

Dignity and Essential Care Inspection (Unannounced)

**Aneurin Bevan University
Health Board: Nevill Hall,
Usk Ward 3/2**

5 and 6 March 2015

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care inspection in Usk Ward 3/2 at Nevill Hall Hospital, part of Aneurin Bevan University Health Board on the 5 and 6 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

Aneurin Bevan University Health Board was established on the 1 October 2009 and covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

Nevill Hall district general hospital was opened in 1969 and provides inpatient, day case and outpatient services together with a complete range of investigations. Nevill Hall is situated on the western outskirts of Abergavenny on the A40 Brecon road and serves a geographical population covering Torfaen, Monmouthshire, Blaenau Gwent and Powys. The hospital is a designated major trauma centre with an Accident and Emergency (A&E) department. Approximately 50,000 new patients attend A&E annually.

Usk Ward 3/2 is a 32 bedded trauma and orthopaedics ward. The ward was divided into two sections. At each end there were three four-bedded bays and four single side rooms. Male bays were at one end with female bays at the other end.

4. Summary

Overall, patients told us they were satisfied with the quality of care they received and the attitude of staff looking after them. We saw staff being kind and caring with patients and working to uphold patients' privacy and dignity. Patients and relatives gave mixed comments about the cleanliness of the ward and the information they received about their condition. Patients raised concerns about staffing levels.

We found that staff were committed to providing good standards of person centred care to all patients.

We saw staff communicating with patients in a manner they could understand. Patients gave varied comments about access to information about their condition and some information leaflets available to patients were out of date.

We saw staff being polite and courteous to patients, treating them with respect and protecting their privacy and dignity. The equipment and environment in bathroom areas could be improved to ensure patient's privacy in these areas is maintained. Staff provided assistance to people with personal care where required.

We found that although patients were being supported to be as independent as possible with their discharge needs, patients' independence was not consistently promoted in their daily routines on the ward.

Patients were encouraged and supported to maintain involvement with their loved ones during their stay on the ward.

We found that staff had adapted the ward environment and routines to allow patients to rest and sleep as much as possible.

Although patients told us and our observations confirmed that staff managed patient's pain appropriately, patient's records did not always accurately reflect this.

Patients were satisfied with the quality of the food provided and staff assisted patients to eat and drink where needed. Improvements should be made to ensure meals are distributed safely, patients can wash their hands prior to mealtimes and patients' nutritional needs and food and fluid charts are implemented and updated appropriately.

We could not be assured that patients' oral health and hygiene needs were being met.

Although staff did their utmost to try to ensure they responded to patient's toilet needs in a timely way this did not always happen in practice. We could not be assured that patients' continence needs were consistently assessed where required.

We saw that appropriate equipment was in place in order to reduce the risk of patients developing pressure sores. Referrals were made to specialist services when required. Risk assessments were not consistently updated.

There was visible and supportive management and leadership in place. The ward sister had introduced a range of developments and had taken the initiative and worked hard to improve practices on the ward. Staffing levels did not consistently meet the Chief Nursing Officer for Wales guidelines for safe levels of staffing which gave the potential for this to be unsafe.

We saw that systems were in place to monitor issues associated with the delivery of safe and effective healthcare services. Staff were able to demonstrate how practices on the ward had improved as a result of audit activity and through staff listening and acting on patient and relative feedback. Aspects of patient documentation should be improved to ensure that the care staff are providing in practice is accurately documented.

Despite this, the inspection did identify a number of areas for improvement. A key consideration for HIW, therefore, will be to get a sense of whether our inspection findings act as a catalyst for the health board to consider the effectiveness of its audit and quality assurance activity, or if the health board's actions are limited to delivering improvement to Usk Ward 3/2 of Nevill Hall Hospital.

This will be a factor for consideration during HIW's 2015/2016 inspection programme as part of a broader evaluation of the arrangements the health board has in place to monitor and ensure the effectiveness of its services. In this respect, HIW will give consideration to, but not be limited by, the following issues in relation to systems for audit and clinical effectiveness:

- The extent to which front-line professionals, both clinical and managerial who deal directly with patients, are sufficiently empowered to speak up and take action if they identify areas for improvement similar to those identified by HIW, and in line with the requirements of their own professional conduct and competence.
- The extent to which there is a culture of openness and learning within the health board that supports staff to identify and solve problems.
- The extent to which the board has the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings.

5. Findings

Quality of the Patient Experience

Overall, patients told us they were satisfied with the quality of care they received and the attitude of staff looking after them. We saw staff being kind and caring with patients and working to uphold patients' privacy and dignity. Patients and relatives gave mixed comments about the cleanliness of the ward and the information they received about their condition. Patients raised concerns about staffing levels.

During the course of our inspection patients and their relatives were invited to complete our questionnaires to tell us about their experiences on the ward. These were completed via face to face interviews or returned to us in the post. In total eight questionnaires were completed by patients and relatives. Patients completing questionnaires ranged in age from 22 – 78years. We also spoke informally with patients and observed the care and treatment being provided to help us understand the patient experience. Some patients and their relatives gave us permission to include their comments within this report, some of which are found below.

