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,

Ward 8

9 & 10 October 2014

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Digital ISBN 978-1-4734-2700-6

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care Inspection in Ward 8 at Prince Charles Hospital, part of Cwm Taf University Health Board on the 9 and 10 October 2014.

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
- Completed HIW patient questionnaires
- 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 area 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 the 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 currently manages two district general hospitals, five community hospitals and a state of the art university health park.

Prince Charles Hospital in Merthyr Tydfil has around 430 beds, and provides acute emergency and elective medical and surgical services, intensive care and coronary care services. The hospital also provides consultant-led obstetric services which include a special care baby unit, in-patient consultant paediatric medicine and accident and emergency services. There are seven operating theatres, a full range of outpatient services and diagnostic facilities. In addition, state of the art facilities are provided within the X-ray department and the hospital is close to being able to provide clinicians with digital images and reports across the site (instead of former x-ray images).

Ward 8 at Prince Charles Hospital has 24 patient beds which are divided to provide a mixture of 4-bedded bays and cubicles; the nurse and ward clerk station occupying an area at the entrance of the ward. The ward accepts female patients only who require care and treatment in relation to a variety of surgical specialties (including gynaecology) and gastroenterology/acute medicine. There are however also occasions when patients with other health care conditions (associated with trauma and orthopaedic services) are admitted to the ward. Patient ages generally range from 17 years to 65 and above.

Ward 8 is closely linked with another ward in the hospital (otherwise known as a buddy arrangement). This is with the intention of managing the admission and flow of patients with defined medical staff working with the established ward teams. This arrangement is intended to reduce the number of medical teams who need to work with the two respective wards, to ensure that communication between all professionals involved in patients' care is as effective as possible.

4. Summary

Overall, we found that the ward team placed an emphasis on ensuring that patients' choices and wishes were considered when providing care, treatment and support. Patients also provided us with very positive comments about the care they had received.

We also gathered evidence in support of the following:

- We found that patients received information about their care in a language and manner sensitive to their needs
- Patients were able to rest at various times during the day
- A number of people who spoke with us said that they were supported by the ward staff to pay attention to their personal hygiene and appearance
- Patients were offered a choice of food and drink which met their personal requirements
- We found that staff provided patients with prompt and discreet assistance to get to, or use the toilet
- Patients were assessed for risk of pressure sores and if considered at risk, they received further and on-going assessment from a registered nurse
- Patients could be confident that due care and attention was paid to the provision of care and treatment in accordance with current health care standards
- Patients was supported by suitable management systems and processes as a means of ensuring their health, safety and welfare

We also identified a number of areas for improvement. These included:

- The health board is advised of the need to demonstrate how patients' confidentiality and privacy is to be respected in the hospital ward
- The health board is advised of the need to ensure that ward staff have access to a sufficient supply of pillows to ensure patients' comfort

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

- The health board is advised of the need to ensure that patients' fluid intake is recorded in an accurate and timely way in order that any deterioration in frail, vulnerable people can be promptly identified

- The health board is required to demonstrate how it will ensure that medical staff comply with Standards for Health Services in Wales[1] regarding the need for effective, appropriate and timely communication and information sharing with ward based staff

- The health board is advised of the need to improve the arrangements in place to ensure the safe and timely prescription and administration of drugs

Details of the remaining identified areas of improvement can be seen within Appendix A of this inspection report (page 28)

[1] Standards for Health Services in Wales 'Doing Well, Doing Better' (April 2010) relates to a framework of standards to support the National Health Service in Wales.

5. Findings

Quality of the Patient Experience

Overall, we found that the ward team placed an emphasis on ensuring that patients' choices and wishes were considered when providing care, treatment and support. Patients also provided us with very positive comments about the care they had received.

During the course of this inspection we distributed 14 (HIW) questionnaires to patients and relatives in an attempt to obtain their views on the services provided within Ward 8. 10 questionnaires were completed on day one of our visit by people ranging in age from 25 – 88yrs who had been on the ward for different lengths of time. One questionnaire was returned to HIW several days after the inspection by a patient's relative. We also observed the care and treatment being provided to help us understand the patient experience and found that staff were kind, compassionate and professional throughout the two days of our inspection. People gave us permission to include their additional comments within this report some of which are found below.

