Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Dignity and Essential Care Inspection (unannounced)

Cwm Taf University Health Board: Prince Charles Hospital, Wards 1 and 2

11 and 12 March 2015

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Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care inspection at Wards 1 & 2 at Prince Charles Hospital, Merthyr, part of Cwm Taf University Health Board on the 11 and 12 March 2015.

Our inspection considers the following issues:

- Quality of the patient experience
- Delivery of the fundamentals of care
- Quality of staffing, management and leadership
- Delivery of a safe and effective service.

2. Methodology

HIW's dignity and essential care inspections review the way patients' dignity is maintained within a hospital ward/unit/department and the fundamental, basic nursing care that patients receive.

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

- Information held by HIW
- Conversations with patients, relatives and interviews with staff
- Discussions with senior management within the health board
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- General observation of the environment of care and care practice.

These inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues about the quality and safety of essential care and dignity.

3. Context

Cwm Taf University Health Board is situated in the heart of South Wales just north of Cardiff, between the Brecon Beacons National Park and the M4 motorway. The health board is responsible for providing healthcare services to the population of Merthyr Tydfil and Rhondda Cynon Taf, estimated to be around 289,400 people.

The health board is made up of four localities - three of which are within the Rhondda Cynon Taf area. These are the Cynon Valley, the Rhondda Valley and Taff Ely area. The fourth locality is Merthyr Tydfil. Cwm Taf is the second most densely populated health board in Wales; many areas being amongst the most deprived in Wales.

Cwm Taf University Health Board manages two district general hospitals, five community hospitals and a university health park.

Prince Charles Hospital

Prince Charles Hospital in Merthyr Tydfil has around 430 beds. The hospital provides acute emergency and elective medical and surgical services, Intensive Care and Coronary Care; consultant-led obstetrics services with Special Care Baby Unit and inpatient consultant-led paediatric medicine. There is also an Accident and Emergency unit and seven operating theatres at the hospital. The hospital also provides sub-regional oral and maxillo-facial services, a full range of locally provided and visiting specialist outpatient services and an extensive range of diagnostic services and facilities. The Radiology department is close to being filmless with digital images and reports available to clinicians across the site. Many of the health board's corporate and management offices are located on this site, along with staff residences.

Ward 1, Ward 2 and cardiology day unit

The coronary care unit (CCU) (Ward 1), cardiac day unit and the cardiology ward (Ward 2) are separated into three distinct areas. However, all are managed by the same ward manager. We were informed that there was some rotation of staff between the cardiology ward and CCU; a dedicated team working within the cardiac day unit. The same team of hotel services staff worked across each of the three areas.

The CCU had seven beds, all of which were arranged around a central nurse station. The unit also had one single patient room.

The cardiology ward had 24 beds. These were arranged in a series of 4 single gender bed bays and single rooms.

We found that patients are generally either admitted directly from the Accident and Emergency Unit or from the University Hospital Wales (UHW), Cardiff following periods of acute cardiac intervention. Similarly, there are occasions when patients are transferred from cardiology at Prince Charles Merthyr, to UHW.

The findings within this report will focus only on Ward 1- CCU and Ward 2 cardiology wards respectively.

4. Summary

Without exception, patients expressed a high level of satisfaction with the care and treatment they had received within the cardiology ward and CCU. Patients also very much appreciated the warm, caring and professional approach from the staff teams.

We saw that staff were professional, friendly and respectful in their manner, with all aspects of patient care being undertaken in a discreet and sensitive way. There was due care and attention given to providing care in accordance with the Fundamentals of Care. The ward environments were calm, well organised, clean and odour free on both days of our inspection.

Staff who spoke with us were open and honest in terms of the challenges they faced in providing safe, effective care to patients. We were also able to confirm that nurses and doctors took time to listen to patients and offered an explanation for tests and treatment in plain language to help them to understand.

It was evident that the staff teams were caring and compassionate. This is because we were provided with numerous positive comments from patients and relatives about the way in which they had been treated within the ward environments. We also observed many instances whereby staff demonstrated a warm, but professional attitude toward patients throughout our inspection.

We found that the ward teams placed an emphasis on encouraging patients to undertake aspects of care in accordance with their wishes and individual abilities.

The ward systems and culture in place ensured patients were assisted to maintain contact with their relatives and friends during their stay in hospital.

We saw that there were adequate amounts of pillows and blankets available and we observed staff asking if patients were comfortable. The wards were well stocked with linen and pillows. This meant that patients were able to access additional bedding for comfort when required.

Conversations with a number of patients indicated that they felt comfortable and pain free. However, we found that the cardiology ward team did not always produce a written record of their assessment of patients' discomfort prior to, or following, the administration of pain relief medication.

We found that people were helped as necessary to pay attention to their personal hygiene and appearance.

