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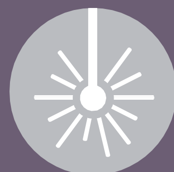
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Graham Davies Ward, Llanidloes War Memorial Hospital, Powys Teaching Health Board

Inspection date: 09, 10 and 11 October 2023

Publication date: 11 January 2024



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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83577-427-4

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

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

Our goal

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

Our priorities

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

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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Llanidloes War Memorial Hospital, Powys Teaching Health Board on 09, 10 and 11 October 2023. We inspected the Graham Davies Ward, which provides rehabilitation of the elderly and palliative care services for up to 14 patients.

Our team, for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we spoke with patients on the ward when appropriate to do so to hear about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 12 questionnaires were completed by staff. Feedback and some of the comments we received appear throughout the report. Where present, quotes in this publication may have been translated from their original language.

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients and their family members provided positive feedback about their experiences and felt well cared for by staff on the ward. Patients appeared clean and well-kempt and were able to wear their own clothes. The ward was calm, and we saw staff providing care in a professional manner. Staff closed curtains when administering care to patients within the communal bays to help protect their privacy and dignity.

We asked the health board to review the communal bathroom facilities to ensure they fully protected patients against the risk of unintended falls.

This is what we recommend the service can improve:
- More accessible information should be made available to patients during their time on the ward
- Staff should fully utilise all the dementia care initiatives available to them
- Further work was needed to ensure Welsh speakers receive services that meet their language needs.

This is what the service did well
- The palliative care suite was a modern facility, which offered dignity and privacy for patients and their families. This was a real asset to the ward and to the community as a whole
- Staff responded to call bells during the inspection in a timely manner.

Delivery of Safe and Effective Care

Overall summary:
The ward environment appeared clean and was accessible for people with mobility difficulties. Personal Protective Equipment was available, and we observed staff washing their hands in between episodes of patient care. There was appropriate and sufficient equipment in place on the ward to support the needs of the patients. Weekly checks were being undertaken on resuscitation and emergency equipment in line with national guidance. Food was prepared on-site daily and looked well-presented and appetising. Patient records were up-to-date and generally well completed.

The ward suffered from a lack of storage, and we asked the health board to tidy the existing storage room as a matter of priority. There was confusion around

which patients required enhanced care and improvements in the paperwork, and we identified the need for better communication between staff.

We noted that a number of large oxygen cylinders were being stored in a side room off the main corridor. We were not assured that this storage arrangement was in compliance with the best practice guidance. We raised this issue with staff and actions were taken to address our concerns.

We were also concerned that some patients were not wearing their patient identification bands during the inspection. While this was resolved immediately, we have asked the health board for an update on further actions to ensure the practice of removing patient identification bands no longer continues.

This is what we recommend the service can improve:

- Some maintenance work was needed to clean dirty skylights and stained ceiling tiles
- All issues and recommendations resulting from fire risk assessments must be actioned immediately
- Decontamination stickers should be used to indicate whether reusable medical equipment has been cleaned and is safe for use
- Staff must improve their knowledge of the Mental Capacity Act, and the Deprivation of Liberty Safeguards (DOLS) process. Also, DOLS assessments must take place as required, and be recorded appropriately within the patient records to ensure patients are not illegally deprived of their liberty
- The storage and security of medication on the ward needs to be reviewed and addressed by the health board.

This is what the service did well:

- There was positive input from multiple services to help support the efficient movement of patients in and out of hospital.

Quality of Management and Leadership

Overall summary:
Multiple organisations and services, such as reablement, continuing healthcare and social services, were involved in discharge planning for patients. Staff members felt that they have appropriate training to undertake their role. We saw that overall compliance with mandatory training for staff was high at 82 per cent. A range of audits were being carried out to monitor compliance with best practice, and scrutiny meetings were in place to discuss issues such as falls and pressure ulcers.

We received some negative feedback in the staff responses to the HIW questionnaires. This was in relation to leadership and management culture on the ward. Specific examples include senior management not being approachable or visible, and communication between senior management and staff not being effective. References were also made to a potential ‘blame culture’ that was prevalent on the ward. We have asked the health board to engage with staff to fully understand their views and identify actions for improvement.

We identified a number of similar areas for improvement during this inspection that were also needed on another Powys Teaching Health Board hospital site in January 2023. The health board must ensure that any improvements identified in HIW inspections are shared throughout the health board and acted upon by all relevant services.

This is what we recommend the service can improve:

- The health board must display information for patients about the Putting Things Right process
- The health board must review any outdated policies to support staff in their roles
- The health board must ensure any IT issues are resolved in a timely manner. In addition, the health board must provide assurance that patients are always provided with patient identification bands on admission, particularly on the weekends
- The health board must ensure that the ‘How we are doing’ board is kept up to date to provide real time information and raise awareness of any improvements needed.

3. What we found

Quality of Patient Experience

Patient Feedback

All patients we spoke with throughout the inspection were complimentary about the care provided and about their interactions with staff. We spoke with some family members during visiting times, who also provided positive feedback and felt that their relatives were being well cared for by staff on the ward.

Person Centred

Health promotion
We saw some information displayed on the ward informing patients about local support groups available to them such as MIND Cymru and how to deal with memory loss. However, there was a lack of other pertinent information available for patients. We did not see information to support patients to improve their health and wellbeing, and we saw very few posters reminding patients of the importance of washing their hands regularly.

The health board must improve the provision of accessible information available to patients during their time on the ward.

Dignified and respectful care
We observed a calm, quiet ward and saw staff providing compassionate care in a dignified and professional manner. We witnessed staff addressing patients by name and explaining what they were doing when providing personal care.

Patients were able to wear their own clothes and all patients appeared clean and well cared for. We saw that attempts were being made to ensure patients maintained their independence by allowing patients to move freely around the ward where possible.

The ward had two communal six bedded bays and a separate two bedded palliative care suite. We observed staff closing curtains when administering care to patients within the communal bays to help protect their privacy and dignity. The palliative care suite was empty during the inspection, but we saw that it was equipped with modern facilities which offered dignity and privacy for patients and their families. The suite had been built following fundraising from the local community and local

charities and was a real asset to the ward and to the local community. The gardens had also been recently refurbished and provided a pleasant experience for patients to sit outside.

