Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Hospital Inspection Report (Unannounced)

## Ward B5 and Ward T5, University Hospital of Wales, Cardiff and Vale 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 healthcare services are provided in a way which maximises the health and wellbeing of people

## Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

## Our goal

To be a trusted voice which influences and drives improvement in healthcare

## Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

# Contents

# 1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an inspection at the University Hospital of Wales, Cardiff and Vale University Health Board on 07 and 08 March 2023. The health board was provided with a 24 hour notice period owing to the nature of the wards with the intention to allow time for COVID safe arrangements to be put in place for the inspection.

The following hospital wards were reviewed during this inspection:

- Ward B5 - 27 beds providing care for patients with acute or chronic renal disease
- Ward T5 – 20 beds providing care for patients having kidney transplants and for patients having pancreas transplants.

Our team for the inspection comprised of three HIW Senior Healthcare Inspectors, two Clinical Peer Reviewers and one Patient Experience Reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

# 2. Summary of inspection

## Quality of Patient Experience

Overall summary:
Patients provided very positive feedback about the care and treatment provided to them.

We found staff treated patients with respect and kindness, and overall made efforts to protect their privacy and dignity when providing care.

While we saw information for patients was available, this was not displayed in a way that made it easy to see. There were limited communication aids available on the ward. In addition, we saw little evidence of an 'Active Offer'.

Patients appeared well cared for and we found staff responded promptly to patients' requests for assistance.

The health board had an up-to-date complaints procedure which was in keeping with Putting Things Right.

This is what we recommend the service can improve:

- The health board must take suitable action to review the provision of communication aids on both wards
- The health board must take suitable action to promote the 'Active Offer'
- The health board must take suitable action to review the review the information available on the wards and how this may be displayed more clearly.

This is what the service did well:

- We saw many examples of staff treating patients with respect and kindness
- We found patients' pain was well managed
- We found staff responded promptly to patients' requests for assistance.

## Delivery of Safe and Effective Care

Overall summary:
We found the hospital and the wards were accessible. However, both wards were cluttered with equipment, and we identified estates related issues that needed to be addressed.

We found good arrangements were in place to prevent patients from developing pressure and tissue damage and to prevent patient falls. We also found good arrangements were in place to meet the nutritional and hydration needs of patients.

Generally, arrangements were in place to provide patients with safe and effective care. However, we found improvements were needed, some of which required the health board to submit an immediate improvement plan to HIW describing the action taken to address these. These related to medicines management, waste management and the handling of infected/soiled linen.

Immediate assurances:

- We found some medicines used on Ward T5 were not securely stored and not managed safely
- We found clinical waste generated by Ward B5 and infected/soiled linen from Ward T5 was not stored safely whilst waiting to be collected for disposal.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board must review the storage provision on both wards and take action to ensure it is sufficient
- The health board must take suitable action to address the outstanding estates issues on both wards
- The health board must take suitable action to promote staff compliance with its infection control policies and procedures
- The health board must take suitable action to reassure staff that when they report concerns, these will be addressed as appropriate
- The health board must take suitable action to ensure staff handle patient information in a way that protects patient confidentiality.

This is what the service did well:

- We found good arrangements were in place to prevent patients on the ward from developing pressure and tissue damage, to prevent patient falls and to meet the nutritional and hydration needs of patients
- We saw a well-attended multi-disciplinary team (MDT) meeting which was effectively managed
- Staff we spoke with demonstrated a good awareness of safeguarding procedures.

## Quality of Management and Leadership

Overall summary:
A suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated.

Senior staff described a system of audit to monitor the quality and safety of services provided on the wards. Given some of our findings the health board needs to consider whether the quality and safety monitoring arrangements on both wards need to be strengthened.

Staff responses were generally positive regarding their immediate and senior managers.

The health board had a comprehensive mandatory training programme, and generally staff training compliance was good. However, we identified poor compliance with mandatory resuscitation training and safe moving and handling training.

In addition, compliance with staff appraisals needed to be improved.

Immediate assurances:

- We identified poor compliance with mandatory resuscitation training and safe moving and handling training, which meant we were not assured there were a sufficient number of staff who had the required up to date skills.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board must review the quality and safety monitoring arrangements to ensure they are strengthened where needed
- The health board must take suitable action to improve compliance with conducting staff appraisals.

This is what the service did well:

- The majority of staff made positive comments about their immediate and senior managers
- The majority of staff told us they would recommend their organisation as a place to work.
- Generally, compliance with staff training was good for many topics.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

# 3. What we found

# Quality of Patient Experience

## Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 20 were completed. This included nine for Ward B5 and eleven for Ward T5. Not all respondents answered all questions.

The responses indicated an overwhelmingly positive patient experience across all areas, with 15 out of 17 patients who answered the question rating the service as 'very good'.

Patient comments included the following:

> *"(B5) I have no complaints I think they work to become a good team on any shift."*
> *"(B5) …the staff are always informative patient and kind."*
> *"(T5) Upsetting time for me but the staff cheered me up when I was down."*
> *"(T5) All staff are excellent including cleaners, dinner ladies etc. knowledgeable, friendly and caring."*
> *"(T5) Every single staff member I have spent time with has been outstanding - never rushed me - I've never felt a burden and I cannot praise them enough."*

We asked what could be done to improve the service the wards provide. Comments included the following:

> *"(B5) TV available for each patient."*
> *"(B5) Have a treatment plan in place and can be adjusted as continuous care."*
> *"(T5) Headphones and remotes for TVs. More servicing of tech equipment. More checks on ward temperature."*
> *"(T5) Am not keen on the doctor rotation system, I would prefer one on one."*
> *"(T5) Waiting lists need to be shorter."*

## Staying Healthy

### Health Protection and Improvement

We saw there were leaflets displayed within both wards for patients and their carers to read or take away with them. These provided health promotion advice and information on managing a range of health conditions.

In addition, information specific to patients with renal conditions was available on the health board's website.

We were told smoking was not permitted anywhere within the hospital. This was in accordance with current legislation to help prevent disease caused by second-hand smoke. We were also told patients were signposted to the health board's smoking cessation service where they could access advice and support to help them stop smoking.

## Dignified care

### Dignified Care

During our inspection, we saw many examples of staff treating patients with respect and kindness and making efforts to maintain their dignity.

Where patients were accommodated in multi-bedded bays, we saw dignity curtains were drawn. We also saw doors to toilets and washing facilities were closed when personal care was said to be being provided by staff. However, on Ward T5 we saw staff missed opportunities to draw curtains or close doors when attending to patients in cubicles.

The patients we saw appeared well cared for and suitably dressed, either in their pyjamas or dignity gowns.

We reviewed the records of four patients who were accommodated on the wards at the time of our inspection. We saw evidence of all patients having had their pain measured, actioned and evaluated regularly using a suitable pain assessment tool. All patients had an up-to-date pain score and we saw evidence of their pain being managed.