We found that sufficient attention was paid to the choice of food available to patients in the form of a varied menu. Patients told us that they thought the food was excellent both, in terms of presentation and taste. We also found that hotel services staff had taken time to know what patients liked to eat, and in what quantity.

We did not observe any issues of concern in relation to oral health and hygiene.

We found that staff approached this aspect of patient care (toilet needs) with sensitivity; always ensuring that peoples' dignity and privacy was maintained.

We were able to confirm that appropriate equipment and assessments were in place in order to reduce the risk of patients developing pressure sores. Referrals were made to specialist wound care services as and when required.

We found that management staff were visible within the ward environment. Conversations with members of the ward teams also confirmed that the ward manager and senior nurse were very supportive of them during their work. We found the staff teams adopted a collaborative and person centred approach toward the provision of safe and effective care to patients.

Staffing levels during the inspection appeared to be appropriate to patients' needs with minimal reliance on bank staff.

We saw evidence of good, effective multidisciplinary working and patients had access to a range of specialist services.

Staff required additional training in the use and application of The Mental Capacity Act and Deprivation of Liberty Safeguards legislation in order to meet the changing, complex needs of patients.

We found there were well established arrangements in place to ensure patients' care and treatment was delivered in a safe and timely manner. Suitable systems were also in place with regard to the reporting of clinical incidents and subsequent learning among the ward teams.

The ward environments were visibly very clean, properly maintained, safe and secure. Equipment was also found to be clean and safely stored within both wards on both days of our inspection.

Staff received appropriate information and training to ensure that patients in their care were safe.

Two areas for improvement were identified. These related to the need for the health board to strengthen arrangements in place for the recording of decisions about active resuscitation and prescribed oxygen therapy.

5. Findings

Quality of the Patient Experience

Without exception, patients expressed a high level of satisfaction with the care and treatment they had received within the cardiology ward and CCU. Patients also very much appreciated the warm, caring and professional approach from the staff teams.

During the course of this inspection, we distributed HIW questionnaires to patients and relatives in an attempt to obtain their views on the services provided within ward 2; patient's views on CCU being obtained through individual conversations as there were only eight patients receiving care and treatment in that area. In addition, a small number of visiting relatives were willing to speak with us over a two day period.

Thirteen questionnaires were actually completed during the inspection. Each person indicated they 'strongly agreed' or 'agreed' the ward was clean and tidy. Patients also provided us with their permission to include their additional comments about cleanliness within this report. For example:

"Cannot fault it. Excellent."

"Always cleaning."

We held conversations with most of the patients and a small number of relatives all of whom expressed their satisfaction with the care and service experienced to date. Some people also specifically indicated that all the staff on the ward provided kind and compassionate care. We did however find that a number of patients receiving care had difficulties with verbal communication associated with short term memory loss and dementia.

Patients and relatives who completed a HIW questionnaire offered additional views in relation to care received and the hospital staff as follows:

"Food is excellent."

"No complaints at all. Been very nice."

"It's been really good how flexible the ward has been with visiting and the staff are lovely."

"The hospital staff on the wards who have treated my (relative) are exceptional."

"The doctors and nursing staff have been outstanding."

Responses within 11 of the 13 completed HIW questionnaires about care received, resulted in a score between eight and 10, (0 representing poor care, 5 indicating that care was average and 10 representing excellent care). The remaining two people (relatives) offered an overall score of five and six respectively in relation to the overall provision of care.

All patients and relatives (who completed questionnaires or spoke with us) either 'agreed' or 'strongly agreed' that staff were kind and sensitive to them. Patients also provided us with numerous positive comments as to how they were cared for on a daily basis.

Each patient indicated that staff helped them to eat if they needed assistance.

Nine patients suggested that they always had access to a nurse buzzer, water, and had a choice in terms of their toilet/continence needs; the remaining four questionnaires having been completed by relatives. Similarly, all patients who spoke with us in the CCU were able to confirm that staff provided care in a way which met their needs, wishes and preferences.

We observed staff assisting a patient to eat their lunchtime meal in an unhurried manner. It was evident that the member of staff concerned was taking care to ensure that the patient had finished eating before offering further amounts of food. The member of staff was also observed speaking quietly to the patient throughout and was not distracted from this element of care at any stage. Conversations with patients, nursing staff and the ward 'hostess' revealed that there was an emphasis on ensuring that patients were encouraged to eat good food at regular times. We also saw that food was attractively presented and served in a prompt way to avoid meals getting cold.

We further found that special diets were provided to patients together with meals of different consistencies in accordance with individuals' ability to swallow.

Delivery of the Fundamentals of Care

We saw that staff were professional, friendly and respectful in their manner, with all aspects of patient care being undertaken in a discreet and sensitive way. There was due care and attention given to providing care in accordance with the Fundamentals of Care. The ward environments were calm, well organised, clean and odour free on both days of our inspection.