Most patients and relatives who completed questionnaires scored the ward between eight and ten out of ten for the overall care and treatment provided, with one patient scoring it five out of ten and one patient scoring it seven out of ten.

In general, patients and relatives were pleased with the overall standard of care and we saw staff treating patients and visitors with dignity and respect. Some patients and relatives made the following comments:

'Been in other wards and this one is pretty good'.

'I have been here 2 days and at the moment the ward runs efficiently and plenty of care is given'.

'My (relative) is totally deaf without her hearing aid and almost blind without her glasses. Her aid and glasses are always on. A big help to her'.

'(Patient) would really benefit from more help with eating and drinking'.

'The deputy sister was very flexible with letting me visit outside normal hours. This helps me and also means I can give my (relative) more help with eating and drinking'.

Patients and relatives made mixed comments about communication and the information they received about their care. For example:

'In early stay staff did not listen to my complaints, due in part to being on wrong ward. It took almost 2 weeks and swelling to prove to doctors where the real problem was. Was at this point the transfer to proper care was undertaken'.

'Knew what was wrong, what surgery would be having but not beyond that – e.g. what plaster and aftercare'.

'Information about my (relative's) progress and next steps is fulsome'.

In general, patients and relatives were very positive about how staff treated them, although one patient raised some individual concerns about staff attitude towards them, which we raised with staff during the inspection. Comments included:

'Nothing is too much trouble to the staff'.

'Staff cannot be faulted...never failed to provide good service and displayed good interpersonal skills with patients'.

'An efficient and good team who support one another'.

'Ignored by...staff. Had problems with getting Parkinson medication and feel blanked...it's insulting to be told "keep your arm still" when you've not had the medicines you should have. I'm very shaky, I've got Parkinsons'.

One relative told us staff were quick to attend to their relative. However, most patients raised concerns about the staffing levels in place and made the following comments:

'I just have to cope as best I can if there's no one available to help' (Response to question about eating and drinking. Was unable to reach jug of water but stated food was put within reach).

'Depends how busy they are' (about staff responding to buzzer).

'The staff are particularly over stretched at night. Makes the care hard, especially with the number of patients'.

'Have much sympathy with staff who appear excessively busy, especially at night or weekends'.

Some patients commented that there were patients with confusion and dementia on the ward which meant staff time was often taken up in caring for these individuals with more complex needs:

'The reason that I have had such a good standard of care is because I have a voice or I'm very vocal. For this ward there's lots of dementia patients who need lots of care. There needs to be more staff to help with toileting, feeding etc.'

'Lot of elderly in ward with obvious mental health/dementia issues which created enormous additional efforts of staff and these patients can be disrupting to other patients and a real strain on the attempted care of other patients'.

Recommendation

The health board should ensure there are sufficient staff in place to meet patients' needs, particularly those patients with dementia and confusion.

Most patients and relatives told us they felt the ward was clean and tidy. During the morning we found some bathroom facilities were not adequately cleaned with wet toilet paper on the floor, dirty wet towels and a slip of paper from a continence pad in the sink. We also found toilet paper and paper towels had run out in one bathroom. We spoke with one of the housekeeping staff who told us there was one cleaner allocated to clean the whole ward in the morning. This meant they were unable to ensure the ward maintained an appropriate level of cleanliness throughout this period. Patients' comments about ward cleanliness included:

'As I'm on bed rest I've not been able to sample the toilets or showers. But from my bed the floors, tables etc. do seem to be clean'.

'Unable to clean fully under beds and lockers. Dirty towels and toilets occasionally between cleaning times'.

'Windows really need to be cleaned..'

'View is stunning but the windows are filthy'.

'Windows could do with being cleaned'.

Recommendation

The health board should consider whether the allocation of housekeeping staff in the mornings is sufficient to ensure bathrooms can be kept clean and tidy for patient use.

Delivery of the Fundamentals of Care

We found that staff were committed to providing good standards of person centred care to all patients.

Communication and information

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

We saw staff communicating with patients in a manner they could understand. Patients gave varied comments about access to information about their condition and some information leaflets available to patients were out of date.

Patients and relatives gave mixed comments about communication with staff and access to information about their care and treatment, as detailed under the 'Patient Experience' part of this report. There were occasions when patients felt they did not receive all the information they required. Throughout the inspection we also saw good practice in this area. For example, we saw nursing staff explaining aspects of patients' care and treatment to them. We also observed a medical ward round and found the team sought the patients' understanding and clarified the situation and plan with patients.

We spoke with staff about how they communicated with patients with additional communication needs. Staff told us they had access to interpreting services and a hearing loop although they stated this was not really used.

Recommendation

Staff should ensure they use the tools available to help them to communicate with patients with hearing loss and additional communication needs in an appropriate, discreet way.

We found information in the leaflet stand was out of date, some of it dated 2007.

Recommendation

Information leaflets should be updated to ensure patients and relatives have access to accurate information.