The bathroom facilities on the ward were communal. During the inspection we found the bathrooms to be clean at all times. However, we had the following concerns about the bathroom facilities:

- The call bell strings did not reach the floor, which meant a patient could potentially be unable to reach the call bell following a fall
- The toiler roll holders were located far away from the toilets, which meant patients could potentially fall trying to reach for them.

The health board must undertake a review and ensure the communal bathroom facilities are safe and accessible for older patients to eliminate the potential risk of patient falls.

Individualised care

We saw evidence of some initiatives that had been introduced to help care for patients living with dementia. For example, red trays and beakers were being used to help staff identify which patients needed help or extra support when eating and drinking. We were also told that funds had been made available to purchase new armchairs and large dementia clocks for the ward. However, we found other schemes were available but were not being used. For example, although the ward had butterfly stickers, they were not being displayed to make staff aware which patients were living with dementia. In addition, we noted that although 'This is me' forms were available, we did not find any completed forms within the patient records.

The health board must ensure they fully utilise all the initiatives available on the ward to provide dementia care in line with the guidelines described in the Dementia Friendly Hospital Charter for Wales.

Timely

Timely care

Each bed had a call bell where patients could ask for help from staff if required. We saw staff responding to call bells during the inspection in a timely manner. Patients were supported to use the toilet when necessary and given appropriate time to ensure they did not feel rushed.

Patients told us that their needs were being met, and that staff would give an explanation if there had been a delay in responding to their call bell.

Equitable

Communication and language

The patients we spoke with told us that they felt that they could speak to staff and that staff have listened to them.

None of the patients on the ward during the time of the inspection were Welsh speakers. However, we saw staff wearing 'Iaith Gwaith' badges to indicate to patients that they spoke Welsh should they wish to do so. We were informed that translation services would be sought and used should patients wish to speak in other languages. A hearing loop was available to help people with hearing difficulties. A large proportion of patients had sensory loss, and the health board may wish to consider utilising more sensory aids such as picture-based tools to aid patient understanding and function.

We saw that limited information was available to patients bilingually. There was also a lack of bilingual signage around the ward and wider hospital.

The health board must ensure that Welsh speakers receive services that meet their language needs as a natural part of their care.

We saw that there was a 'who's who' information board on display to inform patients about who works on the ward. However, we noted that only the doctors and ward managers were included. The health board may wish to consider adding the nursing and support staff, so patients understand more about who is providing their personal day-to-day care.

Rights and Equality

The ward operated an open visiting policy which meant friends or family could visit patients on the ward without needing to book beforehand. Appropriate facilities were in place for patients and their family or friends to engage in. Patients had access to outdoor spaces if required. We were told that rooms were available away from the ward for private conversations and discussions between staff and patients.

Delivery of Safe and Effective Care

Safe

Risk management
We found the environment of the ward to be clean and accessible for people with mobility difficulties. Work had recently been undertaken to redesign the footprint of the ward, which included moving the clinic room to a different location. Plans were also in place to create a central nursing station in the middle of the ward, which would be a positive addition.

We found some areas of the ward were in need of repair:

- A previous leak meant some ceiling tiles were stained and needed to be replaced
- The skylights in the corridor appeared dirty or stained and needed to either be deep-cleaned or replaced.

The health board must ensure that maintenance work is undertaken to resolve these issues.

It was also clear that the ward suffered from a lack of storage space. We saw items being stored in areas where you would not typically expect. For example:

- The resuscitation trolley was being stored in the day room
- Linen trolleys were being stored in the corridor
- We found a pair of scissors and an electric shaver in the drawer of the sluice room
- The medicines trolley was being stored in the ward clerk's office.

Furthermore, the storage room itself was full, cluttered and untidy. We saw cardboard boxes were being stored on the floor which could potentially be an infection prevention and control issue. We also found cardboard boxes stacked on top of each other which was a risk to the personal safety of staff. One staff member provided a similar comment in the HIW questionnaires:

> *"Stores moved from off the ward to a room on the ward, which is used as a dumping ground, struggle to find anything you need with ease. The second room in the palliative care suite being used as a dumping ground."*

While the footprint and environment of the ward is challenging, the health board must review the storage options in order to provide sufficient storage

space and ensure items are stored in appropriate places. The health board must also ensure that the existing storage room is tidied as a matter of priority with evidence submitted to HIW to provide assurance.

We saw that an up-to-date health and safety policy was in place and saw evidence of regular audits being undertaken to identify issues to reduce the risk of harm to patients, staff and visitors. However, during our tour of the ward we noted that a number of large oxygen cylinders were being stored in a side room off the main corridor. We were not assured that this storage arrangement was in compliance with the Welsh Health Technical Memorandum (WHTM) 02-01 guidance. We raised this issue with staff and actions were taken to address our concerns. Further information on the actions taken by the health board can be found in Appendix A of this report.

Furthermore, we noted that the storage arrangements for the oxygen cylinders had been identified as an issue during the most recent fire risk assessment undertaken in January 2023. This issue did not fall under our immediate assurance process due to the action taken during the inspection to remove the risk to patients and staff. However, it is not acceptable that action had not been taken sooner by the health board following the fire risk assessment.

The health board must ensure that all issues and recommendations resulting from fire risk assessments are actioned as soon as possible. Furthermore, the health board must also provide assurance that all actions identified in the fire risk assessment undertaken in January 2023 have been actioned.

We noted that the cleaning cupboard was unlocked at various times during the inspection despite the door having a key-pad. Cleaning liquids were seen hanging on the trolley within this room. We also found on one occasion that two bottles of cleaning liquid had been left unattended on the sink in the sluice room, which was unlocked. We brought this matter to the attention of a member of the domestic staff who took immediate steps to resolve the issues. Further information on the actions taken by the health board can be found in Appendix A of this report.

The health board must remind all staff of the importance of ensuring the door to the cleaning cupboard is always locked and that cleaning materials are not left unattended throughout the ward.