Communication and information

People must receive full information about their care in a language and manner sensitive to their needs

Staff who spoke with us were open and honest in terms of the challenges they faced in providing safe, effective care to patients. We were also able to confirm that nurses and doctors took time to listen to patients and offered an explanation for tests and treatment in plain language to help them to understand.

We found that patients' health, personal and social care needs had been assessed and were regularly reviewed through multi-professional ward rounds. We also found that the ward had a well established process in place for sharing patient information among staff at shift handover times. Conversations with a small number of patients revealed that they felt involved in their care.

The wards visited were not fitted with a hearing loop. Neither did the staff have access to a portable system. In addition, there were no large clocks in the areas occupied by patients in the cardiology ward and there were few pictorial signs in place. This meant that some elderly frail patients may experience some degree of disorientation. We were however told that aids to communication (for example-small whiteboards to write notes for patients) were available from the occupational therapy department so that staff could communicate with patients with hearing difficulties. Conversations with staff also confirmed that the ward had access to welsh speaking staff to support patients who chose to communicate in Welsh.

We found that the ward teams made appropriate referrals to a variety of professionals within the hospital where additional advice about patient care and treatment was required. In addition, staff provided patients with health promotion information and advice to help them make choices about adopting a healthy lifestyle.

Patients did tell us that nurses and doctors always explained the reason for undertaking blood tests and discussed treatment options with them in plain language to help them understand.

We saw that useful and up to date healthcare information was displayed within the corridors leading to the cardiology ward and CCU and patients had access to a wide variety of information leaflets, relevant to cardiac health needs. The information on display also included a poster which included details of how relatives could become involved in the discharge planning arrangements associated with their family member and colourful displays of 'who is who' within the ward teams.

We were provided with a copy of the patient and relatives information leaflet given to patients who are admitted to the CCU. This contained useful contact details and relevant information about the ward.

Discussions with the ward manager revealed the efforts made by staff (in both wards), to take time to listen and actively respond to patients and relatives. The ward manager specifically described a recent improvement to the service whereby additional staff had been employed to work from early evening for a period of five hours. This initiative had enabled registered nurses to spend time with patients and their families during evening visits in order to share information and enable them to raise any concerns they may have. Such discussions were then recorded on a separate relatives 24 hour communications log.

We looked at a sample of multidisciplinary notes in patients' records which confirmed that team communication worked well and was effective in ensuring that staff were kept up to date in relation to the care of each individual patient.

Respecting people

Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

It was evident that the staff teams were caring and compassionate. This is because we were provided with numerous positive comments from patients and relatives about the way in which they had been treated within the ward environments. We also observed many instances whereby staff demonstrated a warm, but professional attitude toward patients throughout our inspection.

We saw staff being polite, courteous and treating people respectfully when assisting them and providing treatment. Patients we spoke with also gave us

examples of how staff provided them with care and support in a discreet manner. They also told us that staff addressed them by their preferred name.

We saw a health care assistant calmly and kindly reassuring a patient who appeared to be distressed. We further observed a member of staff replacing the bedclothes over a patient to maintain their dignity.

A noticeboard in the corridor leading to the cardiology ward and CCU contained details of the health board's dignity pledge, so that patients and relatives were informed of what they could expect from the service.

Doctors and nurses involved in ward rounds were noted to speak with patients in hushed tones as a means of maintaining their privacy and confidentiality.

Staff protected the privacy and dignity of patients when providing assistance with personal care by closing curtains around bed areas and closing doors to toilets and shower/bathing areas.

Staff we spoke with were knowledgeable about their expected professional conduct and duties in relation to respecting people and giving people time to understand their treatment.

Promoting independence

The care provided must respect the person's choices in making the most of their ability and desire to care for themselves.

We found that the ward teams placed an emphasis on encouraging patients to undertake aspects of care in accordance with their wishes and individual abilities.

We saw mobility scores and moving and handling assessments in patient's notes. Staff also told us that they encouraged occupational health and physiotherapy colleagues to contribute to patients' care as far as possible to assist with maintaining and improving their level of independence.

Patients in the CCU told us that staff took time to help them do things for themselves as far as possible. Consideration of the content of patient records and conversations with staff working in the cardiology ward further revealed the use of 'This is Me[1]' documentation which helped staff to get to know patients'

[1] For someone with short term memory loss/dementia, changes can be unsettling or distressing. **This is me** documentation provides information about an individual which can help health and social care professionals build a better understanding of who the person really is.

personal preferences, likes and dislikes regarding the provision of daily care and support.

Patients were encouraged to sit in chairs by the side of the bed at various intervals when their conditions allowed. However there was no day room within the cardiology ward where they could independently spend time away from the ward environment. The CCU did have the benefit of a relatives' room. Conversations with staff indicated that patients were sometimes able to spend time in this area to simply relax or watch television as there were no televisions in the CCU.