All patients (20/20) who completed a patient questionnaire agreed staff had treated them with dignity and respect and were polite to them. In addition, all felt measures had been taken to protect their privacy. Responses from all patients showed staff had provided care to them in a kind and sensitive way.

During our inspection we used online questionnaires to obtain feedback and views from staff working on the wards. A total of 17 were completed.

Most staff (14/17) who completed a questionnaire agreed patients' privacy and dignity were maintained on the ward.

**Communicating Effectively**
While there was a hearing loop located on Ward T5, generally, there was a lack of equipment on both wards to aid communication between staff and patients with communication impairments.

We saw there was some information available to patients bilingually in both Welsh and English on both wards. However, the majority was in English only. We were told there were a small number of Welsh speaking staff working on the wards and they wore badges to show patients they were Welsh speakers. Generally, we saw the Welsh language was not well promoted on the wards and saw little evidence of the 'Active Offer'.

The majority of patients (18/19) who answered the question in the patient questionnaire told us their preferred language was English, with one patient telling us they preferred to communicate in Welsh. The responses from one patient indicated they were not offered the opportunity to speak Welsh and did not feel comfortable using Welsh when on the ward.

Patients we spoke with during our inspection indicated with were happy with the way staff had communicated with them.

When asked whether they are Welsh speakers, the majority of staff (13/14) who answered this question in the questionnaire indicated they were not.

**Patient Information**
We saw signage to help visitors find their way to and from the wards and to other wards and departments within the hospital. We found this was generally easy to follow. However, the health board may wish to consider installing additional signage to help individuals locate Ward T5, which we found more difficult to find.

There were no information boards displayed providing information for patients or visitors to see on the roles of the different staff working on and visiting the ward and how to identify them from their uniforms.

Where leaflets and posters were displayed, these were not always organised to make them clearly visible, making them difficult to read or access.

All patients (20/20) who completed a patient questionnaire agreed they had been given enough information to help them understand their healthcare.

The majority of staff (13/17) who completed a questionnaire agreed sufficient information was provided to patients. However, four disagreed.

## Timely care

**Timely Access**
During our inspection we saw staff responding to patients requests for assistance. Those patients we spoke to told us they did not have to wait long for staff to attend to them after they had used their nurse call bell.

All patients (20/20) who completed a patient questionnaire told us staff had provided care to them when they had needed it. Most patients on Ward B5 (07/09) and all patients on Ward T5 (10/10) who answered the question in the questionnaire agreed they always had access to a nurse call buzzer. When asked whether staff came to them when they used the buzzer, most patients on Ward B5 (08/09) and all on Ward T5 (08/08) who answered the question agreed.

Just under 50% of staff (8/17) who completed a questionnaire agreed they had enough time to give patients the care they need, while the remainder (9/17) disagreed. When asked whether they were satisfied with the quality of care and support they give to patients, most staff (15/17) told us they were.

## Individual care

**Planning Care to Promote Independence**
We saw both wards used the 'This is Me' scheme.

While we saw some signage displayed on Ward B5 to assist patients to find toilets and washing facilities, we did not see similar signage on ward T5. In addition, we did not consider the signage used as being beneficial to patients with a sensory impairment or cognitive difficulties.

Patients we saw appeared well cared for, however we did not observe staff encouraging patients to mobilise, which may help prevent complications associated with reduced mobility following surgery.

During the inspection, we observed a muti-disciplinary team meeting. We saw this was well attended by members of the team and effectively led by one of the ward managers.

**People's Rights**
During our inspection, we found staff providing care to patients in a way that recognised their individual needs and rights.

While there were restrictions in place, we were told patients were able to receive visits from their friends and relatives. However, patients we spoke with felt the visiting arrangements were inflexible.

We saw rooms were available on both wards for patients to meet with family or friends in private. However, we found the room located on Ward T5 was small and the configuration of the furniture was impractical for it to be used.

Senior staff described all staff were expected to complete Equality and Diversity training as part of the health board's mandatory training programme. We saw good compliance with this training.

Most patients (16/18) who answered the question in the patient questionnaire told us they had been involved as much as they had wanted to be in decisions about their health care. All patients (20/20) who completed a questionnaire told us staff had listened to them and their friends and family.

In addition, all patients who completed a patient questionnaire told us they had not faced discrimination when accessing or using the health service.

**Listening and Learning from Feedback**
We saw posters and leaflets displayed in both wards, which provided details of how patients or their representatives could provide feedback to the health board. However, due to their location and the amount of other information being displayed, we felt further efforts could be made to make these more visible on both wards.

The health board had an up-to-date written procedure for managing concerns and complaints received about patient care and treatment. This was in keeping with Putting Things Right. We were told should patients or their representatives make a complaint or raise a concern verbally that cannot be resolved at ward level, they are provided with an information leaflet on how to escalate this. None of the patients we spoke with knew how they could make a complaint.

Senior staff described suitable arrangements for monitoring progress on responding to complaints. Suitable arrangements were also described for sharing patient feedback and information from complaints with the staff teams and for sharing learning.

When asked whether patient experience feedback was collected within the ward, less than 50% of staff (6/15) who answered this question told us it was, and the remainder either told us it was not (3/16) or they didn't know (6/15). When asked whether they received regular updates on patient feedback, over 50% of staff (8/16) who answered the question told us they did and the reminder either told us they did not (7/16) or they did not know (1/16). In addition, when asked whether feedback from patients was used to make informed decisions within the hospital, most staff (10/15) told us they did not know and the reminder either told us it was (4/15) or it was not (1/15).

Most staff (13/16) who answered the question in the questionnaire told us they felt the organisation acted on concerns raised by patients.

# Delivery of Safe and Effective Care

## Safe Care

### Managing Risk and Promoting Health and Safety

We saw the hospital and both wards were accessible to patients, staff and visitors. There was level access to the main entrance of the hospital and lifts provided access to the wards, which were located on one of the upper floors of the hospital.

It was evident that the wards did not have sufficient storage as we saw they were cluttered with equipment, posing a potential trip hazard.

We also saw the wards were in need of redecoration and identified maintenance issues that had not been effectively resolved, such as, the utility lifts near Ward B5 were not working, resulting in waste bins being stored in the corridor; dialysis water points on Ward B5 were visibly rusty, locks to rooms and cupboards on Ward T5 were broken and ceiling tiles on Ward 5 showed signs of water damage.

In addition, dialysis fluids and other chemicals used on both wards were stored in unlocked rooms, which may present a risk to safety.

We saw all patients had a nurse call bell within easy reach so they could summon help from ward staff if needed. We found requests for assistance were responded to promptly by staff.

Senior staff described suitable arrangements for the reporting, recording and investigating incidents and for providing feedback to ward staff.