Of the 11 people who completed questionnaires, ten stated that they 'agreed' or 'strongly agreed' that the ward was clean and tidy (one patient did not comment on this aspect of care). We also saw that the ward was clean, fresh and free from hazards. This meant that patients were being cared for in a clean, safe environment.

75 per cent of patients who completed HIW questionnaires rated the care they had received as 'excellent'. Each person who responded also made positive comments about the way staff treated them, in particular, but not limited to, the nursing staff. For example:

'(they) help with anything needed'

'all the staff have been amazing and so kind'

'the nurses make you feel welcome'

'all the nursing staff are caring'

'the nurses are really lovely and helpful and respect you when helping you'

And

'family had rung up and staff were very nice and informative on the phone'

We observed that staff ensured patients' privacy and dignity when providing care. This is because we saw 'care in progress' signs were in use at times when patients were receiving care and treatment. We found that staff responded to call buzzers promptly and patient questionnaires indicated that staff assisted patients with their toilet needs in a sensitive way.

One patient who spoke with us indicated that they didn't feel they had been provided with enough information about their condition or treatment. Specifically, the person had received conflicting information from two doctors which meant that the physiotherapist did not have a clear written guide about how to manage certain aspects of the patient's needs. We brought this to the attention of ward staff as a result of which appropriate action was taken. The need for effective communication between medical staff, patients and other professionals involved in the delivery of health care services is highlighted further within this report on page 17 as it was an area identified for improvement.

Completed HIW questionnaires indicated that patients had access to water and were able to eat their food at their own pace. We were able to confirm these arrangements. In addition, we held conversations with a number of patients and were told that they had a wide choice of food. We also saw that the food menu catered for patients with identified/special dietary needs (for example - soft foods and diabetic options). We observed however that meal times were not always 'protected'[2] because medical staff visited the ward to review patients when meals were being served on one of the two days of this inspection. This meant that patients were not able to eat their meals undisturbed and the temperature of food which had been served would not be maintained.

We saw some patients choosing to help other patients prepare to eat and drink by putting their bedside tables in place**.** We also observed staff assisting patients to eat and drink by cutting up food and providing encouragement to complete their meals. This meant that people received the assistance they required in order to eat and drink.

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[2] Protected mealtimes. This is a period of time over lunch and evening meals, when all activities on a hospital ward are meant to stop. This arrangement is put in place so that nurses and housekeepers are available to help serve the food and give assistance to patients who need help.

A further sample of comments that patients gave us their permission to include in this report is shown below:

'(I) would like morning visiting times'

'kept awake by another patient all night'

'staff are very busy…I'm glad they've got the staff'

'very comfortable…has all the equipment needed'

'staff are very accommodating with friends and family...when they first washed (my) hair after ITU, made (me) feel so much better'

Delivery of the Fundamentals of Care

We found that patients received information about their care in a language and manner sensitive to their needs.

Communication and information

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

Overall, we found that the ward team made every effort to provide care and support to patients in accordance with their individual needs, wishes and preferences.

We held discussions with three registered nurses. Such discussions revealed that staff made every effort to update relatives with information about their family members and they listened to what relatives had to say; responding to any concerns raised.

We were told that the ward did not have a loop system to help patients with hearing difficulties; staff relying sometimes on the use of written information so that patients were enabled to understand aspects of their care. We also found that the ward team were able to obtain the help of translators to provide patients and their families with clear information to make informed choices, as and when the need was identified.

We spoke with the ward manager and senior nurse to determine how staff were guided to communicate with patients who had been diagnosed with dementia, or presented with symptoms associated with dementia. As a result, we were provided with a booklet called ‘Caring For the Confused Person in Hospital’ which aimed to provide ward staff with an overview of key aspects of care when assisting such patients.

We were also informed that the hospital patient experience team visited the ward every month to speak with 10 patients. The survey they completed each time was based on the Fundamentals of Care which included a focus on communication and the provision of information, which form an important part of patients’ care.

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.

We found that staff addressed patients by their preferred name

We observed staff speaking with and helping people over a two day period and found that they treated patients and their families with kindness, respect and politeness. Patients and relatives also confirmed that staff, (through questionnaire responses and face to face conversations) were attentive and caring. However, some staff told us that there had been a small number of occasions recently when patients had not been spoken to in a courteous way by members of the ward team.