Whilst there were no social activities available to patients in the acute care areas inspected, we were informed that patients in the cardiology ward were encouraged to mobilise in the area at the point when they were considered to be well enough to do that. We also saw that patients were able to purchase newspapers and magazines from the daily trolley provided by the voluntary service.

Relationships

People must be encouraged to maintain their involvement with their family and friends and develop relationships with others according to their wishes.

The ward systems and culture in place ensured patients were assisted to maintain contact with their relatives and friends during their stay in hospital.

The ward had structured daily visiting hours in place. These were 3:00pm-4:00pm and 6:30pm-8:00pm, although we were told that relatives could visit the ward outside of the usual visiting times if a specific need was identified. We were also made aware that the wards had access to a portable telephone handset so that patients were able to speak with relatives.

The ward manager told us, where necessary, patients could have their family members stay with them overnight in the relatives room situated just outside the CCU. This meant that the wards were flexible in ensuring people maintained relationships with their family and were able to receive the support they required from them, during their stay on the ward.

Rest, sleep and activity

Consideration is given to people's environment and comfort so that they may rest and sleep.

We saw that there were adequate amounts of pillows and blankets available and we observed staff asking if patients were comfortable. The wards were well stocked with linen and pillows. This meant that patients were able to access additional bedding for comfort when required.

There was a dedicated rest time during the day (between 2:00pm-3:00pm) and patients stated that staff were quiet and considerate which helped them to sleep well at night. During our two day inspection, both wards, although busy, were calm and conducive to rest.

Patients had access to televisions and radios within the bed bays and individual rooms within the cardiology ward. There were however no televisions or radios within the CCU in accordance with the stated approach to promoting a peaceful environment.

Ensuring comfort, alleviating pain

People must be helped to be as comfortable and pain free as their circumstances allow.

Conversations with a number of patients indicated that they felt comfortable and pain free. However, we found that the cardiology ward team did not always produce a written record of their assessment of patients' discomfort prior to, or following, the administration of pain relief medication.

Examination of a sample of patient records at this inspection demonstrated that the ward teams did not always produce a written record of their assessment of patients' discomfort prior to, or following, the administration of pain relief medication. We were therefore unable to find written records to confirm that such medication had been effective, or that it remained necessary.

Improvement needed

The health board is advised of the need to ensure that patients' level of discomfort, pain or distress is recorded by all staff. This is in order to provide effective and appropriate treatment/medication.

Personal hygiene, appearance and foot care

People must be supported to be as independent as possible in taking care of their personal hygiene, appearance and feet.

We found that people were helped as necessary to pay attention to their personal hygiene and appearance.

Patients told us they were encouraged to be as independent as possible with regard to washing and dressing. Staff did however provide assistance if required, especially within the CCU as stated. All patients appeared clean and well cared for and also told us that they were able to shower each day if they wished. In addition, a patient within the cardiology ward described how much she enjoyed having a regular bath with the support of staff. We saw, and patients confirmed, that they were encouraged to wear their own day or night clothes as they preferred.

Eating and drinking

People must be offered a choice of food and drink that meets their nutritional and personal requirements and provided with any assistance that they need to eat and drink.

We found that sufficient attention was paid to the choice of food available to patients in the form of a varied menu. Patients told us that they thought the food was excellent both, in terms of presentation and taste. We also found that hotel services staff had taken time to know what patients liked to eat, and in what quantity.

We found that patients benefitted from support at mealtimes to the provision of hot drinks and varied meals at regular intervals. Patients told us that they thought the quality and presentation of food was excellent. They also stated that they were offered a hot drink with, and in-between meals. In addition, we were able to confirm that patients with a diagnosis of diabetes were provided with appropriate meals and snacks during each 24 hour period. We further noted that food was prepared in a variety of consistencies for those patients who had identified difficulties with swallowing.

We observed staff assisting several patients to eat their lunchtime meal in an unhurried manner. In each case, the member of staff sat or stood alongside the patient concerned, taking care to ensure that they had finished eating before offering further amounts. We also saw that patients' food and fluid charts were kept up to date. This meant that the wards had an appropriate system in place to ensure that patients' nutritional intake was monitored in an effective manner.

However, we found that patients' water jugs were not usually refreshed more than once per day. This was not in-keeping with guidelines produced by the All-

Wales Catering and Nutrition Standards[2] (which suggests that patients' jugs are refreshed three times daily).

Improvement Needed

The health board is required to describe how it will ensure that it meets the All-Wales Catering and Nutrition Standards with regard to the provision of drinking water for patients.

Consideration of the content of a sample of patients' records confirmed that patients were assessed in terms of whether they were at risk of becoming malnourished. Discussions with staff also confirmed that information about patients who were at risk of weight loss was shared during staff handover sessions.