The majority of staff (14/16) who answered the question in the questionnaire told us they were encouraged to report errors, near misses or incidents. In addition, the majority (15/16) also felt staff involved were treated fairly. Most (13/16) told us they felt the organisation protected confidentiality in this regard. The majority of staff (14/16) who answered the question also felt the organisation took action in response to incidents to ensure they do not happen again. In addition, most staff (10/16) who answered the question told us they were given feedback about changes made in response to incidents.

### Preventing Pressure and Tissue Damage

Within all four of the patient records we reviewed, we saw evidence of patients having been assessed on admission for their risk of developing pressure damage. Appropriate care plans were in place according to the risk identified. Where

needed, we saw evidence of patients being repositioned frequently. We also saw evidence of ongoing monitoring of patients' skin state by staff.

We saw suitable pressure relieving equipment was available and being used appropriately.

**Falls Prevention**
Within all four of the patient records we reviewed, we saw evidence of patients having been assessed for their risk of falls. Where patients had been identified as at risk of falls, we saw appropriate care plans were in place.

**Infection Prevention and Control**
We spoke to staff on both wards. Generally, they were aware of their role regarding infection prevention and control procedures. However, we saw variable practice.

Most staff (15/17) who completed a questionnaire felt there were adequate infection control procedures in place.

We saw an adequate supply of personal protective equipment (PPE) was readily available on both wards. While we saw staff using PPE appropriately on Ward B5, we saw some staff on T5 were wearing masks incorrectly, with the mask not covering their nose. We also saw staff on T5 were not always following the correct procedure for donning and doffing PPE. This may increase the risk of cross infection.

We saw good practice in relation to hand hygiene on Ward B5, however, we saw staff on Ward T5 missed opportunities to wash their hands between attending to patients. In addition, we saw staff on Ward T5 were not always adhering to an aseptic non-touch technique (ANNT) when attending to patients requiring dialysis. This may increase the risk of cross infection.

Generally, both wards appeared visibly clean. However, both were cluttered with equipment which may make effective cleaning difficult. In addition, both wards were in needs of redecorating and some maintenance to help promote effective cleaning of wall and floor surfaces.

All patients (20/20) who completed a patient questionnaire told us they felt the ward they were on was clean. However, the following comment was received:

> *"After being to theatre used gowns are left around the ward for days…"*

Regarding COVID-19, we were told specific restrictions in this regard had, generally, been eased. However, visitors were still encouraged to use hand sanitiser when visiting the wards.

In addition, precautions were still in place where patients had been identified as, or were suspected of, having COVID-19 to help prevent the spread of the virus. We were also told COVID-19 screening was performed where patients were transferred from other hospitals, again to prevent spread.

All patients who completed a patient questionnaire told us they felt COVID-19 measures were being followed, where appropriate.

The majority of staff (13/15) who answered the questions in the questionnaire agreed the health board had implemented the necessary environmental changes and all (14/14) agreed the organisation had implemented practice changes in response to COVID-19. In addition, the majority of staff agreed there was a sufficient supply of personal protective equipment (13/14) and there were appropriate decontamination arrangements in place for the environment (13/14).

There were a number of cubicles on both wards that could be used for patients who required to be nursed in isolation due to an infection risk.

We saw general waste bins and clinical waste bins stored near to the entrance of Ward B5, adjacent to the lifts. We were told the lifts were out of service and had been for approximately three to four months. As a result of the lifts not working, we were told it had become necessary for the bins to be relocated from the designed waste room and stored in this area so they could be easily accessed by portering staff when they needed to be replaced. We saw the bins contained bagged clinical waste and were unlocked. We reported this to the lead nurse who escalated this to the Estates Manager and made arrangements for the bins to be locked.

Later, during the inspection, we identified the bins had been replaced with different bins that were unlocked. The lead nurse confirmed this issue had been escalated again. We confirmed with the Infection Control Nurse the bins should not be stored in this area.

HIW was not assured clinical waste from Ward B5 was being stored safely until collected for disposal nor the associated risk of cross infection and injury to patients and visitors to the ward had been mitigated as far as possible.

HIW saw linen within infected linen bags in an uncovered linen skip stored in the corridor outside Ward T5. We were told this was stored in this area ready for

collecting by portering staff. We confirmed with the Infection Control Nurse the skip should not be stored in this area for long periods.

HIW was not assured infected linen from Ward T5 was being stored safely until collected for processing nor the associated risk of cross infection had been mitigated as far as possible. This was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

**Nutrition and Hydration**

Within all four of the patient records we reviewed, we saw evidence of patients having had a nutritional risk assessment completed within 24 hours of being admitted to the wards. Appropriate care plans were in place where needed. In addition, we found staff were accurately monitoring patients' food and fluid intake, where necessary.

We observed the serving of a lunchtime meal on both Ward B5 and Ward T5. We found patients had a choice of meal. We also found a suitable system in place to identify patients with specific dietary needs.

While meals were placed within easy reach of patients, we saw tables were not cleared or cleaned prior to mealtimes. In addition, there were missed opportunities for patients to wash their hands prior to having their meals. We saw efforts were made to serve hot meals in a timely way to prevent them going cold. We also saw staff helping patients as required. We saw serving staff engaged positively with patients during the mealtime.

The meals were well presented and appeared appetising. We saw staff cleared empty plates promptly.

On both wards, patients had access to drinking water, taking into account any restrictions as part of their care and treatment, and this was placed within their easy reach.

All patients who completed a patient questionnaire told us staff had helped them at mealtimes, if required, and they had time to eat their meals at their own pace. In addition, all told us they always had access to drinking water.

**Medicines Management**

We saw the All Wales medication charts were being used on both wards. These had been completed to show the medicines prescribed, when they had been prescribed and when medicines had been administered. We saw codes had been used appropriately to show the reason for when medicines could not be administered.

While patients' details had been recorded on the charts, we saw these had generally been recorded on the front page only and not on each page as required. We saw medicines were administered to patients safely with staff conducting appropriate checks to correctly identify patients prior to administering their medication.

We saw medicines used on Ward B5 were being stored securely in a designated room. However, there was evidence of overstocking, and the cupboards were disorganised. We saw medicines requiring refrigeration were being stored in a suitable medicines fridge and daily temperature checks had been recorded.

We saw Controlled Drugs, which have strict and well-defined management requirements were being stored securely and had been subject to regular stock checks.

We saw medicines used on Ward T5 were stored in a designated locked room, however, two cupboards and the medicines fridge located in the room were not locked. In addition, some of the cupboards were in need of cleaning. We were not assured medicines were being suitably stored on Ward T5 to reduce the risk of unauthorised access. This posed a potential risk to the safety and wellbeing of patients and other individuals who may access and ingest medication not meant for them.

We saw daily checks of the fridge temperature had not always been recorded. In addition, checks of the room temperature were not being recorded.