Recommendation

The health board is advised of the need to demonstrate how they will ensure that people are treated with respect and courtesy at all times.

In addition, we overheard a conversation being held between a member of the medical staff and a patient during a ward round. The questions being asked of the patient were of an intimate nature and were conveyed in loud tones which meant that what was being said could be easily heard over and above the sound of the television in the area. This matter was brought to the attention of the ward manager as the patient's dignity and privacy were undermined.

Recommendation

The health board is advised of the need to demonstrate how patients' confidentiality and privacy is to be respected in the hospital ward.

We did however see that there were signs in place to inform others that care or treatment was taking place behind closed curtains or in individual cubicles. Discussions held with staff also revealed that patients' diverse needs (social and cultural) were identified from the point of admission to the ward in order to help staff accommodate their preferences and wishes.

We were informed that the ward only accepted female patients which eliminated the need for toilet/bathing areas to be segregated in any way.

Promoting independence

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

The above aspect of the fundamentals of care was not explored at this inspection.

Relationships

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

The above aspect of the fundamentals of care was not explored at this inspection.

Rest, sleep and activity

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

We found that patients were able to rest at various times during the day.

We saw that patients were helped to return to bed having sat in an armchair for periods throughout the day. Other patients were able to do this independently.

We found that noise was minimised as staff completed their work in hushed tones and the sound of the television was reduced at times when some patients wished to rest.

However, we held conversations with ward staff and were informed that there had been a number of occasions when the ward had not been able to obtain a sufficient stock of pillows to ensure patients' comfort.

Recommendation

The health board is advised of the need to ensure that ward staff have access to a sufficient supply of pillows to ensure patients' comfort.

Ensuring comfort, alleviating pain

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

Overall, we found that patients were being helped to cope with pain and discomfort.

Examination of a sample of five patient records demonstrated that the ward team had recorded recent pain scores for two patients who were receiving prescribed medication for pain relief. The records of three patients however provided little or no evidence of their current level of pain, although they were also receiving medication for pain relief.

We found that there was little evidence of the assessment of patients' level of pain after prescribed pain relief medication had been administered. We were therefore unable to find any written evidence to confirm that such medication had been effective, or that it remained necessary. We held a discussion with the ward manager about this issue and were informed that the ward team was working towards achieving the Improving Quality Together [3]silver award as a means of making improvements to the management of peoples' pain; having recognised that this was an aspect of care that needed to be more efficient. This work links with the 1000 lives[4] campaign.

Recommendation

The health board is advised of the need to ensure that patient's level of discomfort, pain or distress is regularly assessed and recorded. This is in order to provide effective and appropriate treatment/medication.

A small number of other patients told us that nursing staff had provided them with medication for pain relief on request.

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.

A number of people who spoke with us said that they were supported by the ward staff to pay attention to their personal hygiene and appearance.

Patient's needs were generally discussed and assistance given with their personal hygiene and appearance where appropriate. This is because we found that patients were able to have a shower or were assisted to wash at the

[3] Improving Quality Together is the national quality improvement learning programme for all NHS Wales' staff and contractors, which builds upon recognised local, national and international expertise. http://www.iqt.wales.nhs.uk/silver

[4] The 1000 Lives Campaign ran from April 2008 - April 2010. It aimed to save 1000 lives and prevent 50,000 episodes of harm in Welsh healthcare. The Campaign was succeeded by a national programme called 1000 Lives Plus in May 2010, which sought to maintain the Campaign's progress and introduce new areas of work. http://www.1000livesplus.wales.nhs.uk/1000-lives-campaign

bedside in accordance with their preferences. We also held conversations with a small number of patients and were informed that they had been offered the opportunity to wear their own daytime clothing as opposed to nightwear.

We found that staff who assisted people with personal care were discreet at all times and all patients appeared to be well cared for.

We saw that the linen cupboard was stocked with dignity gowns.

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.

Patients were offered a choice of food and drink which met their personal requirements.

We held discussions with ward staff and were told that people were encouraged to eat and drink at regular times of the day. We were also told that snacks were available for patients on request and the ward menu changed every six months.

We observed a lunchtime meal being served to patients and saw that food was offered to people in a prompt, but unhurried way. We also saw a member of staff assisting a patient to eat and drink; giving the person plenty of time to swallow prior to offering them more food.