We found that patients were not routinely offered a bowl of water or moist hand wipes prior to eating their meals. Some people were able to access the sink in their ward area without assistance, but others were unable to do this.

Improvement needed

The health board is advised of the need to ensure that patients are offered the opportunity to wash their hands prior to eating their meals in accordance with their wishes and in-keeping with the Fundamentals of Care.

Observation of the lunchtime meal on the first day of our inspection demonstrated that patients were otherwise prepared for mealtimes. For example patients were assisted to sit in a comfortable upright position either in bed or in an armchair and their bedside tables were cleared and cleaned before the meal was served. We also saw that food and drinks were placed within easy reach of all patients.

The ward had established arrangements in place for 'protecting mealtimes'. This means that no ward rounds or other professional visits should take place in order to enable staff to support patients during those important times of the day. Staff did however acknowledge that there were times when mealtimes were interrupted by reviews of patients' medical presentation.

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[2] Link to All Wales nutritional standards.
http://wales.gov.uk/topics/health/publications/health/guidance/nutrition/?lang=en

Oral health and hygiene

People must be supported to maintain healthy, comfortable mouths and pain free teeth and gums, enabling them to eat well and prevent related problems.

We did not observe any issues of concern in relation to oral health and hygiene.

We were able to confirm that there was a good stock of toothbrushes, toothpaste and denture pots available for those who required them. This helped to ensure that patients' dignity was maintained and they were assisted to keep their mouth moist and clean in order to promote eating, drinking and communication.

Patients also told us that they were able to clean their teeth/dentures as regularly as they wanted to.

Toilet needs

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

We found that staff approached this aspect of patient care with sensitivity; always ensuring that peoples' dignity and privacy was maintained.

During the inspection we observed that patient commodes were visibly clean on both days of our inspection; each containing a label to indicate that the equipment was clean and ready for use. We also found all, but one toilet/shower/bathing area to be clean, fresh and appropriately equipped with soap, 'non-touch' paper towel dispensers and toilet paper on both days of the inspection. Specifically, one of the two shower/toilet areas assigned to the CCU was out of use because of identified problems with drainage from the shower unit which gave rise to an unpleasant odour. The ward manager told us that the matter was being addressed by estates staff. However, in the interim, there was only one shower available to each of the eight male/female patients receiving care in the CCU which may compromise patients' wishes and preferences.

Toilets were found to have signs on each door to assist patients in identifying the facilities. In addition, we did not observe any approaches to the provision of care and support which compromised the dignity of patients.

Conversations with patients indicated that staff always approached this aspect of their care with sensitivity. They also told us that they generally obtain a prompt response from staff when they request assistance to access toilet

facilities during the day or night and they were offered a choice in the use of the toilet method they preferred.

However we found that patients in the CCU were not provided with a nurse call bell. We discussed this matter with ward staff and the ward manager and were informed that call bells were not in use as they created such a loud noise that patients would be disturbed when they were resting, especially at night. We were assured that staff were always present at the central nurse station in the CCU to respond to verbal requests for assistance. However, we advised that it may be helpful to patients to pursue the option of having a light as a call bell indicator, as opposed to a loud sound. Access to a call bell would also contribute toward patients' independence and it would prevent their need to call out when they wished to request assistance.

Preventing pressure sores

People must be helped to look after their skin and every effort made to prevent them developing pressure sores.

We were able to confirm that appropriate equipment and assessments were in place in order to reduce the risk of patients developing pressure sores. Referrals were made to specialist wound care services as and when required.

The ward had the use of a variety of pressure relieving mattresses to reduce the risk of patients developing pressure sores. The monitoring records we saw indicated staff regularly checked patients' skin for signs of pressure damage. This meant that recording systems and equipment were in place to try to prevent patients from developing pressure sores.

We saw that the All Wales Pressure Ulcer SKIN bundle was in use[3]. We were told that appropriate referrals were made to the tissue viability services if needed for further specialist input.

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[3] **SKIN bundles** requires documented nursing intervention at least every two hours in the following areas to reduce likelihood of damage; **S**urface – ensure patient is on the right mattress, cushion, there are no creases or wrinkles, **K**eep moving- encourage self movement, reposition patient and inspect skin, **I**ncontinence- meet patient's toileting or continence need, **N**utrition – keep well hydrated, meet patient's nutritional needs.

Quality of Staffing, Management and Leadership

We found that management staff were visible within the ward environment. Conversations with members of the ward teams also confirmed that the ward manager and senior nurse were very supportive of them during their work. We found the staff teams adopted a collaborative and person centred approach toward the provision of safe and effective care to patients.

Staffing levels during the inspection appeared to be appropriate to patients' needs with minimal reliance on bank staff.