Infection, prevention, control and decontamination

We saw that Personal Protective Equipment was available and excess stock was being stored appropriately. Staff appeared to be aware of their roles and responsibilities in regard to reducing cross-infection. We observed staff washing

their hands in between episodes of patient care. Staff were also observed using hand sanitiser regularly.
We saw evidence of cleaning schedules displayed on the wall which were being maintained appropriately. During our inspection the floors and surfaces of the ward generally appeared clean. However, we did find a large dusty old box of magnets laid on the floor in the corridor which did not appear to have been cleaned recently. Furthermore, staff informed us that the ward had not received a deep clean in a number of months due to a lack of available domestic staff.

The health board must remove dusty items and ensure that a deep clean is undertaken of the whole ward environment to support effective IPC and ensure the safety of patients and staff.

We saw that a nightly check list was in place to inspect medical equipment such as commodes, blood glucose meters and blood pressure cuffs for cleanliness and to check they are in working order. While the equipment we inspected during the inspection appeared to be clean, we saw that stickers were not being used to indicate to staff that the reusable medical equipment had been cleaned and was therefore safe to use.

The health board must ensure the use of decontamination stickers to indicate whether reusable medical equipment has been cleaned and is safe for use.

Safeguarding of children and adults
There were numerous patients on the ward that required constant enhanced care and were subject to one-to-one observations. However, during the inspection there appeared to be issues with communication around patient records and staff understanding of which patients required one-to-one observations. For example, we saw one patient receiving one-to-one care, but the patient documentation indicated that one-to-one observations were not required. We also noted that one staff member had undertaken a one-to-one observation for more than two hours. This practice did not adhere to the health board policy, which states that staff should not undertake one-to-one observations for longer than two hours.

The health board must ensure that enhanced care levels are accurately recorded within patient documentation and that this is communicated correctly to all staff during handovers. The health board must also ensure that enhanced care is undertaken by staff in compliance with the health board policy.

Safety precautions were in place to help protect patients from the risk of falls. Patients received a falls risk assessment on admission, and we saw evidence of falls care plans being developed for those who required support. Falls prevention equipment and mats were being used. We were told that falls risk assessments

were being updated weekly. However, we found that the falls risk assessments were not being consistently completed or updated. We also noted that falls mats appeared to be permanently by the bed for some patients, even if they were being monitored on a one-to-one observation. Some of the mats appeared quite high and could potentially be a trip hazard in itself.

The health board must ensure that falls risk assessments are reviewed in a timely manner and completed appropriately. We recommend that the use of falls mats during enhanced care should form part of the risk assessment review.

We saw evidence that some mental capacity assessments were being undertaken when required. We also saw that some patients had received a deprivation of liberty safeguards (DoLS) assessment after being determined that they lacked capacity.

However, where one patient was deemed to lack mental capacity for care and treatment, we could not find a formal mental capacity assessment nor a referral for a DoLS authorisation. We also saw a DoLS assessment for another patient where the review period was out of date. We spoke with staff and there appeared to be limited understanding of the DoLS procedure and associated risks. This was particularly concerning due to the patient cohort on the ward, which included older people who had cognitive impairment.

The health board must ensure that DoLS assessments take place as required and recorded appropriately within the patient records to ensure patients are not illegally deprived of their liberty and therefore unlawfully detained. The health board must also ensure that all staff receive refresher training on the Mental Capacity Act and DoLS process.

Blood management

We spoke with staff and were assured that suitable arrangements were in place to safely supply, store and administer blood to patients when required. We were told that staff do not often administer blood to patients, with alternative options considered first. Should blood transfusions be required, then blood is supplied to the ward by Bronglais Hospital blood bank. Hospital staff regularly attend blood transfusion training and are required to undertake refresher training if they have not administered blood for a six-month period. The all-Wales Blood Transfusion pathway is followed to provide consistency among all staff required to administer blood.

Management of medical devices and equipment

There was appropriate and sufficient equipment in place on the ward to support the needs of the patients. This included hoists, walking frames and monitoring

equipment. Staff were able to describe the arrangements for reporting faults with equipment.

Labels had been put on equipment to indicate when it had last been checked or serviced. However, during the inspection we observed staff using a blood glucose machine which gave a false reading. The staff member used another blood glucose machine which provided a true reading. However, we noted that the first blood glucose machine did not have a label to indicate when it required a service.

The health board must ensure that all medical equipment is serviced regularly to ensure they give accurate measurements. In addition, a system must be implemented to monitor when the servicing or replacement of equipment is due.

We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on the ward. We noted that the resuscitation trolley was being stored in the day room. The health board may wish to consider whether this is the most appropriate place to store the trolley on the ward. During the inspection there also appeared to be an issue with the lock on the trolley; on two separate occasions the drawers were able to be opened. This issue was escalated by senior staff during the inspection.

The health board must provide an update on whether the resuscitation trolley has been repaired or replaced to ensure it remains secure at all times.

Following the inspection, we reviewed the HIW staff questionnaires. One member of staff raised the following concern with us in relation to stock at the hospital:

> *"Another issue is we are always running out of stock, and it seems to take a long time for stock to come in."*

The health board must ensure the process for ordering and receiving stock for the ward is improved to ensure staff have the adequate materials, supplies and equipment to do their work.

Medicines Management

We saw that some medicines and controlled drugs were being stored in the new clinic room that had been relocated within the ward. We saw that the medication and controlled drugs were being stored securely. We saw that the temperature of the fridge was being recorded daily to ensure medication was being stored below the advised storage temperatures. However, we noted that on occasions the temperature had been recorded as exceeding the acceptable temperature range. This could affect the potency of the medications which can potentially be harmful

to patients' health. It was not clear whether staff had escalated this or what action had been taken to address this.

The health board must check that the fridge is suitable for storing medication in light of the raised temperatures noted on the checklist. In addition, staff must be reminded of their responsibilities for escalating any temperatures that exceed the acceptable temperature range.

Lockable medicine cupboards were available on the wall by each bed to allow quick access to patient medication. However, we had concerns about the safety of the current arrangements in place to store the medication trolleys:

- They were being stored in the ward clerk's office which meant the room was not always locked
- On one occasion during the first night of the inspection we saw that the trolleys had not been secured to the wall
- We saw bowel preparation medication was being stored on the bottom tray of one medication trolley which should have been locked inside
- We also found a bag of medication left on the bottom tray following a medication round that had not been put back inside the trolley.