We did not find any visible/anonymised information within the ward which may help staff to easily identify which patients needed assistance at mealtimes. We therefore spoke with members of the staff team and were told that this type of information was shared in detail during shift handover times.

Examination of five patient records showed that fluid intake charts were not completed to demonstrate the amounts of fluid offered and finished by patients who were considered to be vulnerable/at risk. We held discussions with ward staff who indicated that fluid charts were not always completed in a timely way.

Recommendation

The health board is advised of the need to ensure that patients' fluid intake is recorded in an accurate and timely way in order that any deterioration in frail, vulnerable people can be promptly identified.

We also found that a small number of patient records which should have contained all-Wales food charts (so that staff could monitor how much they

were eating) did not provide evidence of this information. This matter was brought to the attention of the ward manager and senior nurse; charts having been added to patient records by day two of the HIW inspection.

Conversation with the ward manager revealed that the ward team was to focus on patient's nutritional needs and staff handover arrangements as part of their forthcoming work toward achieving the Improving Quality Together [5]silver award.

During the two days of our inspection, we saw that patients' food and drink was placed within easy reach.

We held discussions with the ward manager and other senior nursing staff and were informed that the health board was about to formally launch a campaign called 'Drink a Drop'. This was introduced to every clinical area earlier in 2014 following the publication of National Health Service (NHS) hospital patient safety information which highlighted that dehydration had the potential to cause unnecessary harm to patients. The campaign requires all health care staff to encourage a patient to drink a small amount of water every time they see them; water being a basic nutrient essential for good health.

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 found that patients were supported to maintain healthy, comfortable mouths.

We saw that patients were encouraged to clean their teeth, being provided with the right equipment and fresh water to do this. We also found that a number of patient's records contained an assessment and care plan regarding mouth care, with action being taken to help them to keep their mouth clean and moist.

[5] Improving Quality Together is the national quality improvement learning programme for all NHS Wales' staff and contractors, which builds upon recognised local, national and international expertise. http://www.iqt.wales.nhs.uk/silver

Toilet needs

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

Overall, we found that staff provided patients with prompt and discreet assistance to get to or use the toilet.

Patients told us that staff responded to their buzzer calls to use the toilet in a timely way. They also told us that they were offered a choice in the use of the toilet method they prefer (toilet, bedpan or commode).

We saw that all facilities were clean and equipped with toilet paper, a liquid soap dispenser and non-touch towel dispenser.

We held discussions with staff to determine how they assessed patients' toilet requirements and found that appropriate referrals were made to specialist nurses for advice in direct response to peoples' identified needs.

We did not see any patients being helped to the toilet during mealtimes. Conversations we held with staff revealed that it was difficult on occasions to respond to patient requests at these specific times due to the number of patients who require support and assistance to eat their meals. Patients who spoke with us at this inspection however did not indicate that they had any concerns about this aspect of their care and support.

Preventing pressure sores

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

We found that patients were assessed for risk of pressure sores and if considered at risk, they received further and on-going assessment from a registered nurse.

Scrutiny of a sample of five patient records revealed that the ward staff used a recognised assessment tool as a means of identifying those patients who were at risk of developing pressure sores.

We also found records which demonstrated that patients were assisted to change position in bed on a regular basis where needed; otherwise known as intentional rounding. In addition, time spent by patients sitting in an armchair was limited to help reduce the risk of sores developing, as stated by ward staff.

We held discussions with staff and were able to determine that patients' skin was checked at least once daily when a person was found to be at risk of developing pressure sores. Staff also told us that they were able to obtain pressure relieving mattresses for patients as and when required.

We saw evidence that initiatives/targets were in place to reduce the amount of pressure sores on the ward. Information about the incidence of pressure sores was also available for members of the public to see on the wall at the entrance of the ward.

Quality of Staffing, Management and Leadership

Overall, patients can be confident that due care and attention is paid to the provision of care and treatment in accordance with current health care standards.

Staffing levels and skill mix and professional accountability

We held several conversations with the ward manager and two senior nurses and found that efforts had been made to ensure that the number of patients looked after by registered nurses conformed to the Chief Nursing Officer (CNO) Principles. The ward had however experienced a significant increase in staff sickness/absence levels in recent months which had resulted in the allocation of bank registered nurses and agency nurses to help the permanent members of the ward team to care for patients. We were informed that work was currently underway in an attempt to resolve the sickness/absence issue.