We saw evidence of good, effective multidisciplinary working and patients had access to a range of specialist services.

Staff required additional training in the use and application of The Mental Capacity Act and Deprivation of Liberty Safeguards legislation in order to meet the changing, complex needs of patients.

Staffing levels and skill mix and professional accountability

At the time of our inspection, the CCU and cardiology wards respectively, were managed by an experienced ward manager who was well supported by a senior nurse and teams of confident and motivated staff. We also found that the wards offered placements to student nurses; one student having returned to the cardiology ward for a second time having had such a positive experience there in the past. The wards visited also benefitted from healthcare support workers and dedicated ancillary/housekeeping staff.

Conversations with staff revealed that they felt very well supported during their work and were provided with regular and appropriate training opportunities. At the time of our inspection two additional healthcare support workers (HCSWs) had been requested to work in the cardiology ward as a small number of patients required support and supervision to maintain their safety. This short term increase of HCSWs demonstrated that staffing levels were altered in direct response to the identified complex, changing needs of patients. We found staffing levels and skill mix to be appropriate to the needs of the patients during our inspection; staff being easily located in areas occupied by patients during the two days of our inspection.

We found that the wards were using some bank staff on a regular basis. This was due to the small number of vacancies that existed regarding registered nurses. Discussion with the ward manager however indicated that she had recently gained agreement to recruit additional registered nurses within the

cardiology ward and CCU. The use of bank staff would therefore diminish further in the near future.

We found the ward manager and senior nurse to be visible on the ward and staff confirmed that they provided support and direction to the staff teams on a daily basis. We found that the staff teams on both wards worked well together, and as a whole. Conversations with a number of staff demonstrated that they made every effort to provide care to patients in accordance with their wishes and preferences. It was also evident that they supported each other to meet the care needs of patients.

The ward manager worked purely on a supernumerary basis which assisted her to lead the service on a day to day basis as well as enabling her to devise and implement ways of making on-going improvements to patient care.

Effective systems for the organisation of clinical care

We found that the needs of patients admitted to the cardiology ward and CCU in recent years had changed significantly. Specifically, the cardiology ward admitted patients with a broad range of medical conditions, requiring careful management and a coordinated multi-disciplinary team approach. Similarly, patients admitted to the CCU from the University Hospital of Wales tertiary cardiac centre following treatment for acute episodes of ill-health. Conversation with staff did indicate that there were occasions when patient transfers to other areas of care (at the point when their general health and well-being had improved), was delayed.

We observed that the team lead and embraced service change; maintaining close links with the tertiary (cardiac) service provided at the University Hospital of Wales, Cardiff. A large proportion of patients now receive early treatment at Cardiff and are then repatriated to ward one and ward two at Prince Charles Hospital for the next stage of their care and treatment. We were also made aware of how the team at Prince Charles were developing new local services for the local population (for example, developing an outreach service to assist increasing numbers of patients with long term heart failure to maintain their independence in the community and reduce the need for them to be admitted to hospital).

There were three Consultants linked to the ward and we observed good communication between the medical staff and nursing staff and other members of the multidisciplinary team. For example, patients' medical, social care and psychological needs were assessed three times a week through consultant led 'board rounds' which involved nursing and pharmacy staff. Such rounds led to referrals to other health and social care professionals in accordance with

patients' changing needs and assisted with discharge planning arrangements. In addition, the ward manager held daily morning meetings with physiotherapy and occupational health staff where patients' progress and needs were discussed. Staff we spoke with also had up to date knowledge of the people they were caring for and patients' care plans had been updated when there was a change to their care and treatment.

Training and development

Staff told us they were supported to access mandatory training and the staff we spoke with were knowledgeable about their clinical roles and responsibilities. We were told about a new initiative in development at the moment which would result in patients' receiving specific care and intravenous treatment in their own homes. The description of the proposed service clearly demonstrated how staff were being supported to develop innovative ways of reducing patients' admission to hospital.

We were also provided with an example of how the managerial skills of some registered nurses were being developed to prepare them for more senior NHS roles in the future.

The ward manager provided us with information about the in-service training programme for staff who worked in the CCU. She also told us that bank staff who worked within the cardiology ward were always encouraged to attend any mandatory training being offered to permanent members of the staff team. In addition, the ward manager was able to provide us with evidence of the range of e-learning training and taught courses available to staff.

We were informed that two members of staff were about to begin a training course on the specific topic of dementia care. However, none of the staff had been provided with training on delirium and confusion. We also found that there were a number of elderly frail patients receiving care and support who were unable to make decisions about their on-going care and treatment due to varying degrees of cognitive impairment and difficulties with their short term memory.

