time to assist patients in contacting their friends and relatives.

We were told that the biggest change and requirement on staff during the pandemic was the use of personal protective equipment (PPE). We saw evidence to demonstrate that all staff had been face fit tested[3]. Also, where it was necessary to source alternative PPE, we were told that staff would be asked to work in a different clinical area until appropriately fitted PPE could be obtained.

We were told that the ward had sufficient stocks of PPE and we found that regular training for donning and doffing PPE was available for staff. Also, appropriate donning and doffing stations existed on the ward for staff to safely apply, remove and dispose of PPE.

We were told that individual COVID-19 risk assessments had been carried out for staff. Where a high risk was identified, we were told that staff would be supported to move to a different clinical environment and would then return when it was considered safe for them to do so.

We were told that a small number of staff had been on leave due to COVID-19 related reasons, and in each case an investigation had taken place to identify potential workplace causes. This included reviewing various factors, such as similar shift patterns of staff, but no conclusive links were identified.

We were told that there were no known incidents where any of the patients on the ward had contracted COVID-19 as inpatients in the hospital.

We were told that patients who are discharged into a nursing or residential setting are tested for COVID-19 prior to discharge, and would not be discharged without having first received a negative result.

The ward management spoke highly of staff in how they have responded to the needs of the

[3] Fit testing is a means of checking that a respirator face piece matches a person's facial features and seals adequately to their face.

ward, its patients and in supporting each other during the COVID-19 pandemic.

We were told that staff were given the option to work in a different clinical area, however only very few staff took up this option. Also, specialist nurses had supported the wider team by undertaking general nursing duties. Whereas medical staff had provided 24 hour on call advice for nursing staff at weekends and had taken the time to contact families personally in the event of having to deliver bad news.

We were told that mechanisms were in place to support staff, which included check-in calls with staff who are on sick leave and the establishment of a staff support group within the hospital with trained counsellors available every weekday. Staff who have been shielding due to COVID-19 had been subject to an individual risk assessment.

We were told that bank and agency staff had been blocked booked in advance. This ensures that returning staff are familiar with ward procedures, whilst limiting movement across wards to reduce the risk of transmission.

We were also told that additional training has been provided for staff in donning and doffing PPE, as well as 'back to basics' training to support specialist staff in the transition to providing care for COVID-19 patients.

The following areas for improvement were identified:

It became clear to us through discussion with the ward management that staff are beginning to feel detrimental effects from working on a designated COVID-19 throughout a pandemic. It is therefore important that the health board continues to maintain existing and explore further support mechanisms for its staff as the pandemic progresses.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We noted that a comprehensive environmental risk assessment had been completed at a health board level that included input from the ward management. The risk assessment had been recently reviewed and contained clear actions and timescales.

The setting has a range of audits scheduled throughout the year to support patient safety, which include audits on falls and pressure and tissue damage. We reviewed a sample of these and found that overall positive scores had been achieved. We were told that a root cause analysis of any falls and hospital acquired pressure ulcers is undertaken by the matron within

24 hours of a reported case, and the learning is shared with staff on the ward.

We found that patient assessments have continued to be undertaken upon admission to the ward in order to provide care and treatment according to needs. We were told that assessments are regularly updated and overseen by the nurse in charge.

We were told that dignity curtains were available on the ward and we saw evidence to confirm that hand hygiene procedures were adhered to prior to meal times.

No areas for improvement were identified.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We saw that up to date Infection Prevention and control (IPC) policies were in place. We were told that the ward matron and local IPC group maintain oversight of the dissemination and implementation of IPC procedures. Ward staff are informed of the latest IPC information at twice daily safety briefings and this information is put on display on staff noticeboards.

We found that access to the ward was restricted. We were also told that staff and patient movement between wards has been limited, unless absolutely necessary, to limit the risk of transmission to other areas of the hospital.

We were told that there were facilities on the ward to isolate patients where required and that isolation risk assessments were carried out, which includes identifying use of the correct PPE and signage to notify staff of the level of risk.

Non-COVID-19 related infection rates on the ward appeared low. We were told that infection incidents are reviewed by the ward management and that learning is shared with the nursing team.

The following areas for improvement were identified:

We saw evidence of an internal IPC audit that was conducted by the Infection Prevention Team in July 2020. The local audit highlighted a number of issues, some of which were contrary to the evidence provided to HIW in the self-assessment. HIW considered this evidence in conjunction with the verbal responses made in the Tier 1 telephone call and further written evidence provided following the call.

Our concerns were that no action plan had been produced in response to the audit and evidence of remedial action had only been provided on a piecemeal basis for a small

number of the issues identified by the audit. Therefore only limited assurance was available that remedial actions had been put in place and that any learning had been shared following the audit.

We also found insufficient evidence that actions taken in response to the issues raised in the IPC audit had been submitted to the local IPC group, and that no follow-up had been undertaken by the local IPC group. Therefore, we could not be assured that the health board's governance mechanisms provided sufficient oversight of this matter and ensured that audit activity is responded to robustly and learned from.

This issue was dealt with through the HIW immediate assurance process.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.
We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies.