We raised these issues with staff who took immediate action. Further information on the actions taken by the health board can be found in Appendix A of this report.

The health board must provide assurance to HIW on further actions taken since the inspection to improve the storage and security of medication on the ward.

We viewed a sample of the all-Wales Medication Administration Records (the chart) and noted that they had been mainly completed correctly. We saw that some staff members were placing dots on the charts when dispensing medication and then signing the chart when the medication had been administered to the patient. However, we did not always see dots on the medication charts which gave an element of doubt as to whether medication was being signed on administering rather than on dispensing.

The health board must provide clear guidance to nursing staff on its expectations on how the all-Wales Medication Administration Records should be completed.

The ward was supported by a pharmacist and pharmacy technician who both conducted weekly visits to the hospital.

Effective

Effective Care

During the inspection we observed nursing staff administering medication to patients throughout the ward. We saw that staff were undertaking checks with the patient and checking the patient identification band before administering medication. However, we found that four patients were not wearing their identification band and instead, the identification bands had been taped to the patient's bedside trolley by staff. This practice did not comply with best practice guidelines or the health board policy, and we were concerned that it could lead to a significant medication error should the bedside trolley be moved or swapped with another patient. We raised this immediately with senior managers who took action to resolve the issue and provided assurance that this practice was not occurring at other settings throughout the health board. Further information on the actions taken by the health board can be found in Appendix A of this report.

The health board must provide an update on the actions taken since the inspection to ensure the practice of removing patient identification bands no longer continues.

Staff discussed the procedures that were in place to help identify and manage cases of sepsis. We were told that a National Early Warning Score (NEWS) score of three or above requires immediate escalation for a potential sepsis diagnosis. However, we saw one example of a NEWS score of three that appeared to have not been escalated. Upon recalculation, the NEWS score reduced to two which lowered the potential risk of sepsis.

The health board must ensure that NEWS scores of three or above are escalated immediately to ensure potential cases of sepsis are managed appropriately and in a timely manner.

Nutrition and hydration

We found the provision of food and drink to patients was generally managed well. All the meals are freshly cooked on site daily and looked well-presented and appetising. There was good communication between nursing staff and catering staff. Staff used the daily handover meetings to check for any dietary or textured diet requirements.

Patients had access to fluids with water jugs available by the bedside. We observed lunchtime meals being served and saw staff assisting patients in a calm, unhurried and dignified way allowing patients sufficient time to chew and swallow food. We also saw staff providing encouragement and support to patients to eat independently.

However, we did identify some areas for improvement:

- We found that one patient had not received their nutritional assessment for 48 hours following admission
- One patient had received their nutritional assessment and required a food chart to be completed for three days following their admission. However, we could not find evidence that the food chart had been completed.

The health board must ensure that patients receive their nutritional assessments in a timely manner following admission and that food charts are completed when required.

In addition, one member of staff provided the following comment in relation to mealtimes:

> *"There are not healthy options for patients at mealtimes like fresh fruit."*

The health board must reflect on this feedback and determine whether patients are being provided with nutritious, varied and balanced meals.

Patient records

During the inspection we reviewed three patient records. We found the records to be up-to-date and on the whole completed following care and treatment. Patients were being assessed for skin and pressure ulcer risk on admission. There was evidence that patients were being frequently repositioned throughout the day and night and that there was ongoing monitoring of pressure areas. We saw that pain was being measured, actioned and managed appropriately for patients. Patient care was planned in a way that promoted independence.

We noted that while evaluations of care by medical professionals had been signed and dated, there was no evidence of what time the record had been signed. The health board may wish to consider adding in a field to the electronic assessment tool if possible to record the time of entries for completeness.

While we saw evidence of discharge planning, we did not always see documented evidence that the patient had been evaluated and determined medically fit for discharge.

The health board must accurately record evaluations of whether patients are fit to be medically discharged within their patient record.

Efficient

Efficient
We saw evidence of positive input from multiple services to help support the efficient movement of patients in and out of hospital. Timely and efficient processes for hospital discharge and admission are vital, as it is during these times when patients are particularly vulnerable. We found the central patient transfer team for the health board helped to manage patient flow, in conjunction with the nursing staff and local GPs.

Quality of Management and Leadership

Staff feedback

Staff responses to the HIW questionnaire were mixed on many aspects of their experiences of working at the hospital. The majority of staff members were satisfied with the quality of care and support given to patients and felt that they would be happy with the standard of care provided by the hospital for themselves, friends or family. Staff also felt that patients are kept informed and involved in decisions about their care. Some of the positive comments we received included:

> *"Staff at this hospital work very hard to deliver safe and effective care. Many staff have worked at this community hospital for decades and have a great sense of responsibility towards the community in which this hospital is situated in."*

> *"On the whole I am very pleased with my working environment."*

> *"Excellent palliative care."*

However, responses were more negative from staff when discussing staffing resources and the visibility of senior managers. More detail in relation to these aspects of their experiences are detailed in the following sections of the report.

Leadership

Governance and Leadership

While staff members who completed a questionnaire provided largely positive feedback about their direct line managers, responses were less positive about senior management. The majority of staff members felt that senior managers were not visible and that communication between senior management and staff was not effective. Staff also felt that senior managers were not committed to patient care. We also received the following comments from some staff members in the questionnaires:

> *"Senior management are rude and dismissive of us as a team and as a hospital. If the sisters are off, I would feel scared to approach anyone else. When they interviewed us for previous things, they have blamed us and made us feel insecure in our jobs."*

> *"Senior management and senior ward sister not being available when staff need to contact them because they are either working from home, in*

meetings, on annual leave at the same time or they simply pick up their phone and slam it down because they don't want to talk to staff on the ward! As a consequence, staff feel abandoned and alone to sort out issues which are above their pay grade."

We also received feedback from staff during the inspection which indicated that there was a 'blame culture' prevalent throughout the ward, and that staff have been threatened previously with having to pay themselves for broken medical equipment.