Discussions with the ward manager and senior nurse revealed the additional measures that had been put in place to ensure the safety of those individuals and where possible, relatives were encouraged to actively participate in decisions about their family member's care. The ward manager and senior nurse were however reminded of the need to adopt the use of the Mental

Capacity Act and Deprivation of Liberty Safeguards[4] legislation respectively, to ensure that such patients were protected even further, as required. Prompt action was taken in this regard on the first day of our inspection.

Improvement needed

The health board is advised of the need to demonstrate how it will ensure that staff are competent and confident in the future application of current legislation associated with the Mental Capacity Act and Deprivation of Liberty Safeguards. This is to ensure that patients are not unlawfully deprived of their liberty.

Handling of complaints and concerns

We held discussions with the ward sister and senior nurse and found that patients and their relatives were encouraged to discuss care and treatment with ward staff through daily face to face contact. A number of patients also told us they felt able to raise concerns with staff if they were worried about any aspect of their care.

We were told that there had been a small number of complaints made at ward level in the past two years. The senior nurse offered a very good description of how various issues had been dealt with and it was evident that lessons had been learnt from each complaint.

The culture evident in the ward areas

Conversations with staff revealed that they had enough time to provide patients with the care and support they needed. Staff told us that regular staff meetings were held where they were able to share ideas and offer their views about the service provided. We were also informed that they felt able to freely raise any concerns they may have with the ward manager or senior nurse.

Sickness levels and staff turnover within the two wards was reported as being low. This assisted with adopting a consistent approach to the delivery of patient care.

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[4] When a person lacks the mental capacity to make decisions about the care or treatment they need, legislation called The Deprivation of Liberty Safeguards (DoLS) has to be followed to ensure that people are not unlawfully deprived of their liberty.

Delivery of a Safe and Effective Service

People's health, safety and welfare must be actively promoted and protected. Risks must be identified, monitored and where possible, reduced or prevented.

We found there were well established arrangements in place to ensure patients' care and treatment was delivered in a safe and timely manner. Suitable systems were also in place with regard to the reporting of clinical incidents and subsequent learning among the ward teams.

The ward environments were visibly very clean, properly maintained, safe and secure. Equipment was also found to be clean and safely stored within both wards on both days of our inspection.

Staff received appropriate information and training to ensure that patients in their care were safe.

Two areas for improvement were identified. These related to the need for the health board to strengthen arrangements in place for the recording of decisions about active resuscitation and prescribed oxygen therapy.

Risk management

Examination of a sample of patients' records within ward one and ward two indicated that risk assessments were undertaken, monitored and evaluated regularly. These were in relation to patients' ability to eat and drink, falls, mobility, continence care and pressure ulcers.

Senior staff also confirmed clinical incidents were reported via the health board's electronic reporting system and provided us with a description of that process. We also found that there were suitable arrangements in place for the timely investigation of such incidents.

Policies, procedures and clinical guidelines

We held discussions with the ward sister and staff. As a result, it was evident that they were able to obtain a range of guidelines and policies which supported aspects of their patient activity (via the ward computer).

Procedures were in place in respect of safeguarding vulnerable adults. Conversations with members of the ward teams confirmed their understanding of the process. Staff were also aware of the named person in the health board responsible for coordinating the safeguarding process.

We saw that patient records contained information with regard to 'do not attempt to cardio-pulmonary resuscitation' (DNACPR) where appropriate. However, we also saw that decisions were not always fully documented; discussions having been held with patients/relatives. Conversations with medical and nursing staff also highlighted the need for training in this respect.

Improvement needed

The health board is required to demonstrate how it will ensure that all staff are competent and confident in the use of the process for recording decisions associated with DNACPR.

Effective systems for audit and clinical effectiveness

We held a discussion with the ward manager and senior nurse in relation to clinical audits and found that there were well established systems and processes in place to check aspects of the quality of patient care. Specifically, we saw that checks were being undertaken regularly regarding pressure sores and infection prevention and control. The results of audits and any changes to practice within the wards were shared with staff on an ongoing basis and specifically at regular staff meetings. This meant staff were aware of the overall performance of their ward and engaged in learning with a view to making further improvements to patient care.

However, at the time of our inspection, there was no visual display of the results of completed audits in the form of safety crosses[5]. These would ensure the staff teams were able to see, via a simple system, the incidence of relevant clinical incidents such as pressure sores, falls and infections with the intention of taking timely action to prevent re-occurrence.

Patient safety

We found the closing and locking device on the doors leading to the wards ensured that patients were safe from access by unauthorised persons.

All areas of the wards were visibly very clean and free from trip hazards throughout our two days of inspection.

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[5] The Safety Cross has been adapted from industry to make highly visible the incidence of avoidable adverse events. In doing so it ensures that the whole team is aware of avoidable events and thus instils a sense of purpose in working to avoid future events.

We observed that individual patients were discussed at handover and information recorded on a board (held in a locked room to ensure that patient confidentiality was maintained).