Staff we spoke to over a period of two days told us that there had been occasions recently when each registered nurse had needed to provide care and support to eight patients during the day (instead of seven patients, as defined within the CNO guidelines for acute medical and surgical wards). In addition, we found that the ward manager had been unable to work on a supernumerary basis for more than 25 per cent of the time, as opposed to 50 per cent in accordance with agreed health board guidelines. This meant that she was unable to devote as much time as was required to manage and lead the ward team.

Registered nurses did tell us however that the ward team had recently benefitted from an additional Health Care Support Worker (HCSW) as the senior nurse had responded positively to a request for more staff to meet patients' needs within the ward.

Discussions with the ward manager and senior nurses indicated that there were occasions when staff from the established ward team were required to provide support to two hospital clinics (associated with gynaecology services) at times of annual leave or absence on the part of staff usually employed in those areas. We were however assured that ward 8 staff levels were not compromised on such occasions.

Further discussions we held with senior nurses revealed some detail of the work which had recently been completed to try and accurately define the number of registered nurses needed to provide good care in response to patients' complex changing needs within hospital wards. We were also

informed that the result of that work was going to be made available to the health board as a means of demonstrating the need for additional registered nurses.

Effective systems for the organisation of clinical care

We found that ward 8 was closely linked with another ward in the hospital (otherwise known as a buddy arrangement). This was with the intention of managing the admission and flow of patients, with defined medical staff working with the established ward teams to provide care and treatment. This arrangement was intended to reduce the number of medical teams who needed to work with the two respective ward teams to ensure that communication between all professionals involved in patients' care was as effective as possible. However, despite this arrangement, we saw that there were patients being cared for within ward 8 as opposed to wards that provided trauma and orthopaedic services. That meant there would be a need for an additional medical team to visit the ward.

We therefore held discussions with registered nurses about the care and support they usually provided to patients within the ward and discovered that there were often occasions when they were required to care for patients whose needs did not correspond with the specialties that the ward team was trained to provide. We were also told that the issue had resulted in an increase in the number of medical teams who visited the ward; some of whom did not communicate promptly with the registered nurses. Consequently, there had been occasions when registered nurses had not been made aware of changes to patients' care and treatment until later in the working day. We did not find any evidence to suggest that any patient's care had been compromised to date; however, there was a risk that elements of patients' care may be compromised in the future unless communication between medical staff and the ward team improves.

Recommendation

The health board is required to demonstrate how it will ensure that medical staff comply with Standards for Health Services in Wales regarding the need for effective, appropriate and timely communication and information sharing with ward staff.

Training and development

During discussions we held with registered nurses, they clearly described the emphasis that the entire team placed on ensuring that patients received safe and timely care and treatment.

We found that the ward manager had made arrangements to provide staff with a range of training sessions in the past 13 months, which were relevant to patients who received care in this ward (examples were nutrition, stoma care, infection prevention and control). Registered nurses were however open in their conversations with us about their need to receive specific training regarding patients who have difficulties with their short-term memory, delirium[6] and dementia. Conversation with a senior nurse revealed that two staff training events on dementia had been arranged for November 2014 and January 2015. Both events had been designed to focus on helping staff to understand how to manage peoples' behaviours associated with memory loss and provide them with a better knowledge of dementia.

In addition, the ward manager informed us that weekly patient flow[7] meetings assisted the ward team to maintain an understanding of their role in protecting vulnerable adults.

Handling of complaints and concerns

We held discussions with the ward manager 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. Patients were also provided with the opportunity to raise concerns during monthly ward visits from a member of the hospital's patient experience team who spoke with a minimum of 10 patients to obtain their views on the care and support they received.

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[6] Delirium is a state of mental confusion that can occur as a result of illness, surgery or with the use of some medications. Some of the most common causes include infection of the bladder or chest.

[7] The patient flow initiative within Cwm Taf University Health Board aims to reduce the length of time patients wait in accident and emergency, improve discharge times from hospital and ensure all staff are informed about next steps needed for individual patients. http://www.cwmtafuhb.wales.nhs.uk/news/31659

We read summaries of each of the four complaints that had been made in relation to the ward since January 2014 and found that each of those had been investigated in an appropriate manner.