The following positive evidence was received:

Recent sickness rates on the ward appeared to be stable and we were told that staff and ward management have been provided with support by occupational health where required.

We found that suitable procedures existed for ensuring that staffing levels are appropriate and are increased when required, for example an increase in acuity on the ward or staff absence.

We found there was a number of vacancies on the ward at the time of the quality check. However, we were informed that a number of the successful nursing applications were currently undergoing pre-employment checks. It was positive to find that existing agency staff had been successful in being appointed to the ward on a permanent basis.

We also found there was good scope for career development on the ward, for example we saw opportunities for existing staff to develop into ward management and leadership roles and for other staff to undertake nurse training. It was positive to find that the matron was supportive and complimentary of the ward manager who had only recently been promoted into the role.

We were provided with mandatory training statistics and found a high rate of compliance in all areas. The ward had also supported staff through specialist NIV training in order to appropriately manage and care for patients undergoing this treatment.

No areas for improvement were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed below:

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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.
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check

As a result of the findings from this quality check, 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

Immediate Improvement plan

Setting: Ysbyty Glan Clwyd

Ward: Ward 11 (Respiratory / COVID)

Date of activity: 26 August 2020

In advance of the Tier 1 Quality Check, HIW requested the submission of a completed self-assessment and associated evidence. Part of this evidence included any available Infection Prevention and Control (IPC) audits, of which we received an internal health board IPC audit (dated 21st July 2020).
The audit highlighted significant issues in a number of areas within the ward. HIW considered this evidence in conjunction with the verbal responses made in the Tier 1 telephone call and further written evidence provided following the call. Our concerns are as follows:

- No action plan has been produced in response to the audit and evidence of remedial action has only been provided on a piecemeal basis for a small number of the issues identified by the audit. Therefore only limited assurance is available that remedial actions have been put in place and learning applied following the audit
- We saw insufficient evidence that the issues raised in the audit had been submitted to the local IPC group and that no further follow-up had been undertaken by the local IPC group. Therefore, we could also not be assured that the health board's governance mechanisms provided sufficient oversight of this matter and ensured that audit activity is responded to robustly and learned from.

As a result of our findings, HIW is not assured that appropriate actions have been taken and we cannot be assured that patient safety is maintained in relation to the management of infection prevention and control.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	**The health board must provide HIW with details of the action it will take to ensure that:** Effective actions have been taken in response to the IPC audit undertaken on Ward 11 on 21 July 2020	Code of Practice for the Prevention and Control of Healthcare Associated Infections, 2014	Action plan developed to address the concerns raised through the IPC audit undertaken on Ward 11 on 21 July 2020	Matron/Ward Manager	Complete
2	**The health board must provide HIW with details of the action it will take to ensure that:** Appropriate governance mechanisms exist to ensure that IPC issues identified through audit activity are followed up in a timely and effective manner.		Actions to be monitored and reported via existing hospital governance arrangements: 1. Local Infection Prevention Group (Monthly) 2. Site Quality, Safety and Patient Experience Meeting (Monthly) 3. Ward Manager/Matron 1:1 Meetings 4. Ward Manager audit (weekly)	Head or Nursing Medicine	

			5. Matron audit (monthly) 6. Daily Matron walk-about Weekly Head of Nursing/IPC walk-about		

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.

Name: Alison Griffiths

Role: Site Director of Nursing

Date: 07-09-2020

Improvement plan

Setting: Ysbyty Glan Clwyd

Ward: Ward 11 (Respiratory / COVID)

Date of activity: 26 August 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.
Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board should continue to maintain existing and explore further support mechanisms for its staff as the pandemic progresses.	Standard 7.1	• Provision of Wellbeing support and advice services (SWSS) • Referrals to Occupational Health and Wellbeing. (Policy WP33 – Staff Mental Health, Wellbeing and Stress Management Procedure, containing stress, risk assessments for use where appropriate). • Sickness/absence reviews. (Policy WP11 - NHS Wales Managing attendance at work policy).	Head of Nursing/Matron	In place Monthly reviews to be analysed by Matron and reported through the Health Boards governance structure

			• Flexible working arrangements where appropriate. (Policy WP13 - BCUHB Flexible working policy procedure). • Monthly team meetings to include HIW improvement plan actions & ensure team are aware of ongoing support mechanisms. • Provision of Pastoral support • Review the hospitals capacity to deliver MedTRiM (Medical Trauma and Resilience Management) methodology • Black, Asian and Minority Ethnic (BAME) Risk assessment reviews monthly to ensure 100% compliance. Compliance reported through ESR • Vulnerable staff group risk assessment reviews monthly to ensure 100% compliance • PPE Audit daily with weekly reporting to ensure 100% compliance • Covid risk assessment audit daily with weekly reporting to ensure 100% compliance with policy • Staff movement monitoring.	Directorate General Manager Medicine/Clinical Director	05-10-2020 Complete to 100% 15-09-2020 – ongoing for monthly review. Compliance reported through outbreak control meeting and Quality, safety and patient experience meeting (Monthly). In place –

					report provided to DoN monthly.

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.

Name: Linzi Shone, Head of Nursing Medicine

Date: 15-09-2020