Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

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

Inspection date: 09, 10 and 11 October 2023
Publication date: 11 January 2024

This summary document provides an overview of the outcome of the inspection

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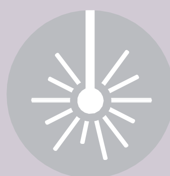

Patients and their family members provided positive feedback about their experiences and felt well cared for by staff. The ward environment appeared clean and was accessible for people with mobility difficulties.

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.

Patient records were up-to-date and generally well completed.

We were 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.

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.

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.

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

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.

This summary version of the report is designed for members of the public.

A full report, which 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 can be found on our website.

Quality of Patient Experience

Overall Summary

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.

Where the service could 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.

What we found this service did well

- Staff responded to call bells during the inspection in a timely manner.

Delivery of Safe and Effective Care

Overall Summary

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.

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.

Where the service could 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.

What we found this 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. 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.

Where the service could 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.**

Staff told us:

> *"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."*

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."*

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.