We are aware that there have been attempts for more engagement from senior management with the staff working on the ward over the last 12 months. However, the feedback we have received from staff demonstrates that there is still further progress that needs to be made in this regard.

The health board must reflect on this feedback and engage with staff to fully understand their views and identify actions for improvement, particularly in relation to the visibility and approachability of senior management and eradicating the 'blame culture' referred to by staff.

We found that some health board policies were out of date during our inspection. These included policies on Putting Things Right and Management of Concerns, Deprivation of Liberty Safeguards and Enhanced Care.

The health board must review any outdated policies to support staff in their roles.

Workforce

Skilled and Enabled Workforce

During the inspection we found that staffing levels appeared appropriate to maintain patient safety within the ward. However, while the majority of staff members who completed a questionnaire agreed that they were able to meet the conflicting demands on their time at work, the majority of staff also told us that they were not enough staff for them to do their job properly. We also received the following comments in relation to staffing resources:

"Staffing on the ward is not appropriate at times and can be unsafe. Staff rotas are not being done efficiently as some days we are short staffed and others over staffed."

"The amount of agency staff being used which is creeping up. Then not being regular ones so you're always with someone who has not worked

there before, lack of continuity for the patients and the staff team. Agency not showing up on a night shift with you having to stay on until someone comes in. Agency staff not having log ins for the computer, so you end up putting their information on as well, creating double your work."

These findings appear in line with national staffing capacity challenges across the NHS. Effective management of rotas is also vital to ensuring the appropriate number of staff are available for each shift. We were told that regular agency staff are booked wherever possible to provide continuity of care for patients.

However, the health board must reflect on this feedback and provide assurance to HIW that the staffing establishment for the ward remains appropriate and able to be fulfilled without regularly using agency staff.

We found suitable processes in place for senior staff to monitor compliance with mandatory training. We saw that overall compliance for staff was 82 per cent. The majority of staff members who completed a questionnaire felt that they have appropriate training to undertake their role. The health board may wish to take note of the additional training suggestions that staff felt would be helpful in their roles:

"Would like more in-depth training regarding the new on-line assessments and referrals."

"It would be useful to have more training on mental health, conflict/aggressive behaviour and transgender patients."

We saw that 75 per cent of staff had received their performance appraisal development review at the time of the inspection. The majority of staff members who completed a questionnaire confirmed that they have had an appraisal, annual review or development review in the last 12 months.

Culture

People engagement, feedback and learning

We saw that information was on display which informed patients how to raise a concern with members of staff on the ward. However, we could not see information on the Putting Things Right process for patients to raise a concern should they not wish to speak to staff directly.

The health board must display information for patients about the Putting Things Right process.

The majority of staff members who completed a questionnaire told us that patient feedback was collected. However, staff also said that they do not receive regular updates on the results of patient feedback.

The health board must provide all staff with learning from patient feedback to help implement any identified improvements to patient care.

We were told that staff had received training to help them understand their responsibilities under the Duty of Candour regulations.

Information

Information governance and digital technology
We received some comments in the staff questionnaires in relation to issues with the digital technology at the hospital:

> *"IT is always an issue and it takes so long to be repaired that you are reluctant to report is as you know you will be on the phone for an hour that you haven't got. So it doesn't get reported until it's actually broke, which is an inconvenience."*

> *"The printer disconnects itself from the computers, on weekends unable to print ID bracelets and labels."*

The health board must ensure any IT issues are resolved in a timely manner. In addition, the health board must provide assurance that patients are always provided with patient identification bands on admission, particularly on the weekends.

Learning, improvement and research

Quality improvement activities
We saw that a range of audits were being carried out to monitor compliance with best practice, and scrutiny meetings were in place to discuss issues such as falls and pressure ulcers. We were told that these findings and lessons learned were being followed up, and actions identified shared with staff.

During this inspection we have made a number of recommendations for improvement that had already been identified on a previous inspection of a hospital ward within Powys Teaching Health Board in January 2023. It is disappointing therefore that the learning from that inspection has not been shared and implemented by all services across the health board.

The health board must ensure that any improvements identified in HIW inspections are shared throughout the health board and acted upon by all relevant services to demonstrate a wider commitment to acting upon learning.

During our tour we saw that a 'How we are doing' board was displayed in the corridor that provided safety performance metrics for the ward such as the monthly number of falls and pressure sores. However, we noted that the board was out of date, and displayed the data for August 2023.

The health board must ensure that the 'How we are doing' board is kept up to date to provide real time information and raise awareness of any improvements needed.

Whole system approach

Partnership working and development

We saw that multiple organisations and services, such as reablement, continuing healthcare and social services, were involved in discharge planning for patients. This was well documented within patient records.

We also saw evidence that where possible, staff worked with the families and carers of patients to ensure the best outcome. Best interest meetings were being held and families and carers were invited to attend weekly multidisciplinary team (MDT) meetings with the medical professionals to ensure they could be involved in decision making on behalf of the patient.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A - Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
During the inspection we noted that a number of large oxygen cylinders were being stored in a side room off the main corridor. We were not assured that this storage arrangement was in compliance with the Welsh Health Technical Memorandum (WHTM) 02-01 guidance. For example, there was no warning sign on the door to indicate that oxygen was being stored inside the room.	We were concerned that staff and patients were not being fully protected against the risks of oxygen being stored inappropriately.	We raised our concerns with the ward manager.	The oxygen cylinders were removed from the storage room to an external location on the wider hospital site before the end of the inspection.
At various times throughout the inspection, we noted that the door to the cleaning cupboard was unlocked. Upon entering the cupboard we found	We were concerned that patients could have access to hazardous materials because	We raised our concerns with a member of the domestic staff.	The cleaning liquids were moved to a secure location, and we were provided with assurance that staff would be reminded about the

cleaning liquids hanging on the trolley. Furthermore, we also found cleaning liquid bottle left unattended on the sink in the sluice room.	they weren’t being securely stored.		importance of ensuring cleaning materials are locked away and that the cleaning cupboard should be kept locked.
On the last day of the inspection we found bowel preparation medication was being stored on the bottom tray of a medication trolley. We also found a bag of medication left on the bottom tray following a medication round that had not been put back inside the trolley.	We were concerned that patients could ingest medication not intended for them. We were also concerned that medication could be taken, or tampered with because they weren’t being locked away.	We raised our concerns with the community services manager.	The medication was immediately locked away inside the trolley and we were also provided with assurance that staff would be reminded of their responsibilities to lock medication away at all times.
During the inspection we saw that four patients were not wearing their patient identification bands. Instead, their ID bands had been taped to their bedside trolley by staff.	We were concerned that staff could potentially administer medication intended for one patient to another patient by mistake if the bedside trolley was moved or swapped with another patient.	We raised our concerns with the community services manager.	The patient identification bands were removed from the bedside trolleys and secured back on to the four patients. We were also provided with assurance that this practice was not common on other hospital wards across the health board.