The culture evident in the ward area

Conversations we held with staff highlighted that they sometimes felt rushed when providing assistance to patients and were not able to raise concerns about such issues with the ward manager, deputy, or senior nurse because they did not want to delay patient care. Staff did emphasise however that they were generally able to raise concerns with the ward manager as she actively encouraged them to discuss any worries about the delivery of services to patients as far as possible.

We held discussions with the ward manager and were provided with evidence that monthly staff meetings were held; topics for information-sharing largely being chosen by members of the ward team.

The ward manager also told us that 92 per cent of the ward staff had been provided with an annual appraisal of their work, which helped to identify the effectiveness of previous training and that which was required for the forthcoming year. Similarly, the ward manager had also received an appraisal from a senior nurse.

We were also told that staff turnover for the ward during the past two years had been low, with only two new people joining the team.

We found the ward team to be motivated, professional, open and honest in respect of their work.

The 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.

Overall, we found that the day to day provision of care and treatment to patients was supported by suitable management systems and processes as a means of ensuring their health, safety and welfare.

Risk management

We found that there was a system of risk management in place to assess, manage and mitigate risk associated with patient care and treatment.

We found that ward based clinical incidents had been reported and investigated in a timely way. Discussions we held with the ward manager and senior nurse also led to a full description and satisfactory resolution of a particular clinical incident that occurred in recent months.

Policies, procedures and clinical guidelines

Overall, we found that staff were able to access a range of policies and clinical guidelines which were relevant to patient activity

We held discussions with the ward manager and staff as a result of which it became evident that they were able to obtain a range of guidelines and policies which supported aspects of their patient activity (via the ward computer). A student nurse who spoke with us also said that she had been provided with a nominated staff mentor and an induction pack, both of which had helped her greatly to understand the day to day operation of the ward.

However, we scrutinised the policy which related to patients' discharge arrangements and found that it was in need of updating; the version made available to us having last been reviewed in January 2010. A senior nurse assured us that staff were guided to plan for patients' safe discharge through the use of current guidelines, however, it remains the case that new, or bank staff who sought to access current policy support in this area would only be able to access the 2010 version.

Recommendation

The health board is advised of the need to ensure that staff are provided with access to current information, guidelines and policy arrangements associated with patients' discharge.

Effective systems for audit and clinical effectiveness

We saw evidence of the use of quality indicators to check (audit) key aspects of patient care.

We held a discussion with the ward manager and senior nurse in relation to the above and found that there were suitable 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 ulcers, infection prevention and control (which are widely recognised within the NHS as quality indicators). Patient falls were also being recorded via an All-Wales reporting system but were not added to the health board care metrics[8] information. We were then told that work was currently underway in an attempt to ensure that all wards gather the same information (quality indicators) to enable the health board to make more useful comparisons between the day to day operation of wards and departments. The number of patient falls would therefore be added to the care metrics system in the future. This was, with a view to making improvements across aspects of patient care and treatment as far as possible.

Patient safety

Overall, we found that patient's health; safety and welfare were actively promoted and protected.

We held discussions with ward staff and found that they were aware of the All Wales policies and procedures for safeguarding patients who may be at risk of abuse. Discussions held with the ward manager also revealed that the ward team had access to specialist advice from a senior nurse in relation to adult safeguarding. We were also told that there had not been any adult protection issues identified within the ward during the past six months.

Examination of a sample of patient records however showed that the individuals concerned had not received any form of mental health assessment at the point of admission to the ward, or thereafter. Given that there were often a large number of patients within the ward who had difficulties with

[8] Care metrics refers to a system of measuring the quality of care delivered to patients. This is considered to be central to providing an NHS that is more transparent, accountable and focussed on improvement.

communication/short term memory loss; this matter should be addressed to ensure that people's needs are fully met in the future.

Recommendation

The health board is advised to demonstrate how it will ensure that patients' mental health needs are assessed from the point of admission.

We found that a small number of patients had their mental capacity assessed in relation to specific aspects of their care and treatment and in accordance with current legislation (The Mental Capacity Act 2005).