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 saw staff being polite and courteous to patients, treating them with respect and protecting their privacy and dignity. The equipment and environment in bathroom areas could be improved to ensure patient's privacy in these areas is maintained.

We saw staff being polite, courteous and treating people respectfully when assisting them and providing care and treatment. We saw staff being particularly caring and responding with compassion and concern to one patient who was confused and calling out.

We saw staff used pegs to ensure curtains were closed when providing personal care and we observed staff working to uphold patients' dignity. We saw that some dignity curtains around basin areas in the toilets were not adequate in screening off the separate areas, blew open and did not provide sufficient length to fully screen off areas. This meant there was the potential for patients' privacy and dignity to be compromised.

Recommendation

The health board should review how staff are ensuring patients' privacy and dignity is being maintained in bathroom areas and ensure appropriate screens and methods are in use.

We saw that patients' preferred names were displayed above their beds. However, patients gave mixed comments about the use of their preferred names, for example:

'(Relative's) name on her bed chart is her official one, although staff do call her her preferred name'.

'Sometimes they call me (shortened name) and I hate that'.

Recommendation

Staff should ensure they address patients by their preferred names.

Staff we observed had a good understanding of maintaining patients' privacy and confidentiality. For example, we saw one staff member ask a patient if they wanted to discuss a matter in a more private place.

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 although patients were being supported to be as independent as possible with their discharge needs, patients' independence was not consistently promoted in their daily routines on the ward.

Our observations and discussions with patients confirmed that not all patients were supported to be independent as their condition allowed, in their daily routines. For example, we found one patient who had not been supported to put on their shoes in the morning to enable them to mobilise independently. We also found patients requiring slip mats for their plates, which would enable them to eat more independently.

Recommendation

The health board should ensure patients are supported to be as independent as possible with their daily routines.

We saw and spoke with a number of physiotherapists on the ward and saw that patients were being supported and encouraged by the physiotherapy team to become as independent as possible ready for discharge. The equipment we saw appeared well maintained and we saw that staff used equipment appropriately and safely when supporting patients.

At the time of our inspection there were a number of patients on the ward who presented with confusion or had a dementia diagnosis. We saw that the health board's 'forget me not' scheme (a scheme whereby patients with confusion are identified with a flower symbol on their beds to indicate that they may require a higher level of assistance) was in use on the ward.

We saw that the ward environment was not particularly accessible or user friendly for patients with confusion, additional and/or sensory needs. The ward sister told us they had a dementia link nurse and had started to consider how to make the environment more dementia friendly. Fully implementing a dementia friendly environment and approach would help assist patients to find areas more easily and independently, as their condition allows.

Recommendation

The health board should consider how to make the ward environment as accessible as possible to patients with confusion/dementia and complex

or sensory needs, particularly in light of the type of patients now admitted onto the ward.

Relationships

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

Patients were encouraged and supported to maintain involvement with their loved ones during their stay on the ward.

The ward had structured visiting hours in place from 2.30-7.30pm. Staff told us the times had recently changed to better suit patients and relatives. We saw that visitors were also welcomed outside of these hours when requested and in particular to help patients who were confused or who needed assistance with eating and drinking.

Most patients saw their loved ones at their bed side. There was a day room available where patients could spend time with their loved ones away from their bedside in relative privacy. Staff told us they now ensured staff handovers happened in the office so that the day room was protected for patient and relative use only. This meant staff had adapted the routine and environment to help patients to maintain relationships with their loved ones.

Rest, sleep and activity

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

We found that staff had adapted the ward environment and routines to allow patients to rest and sleep as much as possible.

We found the heating, lighting and ventilation on the ward created a comfortable environment.

Most patients told us they slept well, although there were occasions they could be disturbed by confused patients. Where it was possible, patients who were distressed confused or who had more complex physical needs were accommodated in single side rooms. After lunch the ward operated a quiet hour whereby staff allowed patients to rest and sleep without being disturbed. This meant staff made the ward environment as conducive as possible to allow patients to rest and sleep.

We saw the ward had sufficient quantities of bed linen available during our inspection allowing beds to be changed promptly and provide extra warmth for patients when sleeping.

There was a day room available where patients could watch television. Staff told us they planned to develop the day room into a more dementia friendly environment. Patients could purchase newspapers from a trolley, some beds had individual televisions for patient use and we saw that the radio was also used at times for patient entertainment.

We saw that some patients' bedside lights were not working and one patient told us this meant they were not able to read at night. We raised this with staff and staff reported this during the inspection so that this could be resolved.

Ensuring comfort, alleviating pain

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

Although patients told us and our observations confirmed that staff managed patient's pain appropriately, patient's records did not always accurately reflect this.

We saw staff helping patients to be comfortable when getting into bed or when assisting them to sit in chairs. Staff assessed and managed patients' pain appropriately.

We looked at patient documentation and found in the majority of cases that patients' pain scores were being documented and monitored and documentation reflected how patients' pain was effectively managed. In one case we found that one patient's pain scores were not consistently recorded and the pain score did not correlate with the times medication was then provided. The patient involved told us their needs in relation to pain were being met. However, this meant that we could not be assured that staff used pain tools in a consistent way to document and assess patients' pain levels.