The health board's policy for room temperature checks was not clear. However, the Medication Code provided to HIW described the temperatures of medication storage areas and medicine fridges should be subject to ongoing monitoring. We were not assured ongoing monitoring of the temperatures of the medication storage area and the fridge on Ward T5 were being conducted to check and demonstrate medicines were being stored at an appropriate temperature according to the manufacturer's instructions. This posed a potential risk to the safety and wellbeing of patients who may receive medication that has not be stored appropriately and so may not be as effective when used for treatment.

We saw vials of insulin and insulin 'pens' were stored in the fridge on Ward T5. We saw some were either not labelled or had been labelled as being opened/first used more than one month previously. We confirmed insulin vials and insulin 'pens' should be dated when first opened/used and not used 28 days after this date. We were not assured the storage of insulin on Ward T5 was being managed safely. This posed a potential risk to the safety and wellbeing of patients who may receive insulin stored in vials or 'pens' for longer than 28 days and so may not be as effective when used for treatment.

We saw Controlled Drugs were being stored securely on Ward T5. However, we identified daily stock checks of the Controlled Drugs had not always been recorded. HIW was not assured checks of Controlled Drugs on Ward T5 were being conducted daily in accordance with the health board's Medication Code and to promote the safe and effective management of these drugs in line with regulatory requirements.

We required the health board to take immediate action regarding the above. This was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

**Safeguarding Children and Safeguarding Adults at Risk**
Senior staff described suitable arrangements for responding to safeguarding concerns. We saw a current written policy and procedures were in place. These were in accordance with the Wales Safeguarding Procedures. Senior staff confirmed staff could contact the health board's safeguarding team for advice on safeguarding matters.

Safeguarding training was part of the health board's mandatory staff training programme. Data provided by senior staff showed variable staff compliance with safeguarding training. Over 80% of staff working on Ward T5 were up to date with training. Compliance for Ward B5 was less, with 51% and 61% of staff being up to date with safeguarding adult training and safeguarding children training respectively. While training compliance could be improved, staff we spoke with demonstrated they had a good understanding of safeguarding procedures.

All staff who answered the question in the questionnaire (15/15) told us if they had a concern about unsafe practice, they would know how to report it. In addition, the majority of staff (13/15) told us they felt secure raising concerns. However, when asked whether they felt confident the organisation would address their concerns, just over 50% of staff (5/11) told us they were, with the reminder either being not being confident (2/15), or they did not know (5/15).

**Blood Management**
We found strict arrangements were in place to ensure the safe administration of blood products on both wards.

Staff we spoke with confirmed a policy was in place and they used the All Wales documentation when blood products were administered.

We were also told staff received training on the use of blood products. Ward link nurses were available to provide help and support.

Staff were also aware of the correct process for reporting adverse events relating to blood transfusion.

**Medical Devices, Equipment and Diagnostic Systems**
We saw a range of equipment was available to meet the assessed needs of patients, such as specialist pressure relieving aids, mobility aids, hoists, commodes and monitoring machines.

We saw equipment had labels to show when they required servicing and saw this was up to date.

Staff we spoke with were aware of the correct procedure to follow to report equipment found to be faulty. However, some staff we spoke with were not sure of the arrangements for testing bedside dialysis ports.

We saw staff were diligent in relation to cleaning shared equipment to prevent cross infection.

## Effective care

**Safe and Clinically Effective Care**
Generally, we found arrangements were in place to provide safe and effective care to patients on both wards.

We found staff had assessed patients using recognised nursing assessment tools to help the early detection of risks, such as pressure and tissue damage and falls. In addition, we found appropriate care plans had been put in place.

We also found the National Early Warning Score (NEWS) documentation was being used and completed. In addition, the Sepsis Screening Tool was available together with a sepsis pathway and associated Sepsis Six care bundle. Staff we spoke with knowledgeable regarding sepsis and its effective management.

Staff we spoke with were aware of how to access the hospital's clinical policies and procedures to support them in their practice.

We saw on both wards notice boards were clearly displayed, which included patients' names. However, other information relating to the status of individual patients was limited. It was not clear whether the intention was for these to be used as Patient Status at a Glance (PSAG) boards to assist communication between the different members of the multi-disciplinary team.

**Quality Improvement, Research and Innovation**
Senior staff described significant work had been done resulting in improved staff recruitment and retention on both wards and across the wider nephrology service.

We were told a staff rotation programme had been introduced. This allowed staff to gain experience of working in different parts of the service and helped them develop a range of skills relevant to their practice. It also helped them to decide in which area they would like to specialise.

Senior staff described arrangements were in place with another nephrology service located in England to discuss practice and share learning with the aim of making service improvements.

**Record Keeping**
We saw patient records were up to date and the notes showed evidence of how decision making relating to patient care had been made using a multidisciplinary team approach.

During the inspection, we saw patient records were in paper form and saw staff also accessing information via computer. We saw on Ward T5 a member of staff had not logged out of the computer system posing a potential risk to patient confidentiality. While we saw patient records on both wards were kept in trolleys, these were not secured to prevent unauthorised access. We also saw patient records stored in an open cupboard on Ward B5.

# Quality of Management and Leadership

## Staff Feedback

During the inspection we used online questionnaires to obtain feedback and views from staff working on both wards. A total of 17 were completed by a variety of staff including nurses, allied health professionals, support workers and administration staff. Not all respondents completed all questions.

Responses from staff were mostly positive. Staff comments included the following:

> *"It has been a refreshing experience to work in this department in the last year after … years of working in the NHS. Culture being developed is extremely positive, always opportunities for continuous improvement."*
> *"The ward is a great environment and we're very supported. Conscious efforts are made even when the skill mix isn't great on a given shift - we pull together and make things work."*
> *"Staff morale horrendous at the moment. Never known it so bad. Between the fight over pay, increasing workload and staff shortages it is not a good job to have."*
> *"Really enjoy working for this directorate. I feel I have been supported in my progression…"*

We asked staff what could be done to improve the service. Staff suggestions included the following:

> ***"I feel more staff on the floor, 6 … instead of 4 health care support workers, or 1 more nurse would help provide safer dialysis. It will also help provide more time for nurses to effectively communicate and work with other teams to improve care and make discharge planning run more smoothly…[and] allow the ward staff time to be able to mentally be able to accept and implement service improvements and changes on the ward to make the ward a better environment for both patients and staff to be in."***

## Governance, Leadership and Accountability

We found a suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated. Senior staff confirmed they visited the wards regularly and were available to provide advice and support to the ward managers and ward teams.

Senior staff described a system for audit and provided examples showing this process. We found the examples provided, did not always have detailed action plans. Senior staff were aware of this and explained work was ongoing to develop the use of the audit system further in this regard.

Given some of our findings the health board needs to consider whether the quality and safety monitoring arrangements on the wards need to be strengthened to ensure issues are identified early and addressed in a timely way.

Senior staff described the wards were represented at various meetings as part of the health board's arrangements for reporting on and monitoring the quality and safety of the services provided. Suitable arrangements were also described for sharing relevant information and updates to policies and procedures with the ward teams.