Medicines management

Ward routine and approach

We considered the approach to medicines management in the CCU during our inspection and found that staff had access to the health board's policy for the safe storage, prescription, administration and dispensing of drugs.

We observed a medication administration 'round' in that same area during this inspection. As a result, we found that staff adopted correct practice in accordance with the existing hospital policy and Nursing and Midwifery Council guidelines. Specifically, we found that staff completed required checks around the medication prescribed and that which was written on individual medication administration records. They also checked patients' identity by asking them to confirm their name; information given being checked with patient identity bracelets.

We were told that the CCU had a dedicated pharmacist who worked well with the ward team. We were also told that the pharmacist would assist those patients to understand the health board's policy for self administration of medication if a person requested to do this whilst in hospital.

Hypo boxes[6] were available to staff in the CCU for patient use.

Our observations and conversations with staff however indicated that prescribed oxygen was noted within nurse documentation, but not recorded on the All Wales Drugs chart.

Improvement needed

The health board is advised of the need to ensure that all prescribed medication is recorded on the All Wales Drugs chart. This includes the administration of prescribed oxygen therapy.

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[6] A "hypo box" provides staff with all the relevant equipment to treat a diabetic emergency as well as guidelines for the effective management of that emergency.

Storage of drugs

We saw that medication was stored in a locked cupboard or fridge; the exception being patient's current medication in the CCU which was stored in lockable areas at the patients' bedside.

We did not observe that any medication had been left unattended during the inspection.

Controlled drugs were stored appropriately. We did not observe any such medication being administered, however we did scrutinise relevant documentation in this regard and found that required security checks were in place.

Preparation of patients

We observed that patients had a drink within easy reach at times when medication was to be administered and where needed, people had been assisted to sit in an upright position beforehand.

Documentation

Patient Records

We looked in detail at five patients' care plans, nursing notes (and medical notes) in total across the two wards and found the recording of care, treatment and support to be of a very good standard. We also saw that plans of patient care had been regularly evaluated and updated where appropriate. We further found that the wards used the National Early Warning System (NEWS) charts and found that staff responded appropriately to changes in patient acuity (level of needs).

Overall, nursing and medical notes were observed to be legible, with entries signed, dated and the time of entry included, which assisted the ward teams to provide appropriate on-going support to patients.

Two of the five records seen related to patients who had a diagnosis of diabetes. Exploration of the content of those records confirmed that the patients' diabetic needs were being managed appropriately. Diabetes nursing care plans were in place in order to assess needs and manage the patients' condition. Staff also told us that appropriate referrals were made, where needed, to the dietician, podiatry and diabetic specialist nurse for additional advice.

The ward had access to a diabetic link nurse who acted as a local point of contact and shared best practice about diabetes care. Staff confirmed they had

received training on diabetes management which was regularly updated and 'Think Glucose'[7] charts were in place.

[7] Think Glucose' is a national initiative led by the NHS Institute for Innovation and Improvement. It aims to improve inpatient diabetes care including effective use of the inpatient diabetes specialist team

6. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit their improvement plan to HIW within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified within Ward 1 and Ward 2 (as defined within the report) at Prince Charles Hospital will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/ units of the health board.

The health board's improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing dignity and essential care inspection process.

Appendix A

Dignity and Essential Care: Improvement Plan

Hospital: Prince Charles Hospital-Merthyr

Ward/ Department: Ward 1(cardiology) and Ward 2 (CCU)

Date of Inspection: 11 and 12 March 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
	There were no areas for improvement identified with regard to this aspect of care.			
	Delivery of the Fundamentals of Care			
Page 13	The health board is advised of the need to ensure that patients' level of discomfort, pain or distress is recorded by all staff. This is in order to provide effective and appropriate treatment/medication.			
Page 15	The health board is required to describe how it will ensure that it meets the All-Wales			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Catering and Nutrition Standards with regard to the provision of drinking water for patients.			
Page 15	The health board is advised of the need to ensure that patients are offered the opportunity to wash their hands prior to eating their meals in accordance with their wishes and in-keeping with the Fundamentals of Care.			
	Quality of Staffing Management and Leadership			
Page 21	The health board is advised of the need to demonstrate how it will ensure that staff are competent and confident in the future application of current legislation associated with the Mental Capacity Act and Deprivation of Liberty Safeguards. This is to ensure that patients are not unlawfully deprived of their liberty.			
	Delivery of a Safe and Effective Service			
Page 23	The health board is required to demonstrate how it will ensure that all staff are competent and confident in the use of the process for recording decisions associated with			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	DNACPR.			
Page 24	The health board is advised of the need to ensure that all prescribed medication is recorded on the All Wales Drugs chart. This includes the administration of prescribed oxygen therapy.			

Health Board Representative:

Name (print): .....

Title: .....

Date: .....