Recommendation

Pain assessment tools should be used in a consistent way to accurately document and assess patients' pain to ensure appropriate management and escalation.

All patients we spoke with told us they received timely pain relief and we saw entries in patient notes from the pain team. This meant that systems were in

place to ensure patients were made as comfortable and free from pain as possible.

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.

Staff provided assistance to people with personal care where required.

Patients appeared well cared for and we found that staff were discreet and sensitive when assisting patients with their personal care routines. Patients were provided with wash bowls to enable them to carry out personal care routines at the bedside where this was preferred or required.

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 satisfied with the quality of the food provided and staff assisted patients to eat and drink where needed. Improvements should be made to ensure meals are distributed safely, patients can wash their hands prior to mealtimes and patients' nutritional needs and food and fluid charts are implemented and updated appropriately.

Patients made positive comments about the meals provided. We observed a meal time on the first day of our inspection and found the food to be appetising with catering staff offering a range of choices to meet people's individual preferences. Patients had access to water jugs that were changed twice a day.

We were told the ward had protected mealtimes in place and professionals we spoke with were aware of this and respected this time. This meant patients were not disturbed when trying to eat their meals.

We saw that MUST¹ scores were not consistently recorded on admission. We found food and fluid charts were not consistently updated and where there were concerns about patients' eating and drinking routines, food and fluid charts had not always been implemented to monitor the patient's risks.

The ward had adapted the Red Tray system so that instead of using physical red trays, a small red tray symbol was attached above patients' beds and on the board in the office, to physically identify those patients who needed assistance at mealtimes or who had food and fluid charts in place. We saw trays being collected from patients with red tray symbols before staff had updated food and fluid charts indicating that the symbol did not always alert staff to the actions they needed to take.

Recommendation

The health board should ensure patients consistently receive a full assessment of their nutritional needs to enable their needs and risks to be safely and appropriately managed. Food and fluid charts should be appropriately implemented, consistently updated and monitored.

During our observations, all patients who required assistance to eat and drink received it. Relatives were encouraged to visit at this time and assist their loved ones to eat. Relatives we spoke with appreciated the flexibility of this approach.

We saw that patients were not supported to wash their hands prior to meal times.

Recommendation

Patients should be supported to wash their hands prior to eating to reduce the risk of cross infection.

We saw meals were provided with metal lids on top and we found some patients struggled when lifting these, particularly as they were sometimes hot.

¹ 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Recommendation

The ward should review the distribution of meals with metal lids to patients and the health and safety risks posed by this practice.

The ward was able to access hot meals and snacks outside of meal times so those patients who may have missed a meal due to a clinical procedure could access food outside of meal times.

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 could not be assured that patients oral health and hygiene needs were being met.

We saw that there was a supply of oral care supplies available on the ward for patient use.

We saw that several patients had poor oral health and patients gave mixed responses about the care provided to maintain their oral health. We looked at patient records and could not be assured from the documentation we saw that staff routinely and consistently assessed patients' oral hygiene needs. Staff told us they did not use the oral health bundle and we did not find care plans to manage patient's oral health needs in patient records.

Recommendation

The health board should ensure patients' oral health needs are routinely assessed and appropriately managed to ensure good oral health.

Toilet needs

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

Although staff did their utmost to try to ensure they responded to patient's toilet needs in a timely way this did not always happen in practice. We could not be assured that patients' continence needs were consistently assessed where required.

Throughout the inspection we found toilets on the ward were not always adequately clean and appropriately equipped with toilet paper and hand washing facilities to reduce cross infection. A recommendation has been made

under the 'Patient Experience' part of the report. Not all locks were in working order and staff reported these to be repaired during our inspection.

We found that patients' continence care was recorded in nursing notes and we were told the All Wales bundle² to assess people's continence needs was used when required. However we did not find full assessments or the use of the bundle in the patient documentation we reviewed, where it would have been appropriate to be in place. We could therefore not be assured that full assessments of patients' continence needs were consistently carried out.

Recommendation

The health board should ensure patients consistently receive a full assessment of their continence care needs to enable their needs and risks to be safely and appropriately managed.

We saw that the ward stocked a range of continence products should patients require these.

We saw that the use of catheters on the ward was low and the culture was for staff to provide a high level of assistance to patients to avoid catheterisation. However, discussions with patients indicated and our observations confirmed that staff were not always able to answer calls for assistance promptly. This meant that patients sometimes had to wait unnecessarily to use the toilet.

Recommendation

The health board should ensure staff are able to respond in a timely way to patients' requests to use the toilet.

² **Continence bundle** is a tool which enables all nurses in Wales to assess the continence needs of their patients, audit the care provided and offer patients the opportunity to give feedback.

Preventing pressure sores

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

We saw that appropriate equipment was in place in order to reduce the risk of patients developing pressure sores. Referrals were made to specialist services when required. Risk assessments were not consistently updated.