The majority of staff (11/12) who answered the question in the questionnaire told us they regularly had sight of new guidance, patient safety alerts and medical device alerts. In addition, most staff (10/13) told us they felt supported to ensure implementation and adherence to these.

During our inspection, managers engaged positively with the HIW inspection process. They demonstrated a commitment to learn from the inspection and make improvements as appropriate.

Generally, staff responses were positive regarding their immediate line managers. All staff (16/16) who answered the question in the questionnaire told us their manager could be counted on to help them with a difficult task at work. In addition, most staff (12/16) who answered the question in the questionnaire told us their manager was supportive in a personal crisis. However, some (4/16) disagreed. While most staff (12/16) who answered the question told us their manager gave them clear feedback on their work, some (4/16) disagreed.

Similarly, staff responses were positive regarding their senior managers. All staff (16/16) who answered the question in the questionnaire told us they knew who the senior managers were, and the majority (15/16) told us that senior managers were visible. Most staff (12/16) who answered the question told us communication between senior management and staff was effective. In addition, most staff (10/16) told us senior managers acted on staff feedback. However, some (6/16) disagreed with this. When asked whether senior managers try and involve staff in important decisions, most staff (10/16) who answered this question agreed and (6/16) disagreed.

When asked in the questionnaire whether the hospital supports staff to identify and solve problems, most staff (10/16) who answered this question agreed. However, some (6/16) disagreed. Just over 50% of staff (9/16) who answered the question told us the hospital took swift action to improve when necessary. However, the remainder (7/16) disagreed.

The majority of staff (14/16) who answered the question in the questionnaire told us the hospital encouraged teamwork. Similarly, the majority (13/16) told us partnership working with other departments was effective. Less staff (11/14) agreed partnership working with outside organisations was effective.

The majority of staff (15/16) who answered the question in the questionnaire told us care of patients was the organisation's top priority. The majority of staff (15/16) told us they would recommend their organisation as a place to work.

## Staff and Resources

**Workforce**
We saw doctors, nursing staff, allied healthcare professionals, healthcare support staff, administration staff, catering/hostess staff and housekeeping staff working on the wards.

During our inspection, the staffing levels and skill mix on both wards appeared appropriate to meet the assessed needs of patients. We were told agency staff were used to cover any shortfalls in staffing that could not be covered by members of the ward team.

Details of staffing levels were displayed on the wards and senior staff confirmed these were kept under review.

When asked whether there were enough staff to allow them to do their job properly, around 50% of staff (9/16) who completed a questionnaire, disagreed. However, most (10/17) agreed there was an adequate skill mix within the team.

The majority of staff (11/16) who answered the question in the questionnaire told us they had received appropriate training to undertake their role. The remainder told us told they had either received partial training (03/16) or the training was not appropriate (02/16). We asked if there was any other training staff would find useful. Staff comments included:

> *"Canulating"*
> *"Attending the renal course."*

The majority of staff (16/17) told us their training or development had helped them do their jobs more effectively and safely and had helped them deliver a better patient experience. In addition, the majority of staff (15/17) told us their training had helped them stay up to date with professional requirements.

We requested details of mandatory staff training. Compliance was generally good for many topics. However, from the data provided we identified poor compliance with mandatory resuscitation training (Ward B5) and safe moving and handling training (Ward B5 and Ward T5).

HIW was not assured a sufficient number of staff working on Ward B5 had the required up to date skills to perform effective resuscitation and was not assured a sufficient number of staff working on Wards B5 and T5 had the required up to date skills to use safe moving and handling techniques when assisting patients. This posed a potential risk to the safety and wellbeing of patients in the event of a patient emergency (collapse) and also to patients who are unable to move independently.

We required the health board to take immediate action regarding the above. This was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

The majority of staff (13/17) who completed a questionnaire told us they had an appraisal of their work in the last 12 months. The remainder either told us they had not (3/17) or could not remember (01/17). In addition, most staff (10/12) who answered this question told us they had been supported by their manager to attend training identified as part of their appraisal, while the remainder (02/12) told us they had not.

Data provided by senior staff showed 40% of staff working on Ward B5 and 63% of staff working Ward T5 had received an appraisal within the last year.

Most staff (12/16) who answered the questions in the questionnaire told us their job was not detrimental to their health. In addition, the majority of staff (15/16) agreed their current working pattern allowed for a good work/life balance. Most staff (12/16) told us the organisation took positive action on health and wellbeing. Most staff (12/16) also told us they were offered full support when dealing with challenging situations. All staff (16/16) were also aware of Occupational Health support available.

All staff (14/14) who answered the question in the questionnaire told us they had not faced discrimination at work. In addition, most staff (12/14) who answered the

question in the questionnaire told us there was fair and equal access to workplace opportunities, and the workplace was supportive of equality and diversity.

# 4. Next steps

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 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 inspection.

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.

# 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 |
|---|---|---|---|
| Immediate concerns were dealt with via HIW's immediate assurance process. | - | - | - |
| | | | |

# Appendix B – Immediate improvement plan

**Service:** Ward B5 and Ward T5, University Hospital of Wales

**Date of inspection:** 7 and 8 March 2023

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.

| Improvement needed | Standard/ Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The health board is required to provide HIW with details of the action taken to:<br>• safely secure medicines used on Ward T5 to help prevent unauthorised access<br>• demonstrate medicines are being stored at an appropriate temperature according to the manufacturer's instructions<br>• discard insulin (vials and pens) at a suitable time | Standard 2.6 Medicines Management | A meeting was held on 9th March 2023 with Estates Team to agree a work plan to resolve the unlockable cupboards in the medication storage room.<br>New locks have been ordered for all cupboards on T5. The Medicines storage room is locked and accessible to staff only.<br>A new keypad lock has been ordered for the existing fridge. This was ordered on 14th March 2023. | Estates<br>Lead Nurse<br>Lead nurse | Complete<br>15th April 2023<br>31 March 2023 |

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| after their first opening/use<br>• demonstrate Controlled Drugs are subject to regular checks. | | Fridge temperature checks have been added to the daily checklist throughout Nephrology and Transplant, and the outcomes of these checks will be recorded in the controlled drug book alongside control drug check. | Lead Nurse/Senior Nurse/Ward Manager | Completed with ongoing monitoring |
| | | A review of insulin stock levels has been undertaken and excess insulin has been removed. | Pharmacy | Completed |
| | | Daily check of insulin that is open and stored in the fridge will be undertaken to include oversight of the date and time of opening. A record of daily checks has been added to the controlled drug book alongside controlled drug and fridge temperature check. | Lead Nurse/Senior Nurse/Ward Manager | Completed with ongoing monitoring |
| | | A medicine safety audit has been undertaken throughout Nephrology and Transplant to ensure compliance | Lead Nurse/Pharmacy/Ward | Completed |