Appendix B - Immediate improvement plan

Service: Graham Davies Ward

Date of inspection: 09, 10 and 11 October 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No immediate assurance issues were identified on this inspection.				

Appendix C - Improvement plan

Service: Graham Davies Ward

Date of inspection: 09, 10 and 11 October 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
There was a lack of pertinent information available for patients.	The health board must improve the provision of accessible information available to patients during their time on the ward.	Health Education, Third sector organisational support & signposting and Putting things right information to be made available at ward level for patients and visitors along with signposting to the local authority.	Ward Manager	March 2024 PTR information completed November 2023
We were not assured that the communal bathroom facilities eliminated the risk of patient falls.	The health board must undertake a review and ensure the communal bathroom facilities are safe and accessible for older patients.	Review with estates re current design and potential for improvement H&S involvement to support reconfiguration where necessary	Community Services Manager (CSM) in conjunction with Health and Safety lead.	March 2024

We found that dementia friendly initiatives were available at the hospital but weren't being routinely used.	The health board must ensure they fully utilise all the initiatives available on the ward to provide dementia care in line with the guidelines described in the Dementia Friendly Hospital Charter for Wales.	This is me documentation to be embedded into team culture and utilised in care planning to support and reflect patients care planning. Champion to be identified and mandatory attendance at charter meetings is required. Butterfly scheme to be implemented at ward level. Ward project for improving environment of care and dementia garden in progress. Reporting through Community services group health and safety meeting by exception.	Ward Manager CSM	April 2024
There was limited information available to patients bilingually. There was also a lack of bilingual signage around	The health board must ensure that Welsh speakers receive services that meet their language needs as a natural part of their care.	Review of bilingual signage has been undertaken and sourced. Active offer of Welsh language in place, data tracking and audit of Welsh language needs not being met developed through dementia	Ward manager CSM Dementia Lead	April 2024

the ward and wider hospital.		hospital charter group for tri-annual reporting.		
We saw that some ceiling tiles were stained and needed to be replaced. The skylights in the corridor also appeared dirty or stained and needed to either be deep-cleaned or replaced.	The health board must ensure that maintenance work is undertaken to resolve these issues.	Repairs/refurbishment required. Project request form (PRF) required. Escalation through CSG Operational group meeting for surveillance and monitoring.	Ward manager CSM	May 2024
The ward suffered from a lack of storage space with items being stored in inappropriate areas. The storage room was also full, cluttered and untidy, with cardboard boxes being stored on the floor and stacked on top of each other.	The health board must review the storage options in order to provide sufficient storage space and ensure items are stored in appropriate places. The health board must also ensure that the existing storage room is tidied as a matter of priority with evidence submitted to HIW to provide assurance.	Review of current ward storage Discussion with departments currently using ward-based storage to find alternative arrangements - this has been completed.	Ward manager	Completed October 2023
The health board had not taken action in a timely manner to reduce	The health board must ensure that all issues and recommendations resulting	Oxygen placement has been stored in an alternative, appropriate location with risk	Ward manager CSM	Complete October 2023

the risk presented to patients and staff by the storage of oxygen cylinders on the ward.	from fire risk assessments are actioned as soon as possible. Furthermore, the health board must also provide assurance that all actions identified in the fire risk assessment undertaken in January 2023 have been actioned.	assessment and correct health and safety storage applied.		
We found a dusty old box of magnets laid on the floor in the corridor. Staff also told us that the ward had not received a deep clean in a number of months.	The health board must remove dusty items and ensure that a deep clean is undertaken of the whole ward environment to support effective IPC and ensure the safety of patients and staff.	These were removed and disposed of shortly after the visit. Review of all areas where equipment no longer required was disposed of. Health board is seeking to purchase deep cleaning system (HPV) and implementing a rolling program of cleaning on a frequent basis. Awaiting SOP and detail. Ward level cleaning SOP in place and staff updated on the requirement for ensuring this is	Ward manager CSM HoN	Complete October 2023 April 2024

		completed at ward level. (This is health board wide). Dashboard and App being resourced to ensure all audit data is accessible and accountability promoted.		Completed October 2023 March 2024
While the equipment we inspected during the inspection appeared to be clean, stickers were not being used to indicate to staff that the reusable medical equipment had been cleaned.	The health board must ensure the use of decontamination stickers to indicate whether reusable medical equipment has been cleaned and is safe for use.	Consistent use of green stickers to identify cleaning completed. Current green stickers are under review due to plastic content and sustainability. However, they are being used and spot checks undertaken until an alternative solution has arrived (currently on order).	Ward managers CSM HoN IP&C Exception reporting via CSG Quality and safety meeting.	Completed October 2023
There appeared to be issues with communication around patient records and staff understanding of which patients required one-to-	The health board must ensure that enhanced care levels are accurately recorded within patient documentation and that this is communicated correctly to all staff during handovers.	Handover process and safety briefs to be reviewed for ward implementation to ensure clear and identifiable process.	Ward manager CSM HoN	Completed October 2023

one observations. We also noted that one staff member had undertaken a one-to-one observation for more than two hours.	The health board must also ensure that enhanced care is undertaken by staff in compliance with the health board policy.	All wards to ensure that GPN065 enhanced observation policy is implemented, and staff rotated when performing 1:1 care provision. Weekly spot checks to be undertaken to ensure staff rotation when 1:1 is being provided in line with policy.		
We found that falls risk assessments were not being consistently completed or updated. We also noted that falls mats appeared to be permanently by the bed for some patients, regardless of whether or not they required one.	The health board must ensure that falls risk assessments are reviewed in a timely manner and completed appropriately. We recommend that the continued use of falls mats during enhanced care should form part of the risk assessment review.	Falls mats being removed from clinical practice routinely, in line with all Wales guidance, these will only be used on wards with single side rooms and all other areas will require MDT discussion prior to implementing to ensure they are appropriately applied. Nursing team have been reminded of the requirement to undertake a timely fall risk assessment and review this depending on the needs of the patient.	Ward Manager Falls Lead HoN	Completed October 2023 Completed October 2023