The ward had pressure relieving mattresses in place to reduce the risk of patients developing pressure sores and there was a system in place to check mattresses regularly to ensure they were working correctly and not damaged. The records we saw and our observations confirmed that staff regularly checked patients' skin for signs of pressure damage. This meant that systems and equipment were in place to try to prevent patients from developing pressure sores.

We saw that Waterlow assessments to assess patients' risk of developing pressure ulcers were done on admission. However the records we saw indicated that these were not consistently reviewed and updated. For example in one case, where a higher risk was identified, this did not lead to an increase in the frequency of assessing the risk. This meant we could not be assured that documentation was updated in line with patients' changing needs to ensure appropriate ongoing management.

Recommendation

Waterlow assessments should be regularly reviewed and updated in response to patients' changing needs to ensure patient's needs and risks are being safely and appropriately managed.

We saw that the All Wales Pressure Ulcer SKIN bundle was in use³ and appropriate referrals were made to the tissue viability services if needed for further specialist input.

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

Quality of Staffing, Management and Leadership

There was visible and supportive management and leadership in place. The ward sister had introduced a range of developments and had taken the initiative and worked hard to improve practices on the ward. Staffing levels did not consistently meet the Chief Nursing Officer for Wales guidelines for safe levels of staffing which gave the potential for this to be unsafe.

Staffing levels and skill mix and professional accountability

At the time of our inspection the management structure on the ward was made up of one ward sister and a deputy with a senior nurse supporting the ward sister. We were well supported by ward and management staff across the two days.

Throughout the two days of our inspection we found that staffing arrangements did not always meet the Chief Nursing Officer for Wales guidelines for safe levels of staffing. These levels were met once throughout the two days on the morning of the second day when there were five registered nurses in place. At other times there were four registered nurses (and between three to four nursing assistants) looking after 32 patients. Staff told us and rotas confirmed that staffing levels often fell below recommended levels. At night, normal staffing levels consisted of two registered nurses and two nursing assistants. Although we did not witness unsafe practice happening as a result of these staffing levels, we saw that patients had to wait for assistance and patients raised concerns with us about staffing levels, saying that this impacted on their care at times.

Recommendation

The health board should ensure staffing levels meet the Chief Nursing Officer for Wales guidelines for safe levels of staffing.

We found an appropriate skill mix to be in place and where newly qualified staff members were working, we saw they were allocated to work with more experienced staff for support. We also saw that where one patient on the ward

required one to one staffing, this had been put in place to meet the patient's needs.

We saw from rotas that the ward used some bank and agency staff when needed. However, on the first day of the inspection, staff were unable to secure a qualified bank/agency nurse to meet staffing levels and they were working short staffed.

We saw that patients had access to multidisciplinary teams including a medical, physiotherapy, occupational therapy and social work team.

We found the ward sister to be visible on the ward and they provided support and direction to the staff team. The ward sister had completed a piece of work with the staff team clarifying team members roles and responsibilities and what was expected in each role and this was displayed on a noticeboard in the office. This meant staff were clear about their roles and we felt this was an area of noteworthy practice.

At the time of the inspection the vacancy rate on Usk Ward was 6.24 qualified nurses. Staff told us they had held interviews the previous week and two new part time registered nurses had been appointed. This meant plans were in place to increase the permanent staff team on the ward.

Effective systems for the organisation of clinical care

We saw that each day the ward sister was visible and provided leadership to the team. Nursing assistants worked under the direction of the nurses and there was a clear structure in place to support staff in their roles.

We saw that written handovers were in place and 'patient safety briefings' which identified any patients at risk. This meant there were systems in place which aimed to ensure continuity in patient care.

We saw from rotas and staff confirmed that the ward sister was included in the staffing numbers. This meant the ward sister was unable to access sufficient regular supernumerary time to fulfil her management responsibilities.

Recommendation

The ward sister should have access to allocated supernumerary time in order to fulfil management responsibilities.

There were 'patient safety at a glance' (PSAG) boards in the multidisciplinary office, so that staff could easily see the most important aspects of patient's care and treatment. We saw that where these were positioned, it was possible for people to see patient's information from the corridor.

Recommendation

PSAG boards should be repositioned where they are not visible from public areas in order to protect patient confidentiality.

The ward sister had introduced a system whereby certain sets of patient documentation were updated weekly, on specific days. This acted as a reminder to staff to ensure documentation was regularly reviewed. We also saw that nurses undertook intentional rounding to ensure they monitored all patients. It was clear that the ward sister and team had taken the initiative to implement, develop and improve systems for the organisation of clinical care and this was an area of noteworthy practice.

We saw that surgery took place in the afternoon unless the patient required a more complicated intervention, in which case surgery was scheduled for the morning. An ortho-geriatrician attended the ward twice/week. We also saw active involvement from a nurse practitioner and the wider multidisciplinary team throughout the inspection. This meant patients had access to a range of skilled medical and health care professional teams.

Training and development

The ward sister had introduced a range of systems for monitoring and ensuring staff received appropriate training and had access to timely personal development reviews. Staff had recently been given 12 hours of study leave and the ward sister was monitoring this to ensure staff used this time to complete mandatory online training.