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| | | with the actions above. This has been added to the Tendable ward audits. | Manager/Practice Development Team | |
| | | The importance of safe medicine storage and medicine management have been communicated to staff at daily safety briefings, handovers, emails, and appropriate staff social media platforms. | Lead Nurse/Senior Nurse/Ward Manager | Completed |
| | | Audits have been added to the Tendable ward audit platform for monitoring of compliance for above actions. These audits will be completed weekly while change is embedded into practice | Lead Nurse | Completed<br>Ongoing |
| | | A new daily nurse in charge checklist has been developed to include the additional medicines management checks including the checking of controlled drugs and fridge temperatures. These audits will be | Lead Nurse | Completed<br>ongoing |

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| | | monitored via the Tenable ward audit platform. | | |
| The health board is required to provide HIW with details of the action taken to safely store:<br>• clinical waste generated by Ward B5<br>• infected/soiled linen from Ward T5<br>until it is collected for disposal or processing. | Standard 2.1 Managing Risk and Promoting Health and Safety<br>Standard 2.4 Infection Prevention and Control | The ward bins are accessed via the service lift directly to the dirty utility. The service lift is currently out of order and there has been a delay in repairing the lift due to access to parts. The time frame for this work to be completed is the end of June.<br>Alternative access to the dirty utility is through the ward, however removing the bins via this route is noisy and has a negative impact on patient experience.<br>In the interim the following actions have taken place<br>• Bins have been moved from the mains entrance of the ward back to the locked waste utility room on T5 and will be accessed via the ward.<br>• Waste collection time has been changed to avoid early morning and late evening to | Estates<br>Lead Nurse/Senior Nurse, Operational Services Manager, Capital Estates | June 2023<br>Complete<br>Complete |

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| | | minimise impact on patient experience<br>• Large metal bins have been removed and replaced by new smaller plastic bins which are easier to move and reduces the amount of noise during waste removal.<br>• Linen storage has been moved to the locked waste utility room on T5 and it has been confirmed with Linen Management Team that linen should be collected from the waste room on T5 | | Complete<br><br>Complete |
| The health board is required to provide HIW with details of the action taken:<br>• to improve mandatory staff training compliance in respect of resuscitation training and safe moving and handling training<br>• to promote patient safety in the interim. | Standard 3.1 Safe and Clinically Effective Care<br>Standard 7.1 Workforce | Intermediate Life Support Training (ILS) is not included on ESR and resuscitation compliance is therefore under represented on ESR. Work is underway with ESR to review the accuracy of data of compliance of resuscitation training.<br>An educational plan has been developed to improve compliance which includes: | Lead Nurse/ESR team<br><br>Senior Nurse/Practice Development Team | April 2023<br><br>May 2023 |

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| | | • Targeted Basic life support (BLS) training for staff whose compliance has lapsed.<br>• Drop in sessions for BLS training to capture ward staff on duty has commenced and will continue for the next 4-6 weeks to capture all staff.<br><br>An education plan has been developed to ensure improved compliance with Manual Handling Training,<br><br>• All staff that are not compliant are to booked on face to face sessions.<br>• For staff who have had an update within 3 years the Practice Development Nurse will provide ward based assessments.<br><br>A compliance level of >90% is expected by May 2023 allowing for long-term sickens and maternity leave.<br><br>The staffing rota will be reviewed to ensure that BLS/ILS trained staff are | Senior Nurse/Practice Development Team<br><br>Senior Nurse/Practice Development Team | May 2023<br><br>May 2023 |

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| | | present on each shift and allocated appropriately to ensure adequate skill mix. | Senior Nurse/Practice Development Team | Complete<br>Ongoing |

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): Lisa Higginson**

**Job role: Interim Lead Nurse**

**Date: 17/03/2023**

# Appendix C - Improvement plan

**Service:** Ward B5 and Ward T5, University Hospital Wales

**Date of inspection:** 07 and 08 March 2023

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/ Regulation | Service action | Responsible officer | Timescale |
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| The health board is required to provide HIW with details of the action taken to remind staff to draw curtains or close doors when attending to patients in cubicles. | Standards 4.1 Dignified Care | All staff are to be reminded of the importance to protect patient's dignity and privacy during care interactions. This is being shared through ward-based hand overs.<br>Spot checks will also take place by the Lead/Senior Nurse. | Ward Managers (B5 and T5)<br>Lead/Senior Nurse | Completed and ongoing<br>Ongoing Monitoring |
| The health board is required to provide HIW with details of the action taken to review the provision of communication aids on both wards to ensure it is sufficient | Standard 3.2 Communicating Effectively | A review of the availability of hearing loops in both clinical areas has taken place which has confirmed that communication aids are available. | Ward Managers | Completed |

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| to meet the communication needs of patients. | | A review will take place on the adequacy and visibility of notices are available to inform patients that hearing loops are available. | Ward Manager | July 2023 |
| | | A review of the available communication resources is underway to establish how best to support patients with communication impairments. | Ward Manager | September 2023 |
| | | This question is part of the Initial assessment documentation on admission. This will be discussed with the Senior Nurse for Professional Standards regarding adding this to the audit schedule on Tendable to measure compliance with this assessment.<br>In urgent circumstances where a patient or family member's communication needs are unable to be met by the wards the UHB Patient Experience Team can provide an electronic devices to | Lead Nurse/ Senior Nurse for Professional Standards | August 2023 |

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| | | support patients/families with their communication needs. These are available for short term loans and can be accessed during office hours. | | |
| The health board is required to provide HIW with details of the action taken to promote the 'Active Offer' | Standard 3.2 Communicating Effectively | A new Welsh Language mandatory training module is now available via ESR, there is a UHB target of 80% compliance (allowing for sickness, annual leave and maternity leave). | Ward Managers (B5 and T5) | October 2023 |
| | | An evaluation of the number of staff able to communicate in Welsh will be undertaken to ensure that they have the Welsh Language symbol on their uniform or lanyard so that they can be easily identified. | Ward Managers (B5 and T5) | September 2023 |
| | | A poster will be placed within each clinical area to ensure patients are aware of the significance of the Welsh Language symbol. | Ward managers (B5 and T5) | July 2023 |

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| | | Welsh language greeting action cards will be placed by all telephones to ensure that staff answer the phone in Welsh and English. | Directorate support Manager | July 2023 |
| | | A review of all information leaflets will take place to ensure that they are bilingual. | Directorate Support Manager | October 2023 |
| | | A review of the standard signage within ward areas will take place to ensure that signage is bilingual. | Estates manager/ Ward manager to review | July 2023 |
| | | Encourage staff to identify patients that their first language is Welsh, and ensure that it is recorded in the Integrated Assessment document on admission. | Ward Manager (B5 and T5) | September 2023 |