		Falls training has been identified to be added to the mandatory training matrix for PTHB inpatient wards.		March 2024
One patient was deemed to lack mental capacity but there was no evidence of a DoLS application nor assessment in place. We also saw a DoLS assessment for another was out of date. We spoke with staff and there appeared to be limited understanding of the DoLS procedure and associated risks.	The health board must ensure that DoLS assessments take place as required and recorded appropriately within the patient records to ensure patients are not illegally deprived of their liberty and therefore unlawfully detained. The health board must also ensure that all staff receive refresher training on the Mental Capacity Act and DoLS process.	DOLS/Safeguarding team to deliver more training to clinical staff. Review of documentation being used on the ward. Increase competence around MCA and BI. Team to be at 85% compliance. Improved compliance with level 3 safeguarding passports.	Ward manager CSM Safeguarding lead.	April 2024
One of the blood glucose machines appeared to be providing false reading	The health board must ensure that all medical equipment is serviced regularly to ensure	This was immediately resolved.	Ward manager CSM	Completed October 2023

but did not have a label to indicate when it required a service.	they give accurate measurements. In addition, a system must be implemented to monitor when the servicing or replacement of equipment is due.	Ward manager to ensure team are aware of checks and escalation and responsibility for the same. Ward manager is responsible for maintaining oversight of equipment management to include servicing.	Exception reporting through Quality and safety group and point of care testing group.	Monthly exception reporting for breaches
During the inspection the top drawers on the resuscitation trolley were able to be opened.	The health board must provide an update on whether the resuscitation trolley has been repaired or replaced to ensure it remains secure at all times.	Intermittent fault identified by Head of Nursing and Inspector during visit. Replacement unit has been ordered. Unit checked twice daily to ensure drawers are secure. Plan to relocate trolley following refurbishment works.	Ward manager	Complete October 2023
One member of staff told us that the ward often run out of stock and that it takes a long time for stock to arrive.	The health board must ensure the process for ordering and receiving stock for the ward is improved to ensure staff have the adequate materials,	Central storage is being reviewed in PTHB. There have been occasional procurement issues with larger	Ward manager	Completed December 2023

	supplies and equipment to do their work.	items of equipment which have been resolved. General stock levels at ward level are monitored with stock rotation in place, and an efficient oracle process in place with no delay in approval processes. The process has a fallback system should an approver be on leave. Ward update on ordering processes to be provided at the next ward meeting to ensure all staff are aware.		
We noted that on occasions the temperature of the fridge in the clinic room had been recorded as exceeding the acceptable temperature range. It was not clear whether staff had escalated this or what	The health board must check that the fridge is suitable for storing medication in light of the raised temperatures noted on the checklist. In addition, staff must be reminded of their responsibilities for escalating any temperatures that exceed the acceptable temperature range.	Regular monitoring of medication storage area temperatures is undertaken with data loggers in place and mean kinetic temperature monitoring is checked, where necessary a degradation factor is applied to the expiry date, meaning that some products require destruction before the official	Ward managers CSM Medicines managements HoN	Completed November 2023 with ongoing monthly monitoring

action had been taken to address this.		expiry date on the manufacturers pack. A joint monthly meeting is in place with Community service managers to ensure management and understanding of any issues and concerns. Escalation of concerns is made through Quality and safety operational group meetings.		
We had concerns about the safety of the current arrangements in place to store the medication trolleys on the ward.	The health board must provide assurance to HIW on further actions taken since the inspection to improve the storage and security of medication on the ward.	Spot checks to be undertaken monthly to ensure medication is not being stored on the bottom of the trolley. Team updated to ensure Trolley is secured when not in use and locked. Observation of medication rounds to be undertaken by ward manager and learning fed back to the team.	Ward manager CSM HoN Medicines management lead.	Completed December 2023 with processes in place for ongoing monitoring

		Health board is currently developing electronic prescribing with new trolleys and therefore an opportunity to embed best practice. Monthly medicines management group reporting to ensure consistency throughout health board.		
We could not be assured whether the all-Wales Medication Administration Records were being signed following administering or dispensing medication.	The health board must provide clear guidance to nursing staff on its expectations on how the all-Wales Medication Administration Records should be completed.	Medicines management have confirmed that the "Dot and Pot" process is taught on induction and medicines management training. Dot and Pot ward based education material is in the ward office and on the ward to act as a reminder. It is possible that this internal system is not known by agency staff and we will add to the agency induction process to ensure consistent application.	Ward manager Head of Nursing.	Completed November 2023

		Electronic prescribing is being introduced in 2024 across PTHB inpatient wards, plan to determine how this approach is delivered to be reviewed with the ePMA team.		
We saw that four patients were not wearing their identification band and instead, the identification bands had been taped to the patient's bedside trolley by staff.	The health board must provide an update on the actions taken since the inspection to ensure the practice of removing patient identification bands no longer continues.	Wrist band audits undertaken weekly have confirmed 100% compliance since visit. This has been confirmed with spot checks during visits. All staff have signed that the Positive patient identification policy has been read and understood. Audits of all inpatient wards undertaken, and ward managers have confirmed that the policy is adhered to. There have been 0 datix where a wrist band omission has been identified.	Ward manager CSM HoN	Completed October 2023 with ongoing weekly monitoring