We observed the overall presentation of the ward over a period of two days and found the patient environment to be clean, maintained and safe with one exception. Discussions we held with ward staff identified that the ward treatment room was used at times to accommodate patients from the accident and emergency department. We were subsequently informed that the decision to use the ward treatment room in that way was only ever made as a means of minimising time spent by people in the accident and emergency department when all other ward based options had been explored. Our observations of the treatment room environment however revealed that there was no nurse call buzzer, the window was ill-fitting and there was a potential risk of contamination of sterile goods and equipment which were stored there in large quantities. Such equipment could potentially become contaminated by a patient who had not been screened for the presence of infectious conditions. Staff would also need to access the treatment room area frequently to obtain sterile supplies which may compromise the patient's privacy and dignity. Additionally, other patients may not be able to receive a physical examination for gynaecology conditions because the room would not be available for its intended purpose.

Recommendation

The health board is advised of the need to demonstrate how the risks concerned with the use of the ward treatment room for in-patient care are to be identified, monitored and where possible reduced or prevented.

<u>Medicines management</u>

Overall, we found that the ward was compliant with current legislation and guidelines in relation to medicines management.

Ward routine and approach

We held discussions with the dedicated ward pharmacist who completed a monthly audit of the systems in place regarding medicines management. We were able to confirm that there was an 'out of hours' store of prescribed patient medicines available.

We saw that intravenous fluids were being prescribed on the All Wales Medication Administration Record (MAR) as required. However, we observed that some handwritten notes which had been added to the front of a patient's MAR by the dedicated pharmacist had not resulted in the action required by the relevant medical staff. Specifically, the start date of two forms of prescribed medication was either absent or unclear. In addition, a registered nurse had signed the MAR of the same patient as having administered prescribed medication on the morning of day one of the inspection, but the signature corresponded with a future date. The incorrectly signed boxes therefore left blank spaces where there should have been signatures. Both issues created the risk of errors in the administration of prescribed medication to the patient concerned. The above matters and several others (where dates were absent on medication administration records-alongside prescribed medication) were brought to the attention of the senior nurse in the absence of the ward manager who ensured that corrective action would be taken.

Recommendation

The health board is advised of the need to improve the arrangements in place to ensure the safe and timely prescription and administration of drugs.

Storage of drugs

We found that medication was either securely stored inside a locked room or at patients' bedside in a locked area.

Preparation of patients and administration of drugs

Observation of the administration of medication to patients indicated that they had access to a drink to help them swallow their tablets. We also observed the registered nurse helping patients to sit in an upright position before they were provided with their medication.

We found that the registered nurse checked medicines and patient's identification bands before administering drugs. We also saw that patients were provided with the necessary support and assistance to take their medication. We did not observe any patient medication being left unattended. On occasions when drugs had not been administered, the medication administration records

showed evidence that the correct written code had been applied as required by the current health board policy and relevant professional guidelines.

Controlled Drugs

We saw that controlled drugs were stored in a locked cupboard and administered correctly. We also found that there were suitable arrangements in place to check and record ward stock levels of controlled drugs.

Documentation

Patient Assessment/care planning and evaluation

We scrutinised the content of five patient's records, spoke with the patients concerned and staff who were familiar with their care and treatment.

As a result, we found that the records contained a combination of risk assessments associated with, patients' falls, pressure ulcers, infection and mouth care. However, we found that a number of records were incomplete and where risks had been identified there was either no care plan, or a pre-printed plan of care which was not in any way individualised. Where care plans existed, the recorded entries which related to evaluation of the care given provided very little useful information. This meant that the staff team did not have a clear guide as to how to meet patients' identified and changing needs.

The ward team were using National Early Warning System charts (NEWS) to record patient observations (which included their pulse, blood pressure and temperature) which enabled them to seek help from medical staff in direct response to the deterioration in people's clinical presentation.

However, one patient's record did not contain a record of their weight and documentation stated that they were at nutritional risk. The records of the same person also failed to contain a current recording of their level of pain although they were being provided with pain relief. In addition, there was no evidence that an All-Wales food chart had been used to record the daily intake of the patient with a view to monitoring whether they were eating adequate amounts of food. The above matters were brought to the attention of the ward team-prompt corrective action being taken by day two of the inspection.

We held discussions with the ward manager and a senior nurse about the above and were informed that work had recently been completed in another area of the hospital to reduce the complexity of patient documentation. We were told that the success of that initiative may be used as a means of making improvements in the recording of patient care across ward areas.