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| | | The Wales Interpretation and Translation service (WITS) is available throughout the UHB operating times are 7am-10pm with an emergency service 10pm-7am Monday – Sunday. Information of how to access is available in clinical areas<br><br>Staff will be reminded of the process of how to contact the phone version of Language Line when the service is needed. Information will be readily available on posters to support staff in accessing this service.<br><br>Language Line Video Services is available in the UHB and is accessed using electronic devices. The Patient Experience team can support this service in urgent cases when communication needs can not being met. There are Cost implication for all Clinical Boards to when utilising this service | Ward Manager (B5 and T5) | June 2023 |

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| | | There is also a Sign Live Video Service for patients with hearing impairments, this requires wards to have an electronic device and an account set up for payment to access this service. | | |
| The health board is required to provide HIW with details of the action taken to review the provision of information available for patients/visitors on the wards and how this may be displayed more clearly.<br><br>This must include information for patients/representatives on how they may provide feedback and make a complaint. | Standard 4.2 Patient Information | A review of all information available on the ward for patients and visitors will take place on all ward areas.<br><br>• Any outdated information will be removed<br><br>• Identify key location for displaying information within both clinical areas to ensure they are accessible to patients and visitors.<br><br>A review will take place in both ward areas to ensure that the information required for service users and families to provide feedback is accessible. | Ward Manager (B5 and T5)<br><br>Ward Manager (B5 and T5)<br><br>Ward Manager (B5 and T5)<br><br>Ward Manager (B5 and T5) | August 2023<br><br>August 2023<br><br>August 2023<br><br>July 2023 |

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| | | • Service user Feedback Posters will available in all clinical areas and will be placed at the bedside to enable patients/carers and family members to provide feedback regarding their experience<br><br>Posters have been produced by the Patient Experience Team that to ensure that patients and families are aware of the complaints process and how to raise a concern which will be in place the both ward areas? | Ward Manager (B5 and T5)<br><br>Ward Managers | June 2023<br><br>June 2023 |
| The health board is required to provide HIW with details of the action taken to review the provision of signage used on the wards to ensure it meets the needs of patients with sensory impairment or cognitive difficulties. | Standard 3.2<br>Communicating Effectively<br>Standard 6.1 Planning Care to Promote Independence | A review will take place to promote availability of a hearing loop which is present on both wards.<br><br>The ward manager will work with the patient experience team to explore available options for supporting patients | Ward Managers (B5 and T5)<br><br>Patient Experience Team/Ward Managers (B5 and T5) | June 2023<br><br>October 2023 |

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| | | with sensory or cognitive impairment to ensure that this need is met in the clinical areas. | | |
| The health board is required to provide HIW with details of the action taken to ensure where appropriate and safe to do so, patients are encouraged to mobilise to help reduce complications associated with reduced mobility. | Standard 6.1 Planning Care to Promote Independence | An enhanced recovery programme is being developed on T5 to promote early mobilisation for patients post-surgery to aid recovery where safe and appropriate<br><br>Patients with reduced mobility that require additional support to mobilise will be Identified during the daily ward round which is relayed to the allied health professionals on a daily basis to ensure that their needs can be met. | Clinical Lead for Transplantation and Ward Manager T5<br><br>Ward Managers (B5 and T5) | October 2023<br><br>July 2023 |
| The health board is required to review the quiet room located on Ward T5 provide and provide HIW with details of the action taken to ensure it is suitable for its intended use. | Standard 6.2 Peoples Rights<br><br>Standard 2.1 Managing Risk and Promoting Health and Safety | A review of the quiet room has identified that whilst the room is small, there are no other options within the footprint of the ward for an alternative.<br><br>Funding to create a more calming comfortable environment is being sourced to | Lead Nurse<br><br>Ward Manager T5 | Completed<br><br>August 2023 |

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| | | update furniture and decorate the room.<br><br>There is a quiet room available on B5 corridor that can be used for meetings with patients and families if needed which is away from the clinical area. This area is currently being renovated which has been supported by the 'Daring to Dream' charity. | Lead Nurse | Completed |
| The health board is required to provide HIW with details of the action taken to raise awareness amongst staff of the arrangements for patients or their representatives to provide feedback and how this is used. | Standard 6.3 Listening and learning from Feedback | A review will take place of availability of posters and QR codes to inform patients and family member to provide feedback through the UHB process.<br><br>To liaise with the Patient Experience Team regarding accessing Patient feedback posters and bedside stickers.<br><br>A request will be raised for the Patient Experience Team to undertake a targeted face to | Ward Managers (B5 and T5)<br><br>Lead/Senior Nurse and Ward Managers (B5 and T5)<br><br>Ward Manager (B5 and T5) | Complete<br><br>Complete<br><br>July 2023 |

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| | | face feedback in both ward areas<br><br>Management will engage with all staff to develop a process evaluate themes and trends and the best way of sharing patient and family feedback and concerns to ensure learning is achieved. | Ward Manager (B5 and T5) Senior Nurse | July 2023 |
| The health board is required to review the storage provision on both wards and provide HIW with details of the action taken to ensure this is sufficient. | Standard 2.1 Managing Risk and Promoting Health and Safety | Ward Managers will ensure that a weekly review of stock/items within clinical areas takes place and removal of any unnecessary equipment.<br><br>A schedule for environmental cleaning will be allocated ward based staff in both ward areas to ensure that areas are clean, tidy and uncluttered.<br><br>Physiotherapy team will review the current stock and storage of equipment on the ward and remove any surplus equipment. | Ward Managers (B5 and T5)<br><br>Ward Managers (B5 and T5) Physiotherapy department<br><br>Physiotherapist | Complete<br><br>June 2023<br><br>July 2023 |

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| | | A walk around of both clinical areas will take place collaboratively with the estates team to evaluate how additional storage areas can be achieved within the current ward footprint. | Estate Management/Ward Managers | July 2023 |
| The health abord is required to provide HIW with details of the action taken to address the outstanding Estates issues identified on both wards. | Standard 2.1 Managing Risk and Promoting Health and Safety | A walkabout of both clinical areas will take place with the estates team to develop an action plan to agree on the priorities of work and timeframes for completion. | Estates Department/Lead Nurse | August 2023 |
| The health board is required to provide HIW with details of the action taken to ensure dialysis fluids and other chemicals used by the wards are stored safely. | Standard 2.1 Managing Risk and Promoting Health and Safety | All dialysis fluids on B5 are stored in an appropriate room. The ward managers will communicate the importance of keeping this area locked at all times via safety briefings on every shift handover and spot checks for one month.<br>The Dialysis fluid on T5 is currently stored in a store room which is not locked, a lock has been ordered. | Ward Managers (B5 and T5)<br>Lead Nurse | August 2023<br>Complete |