We saw that the ward made use of specialist nurses to promote best practice, for example in infection control.

Handling of complaints and concerns

We held discussions with staff and found that patients and their relatives were encouraged to discuss care and treatment with ward staff through daily face to face contact. We requested complaints records for the last year and found that nine complaints were held on record for Usk ward between 01/04/2014 – 05/03/2015.

Patients and relatives told us they felt able to raise concerns and complaints with staff. The ward had run out of complaints leaflets which would make complaints information accessible to patients and relatives.

Recommendation

The health board should ensure information about making complaints is accessible to patients and relatives.

We investigated one individual complaint in detail and found that the patient was awaiting a full response to a complaint they had made on 15 December 2014 in relation to a medication concern that was impacting on their immediate health and wellbeing. A response had been due on 29 January 2015 and at this point the patient had been sent a holding letter. The patient told us their concern was still ongoing and having a negative effect on their wellbeing and they had now raised it through another avenue as they had not heard anything further. This meant we could not be assured that when patients raised concerns, these would be dealt with in a timely way. We raised this with staff at the end of the inspection for further investigation.

Recommendation

Patient concerns and complaints should be assessed, prioritised and addressed in a timely way.

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 saw that systems were in place to monitor issues associated with the delivery of safe and effective healthcare services. Staff were able to demonstrate how practices on the ward had improved as a result of audit activity and through staff listening and acting on patient and relative feedback. Aspects of patient documentation should be improved to ensure that the care staff are providing in practice is accurately documented.

Risk management

Incidents

We found that ward based clinical incidents were reported using an electronic system. Incidents were followed up by both management and ward based staff. We saw records for incidents and could not be assured that they were consistently reviewed and therefore learning was not disseminated in a timely way. For example, one incident that had occurred in October 2014 had not been reviewed until February 2015.

We followed through one patient's fall to ensure it had been appropriately recorded and managed as an incident. The system showed the incident as having been recorded on the system six days after the incident occurred although staff assured us immediate risks had been managed at the time. We could not be assured all incidents were consistently reported and reviewed in a timely way.

Recommendation

The health board should ensure incidents are reported and reviewed in a timely way.

Policies, procedures and clinical guidelines

We held discussions with the ward sister and staff. As a result of this 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).

Whilst observing a medical round it became clear that the current health board's antibiotic policy was not available on the ward computer. The

consultant was able to access the policy on their mobile phone. However all health board policies should be available on the ward for ease of access.

Recommendation

All health board policies should be easily accessible to staff on the ward.

Effective systems for audit and clinical effectiveness

We held a discussion with the ward sister, senior nurse and divisional nurse in relation to clinical audits 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 of hand hygiene, pressure ulcers, MRSA, credits for cleaning, medication errors and falls. The results of audits were displayed prominently on noticeboards for staff, patients and the public to see. Changes to practice on the ward were shared with staff at handovers, informally and through notices on the board in the office.

Staff were able to give examples where practices on the ward had changed as a result of quality assurance and audit activities. For example, following feedback from patients and relatives, staff had worked on the environment of the day room to try to make it more welcoming, friendly and for the use of patients and visitors only. Staff told us they had brought one relative back to see the work they had done which led to positive feedback. There was a 'You said, We did' board in place which gave further examples of changes staff had made as a result of patient and relative feedback. This was an area of noteworthy practice.

We saw that initiatives from the 1000 Lives campaign⁴ were being used, such as safety crosses displayed on the ward wall and used in a meaningful way to make highly visible the incidence of avoidable adverse events.

⁴ **The 1000 Lives Campaign** aims to improve patient safety and increase healthcare quality across Wales.

Patient safety

Ward Systems

The ward used 'safety briefings' to ensure the whole staff team kept up to date with any patient safety risks or incidents. This meant there was continuity in passing on relevant concerns across the staff team.

Safeguarding

We explored the systems in place for protecting vulnerable adults from abuse (POVA) and found these to be robust. We followed one patient's case where staff had raised concerns about the patient's home life on discharge. We found that an immediate referral had been made by telephone to the appropriate team and during the inspection a member of staff attended from the corresponding local authority to discuss concerns with the patient involved. This meant that staff had made appropriate and timely referrals where they were concerned for patient welfare.

Medicines management

Administration and recording of medicines

Medicines were administered on an individual basis from stock cupboards, using a trolley. We observed staff administering medicines and found some staff to be skilled and competent. We saw staff correctly positioning patients and making accurate recordings in patients' Medication Administration Records (MARs).

However we saw two staff administering controlled drugs by signing to record they had witnessed the patient taking their medication before administering the medication to the patient. We also saw that after signing, one staff member administered the controlled drug instead of the recommended two staff members to check the identity of the patient. We raised this concern formally through an immediate assurance letter to the health board. The health board provided us with sufficient assurance that our concern was being addressed.

Storage of drugs

We saw that when staff administered medicines from the trolley they ensured it was locked and secure to prevent access by unauthorised persons.