Recommendation

The health board is advised of the need to demonstrate how it will ensure that improvements are made to the recording of all aspects of patients care.

Care of patients with diabetes

We selected and scrutinised the records of two patients who had been diagnosed with diabetes. One record provided evidence of a care plan and evaluation of the care provided but the second contained limited care planning information. This meant that staff may not always be provided with a clear guide as to how to meet the patient's needs.

We found that the ward staff had access to 'hypo-boxes' on the ward to enable them to address patients' low blood glucose levels in a prompt way.

We held discussions with the patients concerned. Both indicated that they were well informed about their health care condition as a result of information provided during diabetic clinic appointments and within the ward. Patients told us that they had been provided with snacks at times when their blood glucose levels had been found to be low. There was limited evidence of support provided to patients to enable them to self manage their diabetes whilst in hospital. However, we found that staff did work with patients to negotiate future care and treatment, appropriate referrals being made to the hospital's specialist diabetes team and the dietetic department.

Conversations held with patients revealed that they had access to relevant health promotion material about diabetes within the ward.

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 8 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.

1. Appendix A

Dignity and Essential Care: Improvement Plan

Hospital: Prince Charles

Ward/ Department: 8

Date of Inspection: 9 and 10 October 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
	None			
	Delivery of the Fundamentals of Care			
Page 10	The health board is advised of the need to	This will be actioned by Clinical Director for	Clinical Director for	

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	demonstrate how they will ensure that people are treated with respect and courtesy at all times.	Surgery via the Surgical Sub Directorate Surgical Forums	Surgery	March 2015
Page 10	The health board is advised of the need to demonstrate how they will ensure that patients' confidentiality and privacy is to be respected in the hospital ward.	This will be actioned via the Medical Director through the Medical Leadership Forum	Clinical Director for Surgery	March 2015
Page 11	The health board is advised of the need to ensure that ward staff have access to a sufficient supply of pillows to ensure patients' comfort.	The House keeping manger will be tasked to take the action forward	Head of Facilities	January 2015
Page 12	The health board is advised of the need to ensure that patient's level of discomfort, pain or distress is regularly assessed and recorded. This is in order to provide effective and appropriate treatment/medication.	The Head of Nursing will cascade the findings via the Acute Services Patient Safety Forum to inform the need for improvements to be made	Head of Nursing	December 2014
Page 14	The health board is advised of the need to ensure that patients' fluid intake is recorded in an accurate and timely way in order that any deterioration in frail, vulnerable people can be promptly identified.	The Senior Nurse will instruct the ward manger to take forward the necessary remedial action needed and oversee the process	Senior Nurse	January 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of Staffing Management and Leadership			
Page 18	The health board is required to demonstrate how it will ensure that medical staff comply with Standards for Health Services in Wales regarding the need for effective, appropriate and timely communication and information sharing with ward staff.	This will be actioned via the Medical Director through the Medical Leadership Forum	Medical Director	May 2015
	Delivery of a Safe and Effective Service			
Page 21	The health board is advised of the need to ensure that staff are provided with access to current information, guidelines and policy arrangements associated with patients' discharge.	The Head of Nursing will will action this via the Senior Nurse tasked to update the discharge policy	Head of Nursing	May 2015
Page 23	The health board is advised to demonstrate how it will ensure that patients' mental health needs are assessed from the point of admission.	The Clinical Director will action via the Acute Medical Directorate meetings	Clinical Director	May 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Page 23	The health board is advised of the need to demonstrate how the risks concerned with the use of the ward treatment room for in-patient care are to be identified, monitored and where possible reduced or prevented.	The Director of Nursing, Midwifery & Patient Services will action this through the Chief Operators Operational team	Nurse Director	December 2014
Page 24	The health board is advised of the need to improve the arrangements in place to ensure the safe and timely prescription and administration of drugs.	The Head of Pharmacy will take the action forward via the Medicines Management Executive Committee	Head of Pharmacy	February 2015
Page 25	The health board is advised of the need to demonstrate how it will ensure that improvements are made to the recording of all aspects of patients care.	This will be actioned the Health Boards Nursing Documentation Working Group	Assistant Director of Nursing- Operations	June 2015

Health Board Representative:

Name (print): .....

Title: .....

Signature: .....

Date: .....