We saw one example of a NEWS score of three that appeared to have not been escalated for a potential sepsis diagnosis.	The health board must ensure that NEWS scores of three or above are escalated immediately to ensure potential cases of sepsis are managed appropriately and in a timely manner.	Training needs analysis undertaken across inpatient wards. Head of clinical education and HoN have reviewed and sourced Sepsis & NEWS training. Training to be implemented with 2 yearly updates as part of training metrics. All datix case reviewed. System/process to be reviewed for how NEWS escalation is escalated, captured and reported.	Ward manager CSM HoN	Completed November 2023 April 2024 Completed November 2023
We found that one patient had not received their nutritional assessment for 48 hours following admission. We also could not find evidence that a food chart for another patient	The health board must ensure that patients receive their nutritional assessments in a timely manner following admission and that food charts are completed when required.	Assessments to be audited on WNCR by digital nurse - wards prompted to ensure completion where gaps are identified. SOP for the timescale of assessments is in place. Ward manager to ensure this becomes an agenda item in	Ward Manager CSM Head of Nursing Dietetics Quality Improvement Manager.	April 2024 Completed October 2023 Completed December 2023

had been completed as required.		regular ward meetings and exceptions reported through 1:1 and quality and safety meetings by exception. Nurse in charge to review paper documentation and ensure nutrition and hydration are being adequately documented. Monitoring through health board annual MDT nutrition and hydration and catering 360 audit.		Completed December 2023 April 2024
One member of staff felt that there were not enough healthy options provided for patients at mealtimes.	The health board must reflect on this feedback and determine whether patients are being provided with nutritious, varied and balanced meals.	Staff are encouraged to feedback into the Nutrition and hydration group meeting to have a voice in patient nutrition. Quality improvement projects for healthy eating and sustainable nutrition to be reviewed at ward level to enable local empowerment for patient centred care initiatives. Civica feedback for meals is actively sought from patients.	Ward manager Head of facilities HoN	Completed December 2023

We did not always see documented evidence that patients had been evaluated as medically fit for discharge.	The health board must accurately record evaluations of whether patients are fit to be medically discharged within their patient record.	Proactive re-engagement in board rounds and 6 goals. Doctors reminded to record discharge information and nursing team to be reminded during the next ward meeting to ensure nursing document reflects the MDT discussion.	Ward manager CSM MDT	February 2024
We found that some health board policies were out of date during our inspection.	The health board must review any outdated policies to support staff in their roles.	Organisational processes in place to ensure policies are reviewed and updated on a regular basis.	Board Secretary	April 2024
Staff responses to the HIW questionnaires were negative in relation to some aspects of working on the ward.	The health board must reflect on this feedback and engage with staff to fully understand their views and identify actions for improvement, particularly in relation to the visibility and approachability of senior management and eradicating the 'blame culture' referred to by staff.	It is recognised that there have been historical concerns from the team with the management of investigations. We have introduced team culture initiatives from the workforce and organisational development team, along with restorative supervision style feedback following incidents.	CSM WOD HoN	March 2024

		The team are making every effort to be increasingly visible and proactive on the ward.		
Staff responses to the HIW questionnaires were negative in relation to staffing resources.	The health board must reflect on this feedback and provide assurance to HIW that the staffing establishment for the ward remains appropriate and able to be fulfilled without regularly using agency staff.	The health board have made a decision to utilise all Wales safe staffing process (bi-annually), this includes the professional judgement of the nurse in charge of the ward and triangulation against Datix harms, staffing levels and complaints/Concerns. During a review in March 2023 we reduced the bed base from 18 to 14 to support safer staffing. Active recruitment including internationally educated nurses arriving in Spring 2024 will further reduce vacancy and strengthen the team through the reduction of agency use. Where agency nurses are attending the ward, they are block booked to offer continuity	HoN DDON Nurse staffing lead	June 2024

		of care and understanding of health board processes.		
We could not see information on the ward about the Putting Things Right process.	The health board must display information for patients about the Putting Things Right process.	The updated Llais board was in the process of being updated and has subsequently been refreshed with the most up to date information. Staff reminded to signpost patients and visitors to the correct application of the Putting things right (PTR) process.	Ward manager	Completed October 2023
The majority of staff who completed a questionnaire said that they do not receive regular updates on the results of patient feedback.	The health board must provide all staff with learning from patient feedback to help implement any identified improvements to patient care.	Frequent feedback is provided to the ward when this comes via the quality team/CSM/HoN. Ward managers requested to add as a standing agenda item and minute this to ensure all teams are aware of the feedback being received. Feedback is also shared through ward managers meetings to	Ward manager CSM HoN	Completed October 2023

		ensure shared learning across the health board.		
We received some comments in the staff questionnaires in relation to issues with the digital technology at the hospital.	The health board must ensure any IT issues are resolved in a timely manner. In addition, the health board must provide assurance that patients are always provided with patient identification bands on admission, particularly on the weekends.	Recent IT issues with printing have been resolved following a consolidation project. Datix to be used to report instances where there is a lack of service. Reporting through Quality and safety group.	Ward manager CSM HoN	Completed November 2024
We saw similar areas for improvement identified during this inspection that had previously been identified on another Powys Teaching Health Board hospital site in January 2023.	The health board must ensure that any improvements identified in HIW inspections are shared throughout the health board and acted upon by all relevant services to demonstrate a wider commitment to acting upon learning.	Feedback and learning is shared across all services following a visit. Thematic action plan being developed from all 6 visits to ensure a cohesive, collaborative approach to resolving some of the issues that we see. Action plan review meetings have been introduced monthly to ensure progress is being made	CSM HoN AD	Completed October 2023

		and that support for escalation is available.		
The safety performance metrics board for the ward was out of date and displayed the data for August 2023.	The health board must ensure that the 'How we are doing' board is kept up to date to provide real time information and raise awareness of any improvements needed.	Whole system methodology for how we are doing boards is in review with update expected early 2024. All ward managers to be reminded of the importance of up to date, accurate information being displayed. Monthly spot checks undertaken to ensure data aligns with reporting.	Ward Manager CSM HoN	March 2024 Completed October 2023 Completed October 2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Linzi Shone

Job role: Professional Head of Nursing

Date: 18/12/2023