During the two day inspection we found that not all medication was stored securely to prevent access by unauthorised persons. In the room connected to the treatment room, used by pharmacy, with sliding door access, we found

medicines repeatedly stored insecurely. This was noted on three occasions throughout the inspection despite the inspection team raising the concern in each case immediately with staff and the pharmacist on the ward. We found the sliding doors unlocked and open on all occasions without staff being present. We found medicines left on the side, medicines (including antibiotics) that could be easily accessed from a sharps box under the table and on one occasion the cupboard doors (where medicines were stored) had been left wide open. Due to concerns remaining at the end of the inspection, we raised this concern formally through an immediate assurance letter to the health board. The health board provided us with sufficient assurance that our concern was being addressed.

We found the treatment room was not being locked due to the key pad system being broken. We raised this concern and by the end of the inspection, a new locking system had been put in place and was in use.

We found the fridge door was not being locked in line with the health board's 'Medicines Management Policy'. We understand an order has been placed to put a lock onto the fridge. We seek assurance that this has been completed and the fridge is now being locked. The room temperature and fridge temperatures in the treatment room were not being monitored in line with the health board's 'Medicines Management Policy'. Due to concerns remaining at the end of the inspection, we raised these concerns formally through an immediate assurance letter to the health board. The health board provided us with sufficient assurance that these concerns were being addressed.

We found insulin stored in the fridge which was out of date. We raised this concern immediately and this was removed.

Recommendation

The health board should ensure processes are in place to remove medicines when they are out of date.

We saw that oxygen was being stored in a public corridor.

Recommendation

Oxygen should be stored safely in line with relevant guidelines.

Documentation

Patient Assessment

We looked in detail at a sample of patients' care plans and notes relating to their care. We found patient files to be well organised and documents and assessments were only put into files where they were required. This meant all information held about the patient in their file was relevant and it was easy to follow the patient pathway.

We found full and detailed multidisciplinary notes and assessments in patient files such as physiotherapy assessments which provided a high level of detail about how the patient was progressing. These notes were kept in the same place as the patient's medical notes which meant relevant information from a range of disciplines was kept together for ease of access and use. In one case we were able to see that patients' discharge needs had been identified early on to ensure plans could be started in a timely way.

We found medical notes were logical, sequential and up to date, however at times were difficult to read. We saw that the WHO surgical safety checklist⁵ had been completed for patients. We found 'do not attempt resuscitation' (DNAR) forms were kept in different parts of patient files which could lead to confusion if staff needed to access them quickly in an emergency.

Recommendation

DNAR decisions should be recorded in one consistent place where staff know where to find it.

Generally, we found appropriate care plans had been initiated by staff but we found that some care plans and risk assessments were not regularly reviewed and evaluated. The ward sister had recognised this and put a weekly system in place to try to ensure documentation was regularly reviewed. Care plans were standardised and it was difficult to understand the individual holistic needs of the patient by looking at the documentation in place.

⁵ **(WHO) Surgical Safety Checklist** is for use in any operating theatre environment. It is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.

Recommendation

Care plans and risk assessments should be regularly reviewed and updated to reflect changes in patients' needs, care and treatment. Care plans should ensure patients' needs are being managed in an individualised way.

Generally, we found relevant risk assessments had been completed on admission but were not consistently reviewed and updated to reflect changes in patients' needs. We found that where these were updated and where risks reached certain levels, All Wales bundles⁶ were implemented and recognised pathways followed to manage the risk. However, this was not consistent across the documentation we saw, for example, we found that MUST scores were not consistently recorded on admission. We also found that Waterlow assessments were in place but we found food and fluid charts were not consistently updated and where there were concerns about patients' eating and drinking routines, food and fluid charts had not been implemented. We saw limited use of continence assessments and diabetic care plans were not in use. These concerns have been raised and recommendations made in the relevant sections under the Fundamentals of Care. However as a result of looking at documentation as a whole we could not be assured that relevant risk assessments and care plans were consistently updated or that audit systems in place had identified this.

Recommendation

The health board should ensure relevant risk assessments and care plans are consistently implemented and reviewed. There should be systems in place to identify when this has not happened and resolve it.

Nursing notes were updated contemporaneously in line with best practice guidelines to ensure any issues were captured and dealt with in real time. We found the intentional rounding⁷ system being used in a meaningful way and nurses had recorded useful observations of patients on a regular basis. We saw

⁶ **Bundles** are All Wales or Health Board wide agreed interventions and approaches to specific areas of health care. These ensure consistent evidence based nursing practice.

⁷ **Intentional rounding** is a structured process where nurses on wards in acute and community hospitals and care home staff carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.

evidence that care provided was being evaluated to ensure any changes could be identified.

Diabetes Care

The ward had access to a diabetic link nurse to act as a local point of contact and share best practice on diabetes care. There was also a diabetic champion on the ward. Staff told us they had received training on diabetes management. We were unable to check training statistics to confirm specific staff training compliance.

We looked at two diabetic patient records in detail and found that their diabetic needs were being managed appropriately. However, we found that although staff were monitoring both patients' blood glucose levels and administering insulin appropriately, they did not have clear guidelines to follow in terms of a formalised care plan. This meant the treatment staff were providing in terms of diabetes care was not being formalised or evaluated. We found that diabetic patients' foot care was not routinely assessed. We could therefore not be assured that documentation for diabetes care was consistently implemented and monitored.