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| | | The lead nurse will explore if these audits can then be monitored as part of the medicines management audit on the Tendable audit system. | Lead Nurse/ Senior Nurse for Professional Practice | August 2023 |
| The health board is required to provide HIW with details of the action taken to promote staff compliance with the health board's infection control policies and procedures.<br><br>This must include the use of and the donning / doffing of PPE, hand hygiene and ANNT. | Standard 2.4 Infection Prevention and Control (IPC) and Decontamination | The Practice Development Nurse Team will develop a detailed action plan to ensure that all staff are retrained in ANTT process where appropriate as a priority.<br><br>Monitoring of IP&C mandatory training compliance will take place via ESR. Progress and compliance will be discussed at monthly 1:1 meetings with the ward managers and Lead/Senior Nurse.<br><br>IP&C audits will continue via Tendable audits to monitor compliance, themes and trends themes will be shared at internal Quality and Safety meetings for learning. | Practice Development Team<br><br>Ward Managers (B5 and T5)<br><br>Lead Nurse | Complete<br><br>Completed - ongoing<br><br>Completed – Ongoing |

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| The health board is required to provide HIW with details of the action taken to remind staff of the importance of cleaning/clearing tables prior to mealtimes and of offering patients the opportunities to wash their hands. | Standard 2.5 Nutrition and Hydration<br><br>Standard 2.4 Infection Prevention and Control (IPC) and Decontamination | A schedule of daily activity will be established for health care support workers to ensure a routine is embedded where tables are cleaned and decluttered prior to meal times and that patients are supported to wash their hands. | Ward Managers (B5 and T5) | July 2023 |
| The health board is required to provide HIW with details of the action taken to remind staff to record patients' details on all relevant pages of the medication charts. | Standard 2.6 Medicines Management | HIW report shared with all staff to share learning.<br><br>All staff through multiple meetings, supervisor feedback and face to face discussions have been reminded to fully and accurately complete the medication chart<br><br>To be included as part of Medicines Management audit and updates | Lead Nurse<br><br>Clinical Director, Directorate Manager and Lead Nurse<br><br>Ward Managers (B5 and T5) | June 2023<br><br>June 2023<br><br>June 2023 |
| The health board is required to provide HIW with details of the action taken to improve staff compliance with mandatory safeguarding training. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk | An education plan has been developed to ensure all staff are compliant with safeguarding training. | Ward Managers (B5 and T5) | August 2023 |

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| | | • Monthly meetings have been put in place for ward managers and Lead/Senior Nurse to discuss mandatory training requirements and ensure improvement with compliance and identify areas/individuals that require additional support | Lead/Senior Nurse | Complete – Ongoing |
| | | Practice Development Nurse Team will support staff who are unable to access ESR to support their training requirements | Practice Development Nurse Team | Complete – ongoing |
| The health board is required to provide HIW with details of the action taken to reassure staff that when they report concerns about unsafe practice, these will be addressed by the health board as appropriate. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk | Staff will be encouraged to utilise the DATIX incident reporting system. | Lead Nurse | Complete – Ongoing |
| | | Managers will be encouraged to provide feedback to staff when they have reported incidents using the feedback function on Datix, and provide face to face feedback where appropriate maintaining patient confidentiality. | Lead Nurse | Complete – Ongoing |

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| | | The Lead Nurse extracts a report from Datix on a Quarterly basis which is shared with staff and at Q&S meetings. | Lead Nurse | Complete – Ongoing |
| The health board is required to review the use of the notice boards on both wards as PSAG boards and provide HIW with details of the action taken to ensure these are used safely and effectively. | Standard 3.1 Safe and Clinically Effective Care | A review will be undertaken of the appropriate use PSAG boards in the clinical area as currently the boards are used to support patient flow rather than being utilised as PSAG boards.<br>• An evaluation will be undertaken regarding the benefits of PSAG boards and how they promote safe and effective care.<br>• Discussions will take place with other ward areas within the UHB that are using PSAG boards effectively to inform the review. | Ward managers (B5 and T5)<br>Ward managers (B5 and T5)<br>Ward managers (B5 and T5) | July 2023<br>August 2023<br>August 2023 |

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| | | • All notice boards will be clearly labelled to ensure that they are used appropriately, and patient confidentiality is maintained | Ward managers (B5 and T5) | August 2023 |
| The health board is required to provide HIW with details of the action taken to ensure staff handle patient information in a way that protects their confidentiality. | Standard 3.5 Record Keeping | The Lead Nurse is evaluating themes and trends relegated to this area and will be presenting the findings at this in all directorate and Q&S meetings and supported by the Clinical Director<br><br>Ward manager/senior nurses will undertake spot checks to ensure compliance with the correct storage of patients medical records which will be discussed in the monthly managers meetings and reiterate staff responsibility regarding the safe storage of patient records.<br><br>Lockable trolleys are available in both clinical areas to safely store medical records | Clinical Director, Directorate Manager and Lead Nurse<br><br>Ward Manager/senior Nurse<br><br>Ward Managers (B5 and T5) | August 2023<br><br>June 2023<br><br>Complete |

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| | | Both B5 and T5 now have lockable cupboards where excess notes are stored<br><br>All professional leads will be informed to discuss with their teams the importance of complying with Information Governance policy and undertaking mandatory online eLearning training on ESR<br><br>Mentoring of nursing staff training will take place alongside other mandatory training compliance | Ward Managers (B5 and T5<br><br>Lead Nurse<br><br>Ward Managers | Complete<br><br>June 2023<br><br>Complete - Ongoing |
| The health board is required to review the quality and safety monitoring arrangements on the wards and provide HIW with details of the action taken to strengthen these where needed. | Governance, Leadership and Accountability | A schedule of regular ward place audit is in place to monitor Quality and Safety in the clinical areas, this is undertaken using the Tendable Ward audit system.<br><br>The Action plan function on Tendable is now active which with strengthen the monitoring process and appropriate escalation, training on this function is currently in progress. | Lead Nurse<br><br>Lead Nurse/ Senior Nurse for Professional Standards/ Ward Managers (B5 and T5) | Complete – Ongoing<br><br>August 2023 |

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| | | Tenable ward audit results and actions are discussed at the monthly directorate Q&S meeting and internally reported to the Clinical Board Quality, Safety and experience meetings. Audit results are also shared through Performance Review Panel with Clinical Board | Lead Nurse | Complete – Ongoing |
| The health board is required to provide HIW with details of the action taken to improve compliance with conducting staff appraisals. | Standard 7.1 Workforce | Ward managers and additional appropriate staff, that are trained to perform Value Based Appraisals, have been given allocated time to ensure that they have the capacity undertake the appraisal and ensure they are completed meaningfully. This will be a focus over the next few months to ensure and improvement to achieve >80% compliance | Ward Managers (B5 and T5) | August 2023 |

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| | | The Practice Development Nurse Team have also been allocated to undertake VBA's with staff to improve compliance<br><br>Compliance with VBA's will be discussed as part of the monthly ward manager/senior nurse 1:1 meetings to monitor progress | Practice Development Nurse<br><br>Ward Manager/Senior Nurse | Complete – ongoing<br><br>Complete – Ongoing |

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):** **Claire Main**

**Job role:** **Director of Nursing**

**Date:** **06/06/23**