Recommendation

The health board should ensure all diabetic patients have clear care plans and risk assessments in place for staff to follow and to ensure care can be evaluated and is appropriate.

We found the management of diabetic patients' nutritional needs to be inconsistent. In one case we found the patient's nutritional needs had been assessed and due to concern an appropriate referral had been made to the dietician. In the other case we found the patient's MUST score had not been carried out, food and fluid charts had not been consistently updated and there was a conflicting care plan and medial report on the patient's intake and appetite. This was in relation to a patient who had experienced significant weight loss.

Recommendation

Diabetic patients' nutritional needs and risks should be assessed and managed in a consistent way.

Diabetic meals were provided on the ward and diabetic patients were able to access snacks outside of mealtimes. This meant diabetic patients' dietary needs were catered for on the ward.

Hypo-boxes⁸ containing equipment and medication to treat a diabetic emergency were available on the ward, fully stocked and clearly visible.

⁸ 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.

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 Usk Ward 3/2 at Nevill Hall 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: Nevill Hall Hospital

Ward/ Department: Usk Ward 3/2

Date of Inspection: 5 and 6 March 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Quality of the Patient Experience				
Page 8	The health board should ensure there are sufficient staff in place to meet patients' needs, particularly those patients with dementia and confusion.			
Page 8	The health board should consider whether the allocation of housekeeping staff in the mornings is sufficient to ensure bathrooms can be kept clean and tidy for patient use.			
Delivery of the Fundamentals of Care				
Page 9	Staff should ensure they use the tools			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	available to help them to communicate with patients with hearing loss and additional communication needs in an appropriate, discreet way.			
Page 9	Information leaflets should be updated to ensure patients and relatives have access to accurate information.			
Page 10	The health board should review how staff are ensuring patients' privacy and dignity is being maintained in bathroom areas and ensure appropriate screens and methods are in use.			
Page 10	Staff should ensure they address patients by their preferred names.			
Page 11	The health board should ensure patients are supported to be as independent as possible with their daily routines.			
Page 11	The health board should consider how to make the ward environment as accessible as possible to patients with confusion/dementia and complex or sensory needs, particularly in light of the type of patients now admitted onto the ward.			
Page 13	Pain assessment tools should be used in a consistent way to accurately document and			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	assess patients' pain to ensure appropriate management and escalation.			
Page 15	The health board should ensure patients consistently receive a full assessment of their nutritional needs to enable their needs and risks to be safely and appropriately managed. Food and fluid charts should be appropriately implemented, consistently updated and monitored.			
Page 15	Patients should be supported to wash their hands prior to eating to reduce the risk of cross infection.			
Page 16	The ward should review the distribution of meals with metal lids to patients and the health and safety risks posed by this practice.			
Page 16	The health board should ensure patients' oral health needs are routinely assessed and appropriately managed to ensure good oral health.			
Page 17	The health board should ensure patients consistently receive a full assessment of their continence care needs to enable their needs and risks to be safely and appropriately managed.			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Page 17	The health board should ensure staff are able to respond in a timely way to patients' requests to use the toilet.			
Page 18	Waterlow assessments should be regularly reviewed and updated in response to patients' changing needs to ensure patient's needs and risks are being safely and appropriately managed.			
Quality of Staffing Management and Leadership				
Page 19	The health board should ensure staffing levels meet the Chief Nursing Officer for Wales guidelines for safe levels of staffing.			
Page 20	The ward sister should have access to allocated supernumerary time in order to fulfil management responsibilities.			
Page 20	PSAG boards should be repositioned where they are not visible from public areas in order to protect patient confidentiality.			
Page 21	The health board should ensure information about making complaints is accessible to			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	patients and relatives.			
Page 22	Patient concerns and complaints should be assessed, prioritised and addressed in a timely way.			
Delivery of a Safe and Effective Service				
Page 23	The health board should ensure incidents are reported and reviewed in a timely way.			
Page 24	All health board policies should be easily accessible to staff on the ward.			
Page 26	The health board should ensure processes are in place to remove medicines when they are out of date.			
Page 26	Oxygen should be stored safely in line with relevant guidelines.			
Page 27	DNAR decisions should be recorded in one consistent place where staff know where to find it.			
Page 27	Care plans and risk assessments should be regularly reviewed and updated to reflect changes in patients' needs, care and treatment. Care plans should ensure patients'			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	needs are being managed in an individualised way.			
Page 28	The health board should ensure relevant risk assessments and care plans are consistently implemented and reviewed. There should be systems in place to identify when this has not happened and resolve it.			
Page 29	The health board should ensure all diabetic patients have clear care plans and risk assessments in place for staff to follow and to ensure care can be evaluated and is appropriate.			
Page 29	Diabetic patients' nutritional needs and risks should be assessed and managed in a consistent way.			

Health Board Representative:

Name (print):

Title:

Date: