GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 August 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health and Social Care (Quality and Engagement) (Wales) Act: How we met the Duty of Quality and the Duty of Candour in 2023 to 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Interim Director of Nursing, Quality and Patient
SWYDDOG ADRODD: **REPORTING OFFICER:**	Cathie Steele, Head of Quality and Governance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

All NHS organisations are required to publish an Annual Quality Report and an Annual Duty of Candour Report as part of the organisation's annual reporting process.

The purpose of this report is to share with the Quality, Safety and Experience Committee the current draft *Health and Social Care (Quality and Engagement) (Wales) Act: How we met the Duty of Quality and the Duty of Candour* for 2023 to 2024 (appendix 1).

Cefndir / Background

The Quality and Engagement Act became law on 1 June 2020 and came into force on 1 April 2023.
The Act:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality
Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient, and equitable care in the context of a learning culture. To help achieve this, the Act:

- Places an overarching duty of quality on the Welsh Ministers; and
- Reframes and broadens the existing duty on NHS bodies.

This ensures the concept of "quality" is used in its broader definition, not limited to the quality of services provided to an individual or to service standards.

NHS bodies are placed under a duty to report on the steps they have taken to comply with the duty of quality on an annual basis.

The Duty of Candour
A culture of openness, transparency and candour is widely associated with good quality care. To help achieve this, the Act places a duty of candour on providers of NHS services (NHS bodies and primary care) – supporting existing professional duties.

The duty requires NHS providers to follow a process when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal, and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

Under the duty, NHS Bodies will be required to report annually on compliance with the duty and publish their reports. Local Health Boards will be required to collate this information from those primary care providers with whom they enter into a contract or arrangements for services and publish a combined report.

When reporting, NHS Bodies will be required to specify if the duty of candour has been triggered in the reporting year (defined as each period of 12 months ending on 31st March, (each financial year), and if it has:
1. state how often the duty of candour has been triggered during the reporting year.
2. give a brief description of the circumstances in which the duty was triggered; and
3. specify any steps taken by the body with a view to preventing similar circumstances from arising in the future.

The report must be prepared as soon as practicable after the end of each financial year.

Asesiad / Assessment

Preparation of the Quality and Engagement Act Annual Report
A request was made to all services and directorates for examples for potential inclusion in the annual quality report for 2023/24, of new services, new initiatives or developments which improve quality of care for Hywel Dda residents.

Duty of Candour data within DatixCymru was also validated and information gathered in preparation for the report.

The initial intention for the report was to develop a MS Sway format report. However, due to conflicting priorities this has not been achievable for this year.

Attached as appendix 1, is the proposed annual report for 2023/24

Developing Always on Reporting
Information on the duty of candour and duty of quality has been provided regularly to QSEC through the quality assurance report. It is proposed that this regular reporting mechanism continue.

An internet page has been develop with the intention of publishing examples of quality improvement regularly throughout the year.

Next Steps

The finalised Quality and Engagement Act annual report will be presented to the Annual General Meeting in September 2024.
Argymhelliad / Recommendation The Quality, Safety and Experience Committee is asked to: • Provide comment on the draft report for 2023/24 • Note and support the proposed next steps. • Ratify the report ahead of being presented for Board approval.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.22 Monitor progress of and assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	No corresponding risk identified on organisational risk register
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	DatixCymru EQIiP Programme
Rhestr Termau:	Contained within the body of the report

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This annual requires resource in the form of staff time to produce it. This comes principally from the Director of Nursing, Quality and Patient Experience's budget. Resource will also be required from other areas such as Communications.
Ansawdd / Gofal Claf: Quality / Patient Care:	This annual report reports on the quality of HDdUHB services to the public, and is an important part of the Health Board's Annual Reporting process.
Gweithlu: Workforce:	Development of staff through pooling of skills and integration of knowledge
Risg: Risk:	This annual reporthas reputational risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Cyfreithiol: Legal:	This annual report has legal risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Enw Da: Reputational:	This annual report has reputational Risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Gyfrinachedd: Privacy:	N/A

Cydraddoldeb: **Equality:**	This annual report reports on services only. It aims to cover as many areas of service as possible, but it is not possible to cover everything within the report.

Health and Social Care (Quality and Engagement) (Wales) Act

How we met the Duty of Quality and the Duty of Candour

2023 to 2024

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Alternative formats and large print are available on request by calling 01267 239554

Welcome from the Chair of the Quality, Safety and Experience Committee and Interim Director of Nursing, Quality and Patient Experience

We are delighted to bring you this report for 2023 to 2024 which shows how we, Hywel Dda University Health Board (the Health Board), are fulfilling our requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act).

This report provides you with a summary of the work that has been undertaken in the last year, and demonstrates our commitment, to improve the quality of our services and to meet the needs of our patients across Carmarthenshire, Ceredigion, Pembrokeshire and borders. It also describes what is in place to ensure the health board is able to meet its obligations under the Act in relation to the Duty of Candour, how often the Duty has been triggered and what the themes are.

This report does not cover all the work we have undertaken during 2023 to 2024 but provides examples of what we have done over the past year. To the best of our knowledge the information provided in this Annual Quality and Engagement Act report provides an accurate and representative picture of how we are meeting our duties. The implementation of the Act has been subject to Internal Audit scrutiny and awarded a level of assurance of substantial assurance.

We continuously monitor our systems and processes so that we can learn and improve to ensure safe and high-quality care. We welcome your feedback in the form of complaints, concerns and compliments and provide a variety of ways in which you can do that. We work together with Healthcare Inspectorate Wales and Llais who give us independent feedback in light of visits to the Health Board and ensure that we act upon their recommendations.

Anna Lewis, Independent Member – Community and Chair of the Quality, Safety and Experience Committee

Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience

About the Annual Quality and Engagement Act Report

Welcome to our Annual Quality and Engagement Act Report for 2023 to 2024. This report is intended for our population, as well as our board. It gives us the opportunity to share with you how we are fulfilling our requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act).

The Health and Social Care (Quality and Engagement) (Wales) Act became law on 1 June 2020 with its full implementation completed in April 2023. Its intention is to:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of the people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

Significant progress has been made to improve the quality of health services in Wales but we still have challenges and changes that we must make to achieve better outcomes for patients across Carmarthenshire, Ceredigion, Pembrokeshire and the borders.

The Duty of Candour

The key intention of the Duty of Candour is to promote a culture of openness, learning and improving that is owned at organisational level, whether a person receives care from the NHS, or from a regulated provider of health care services, and that person can be assured that they will be dealt with in an open and honest way by their care provider. Separate work is being taken forward by Welsh Government to make Regulations to place a duty of candour on providers of independent health care in Wales, using powers under the Care Standards Act 2000.

Meeting the Duty of Candour: how we are ensuring we are open and transparent

The health board recognise the importance of the Duty of Candour in promoting a culture of openness and ensuring that there is learning and improving that is owned at organisational level.

Organisational Requirements

NHS bodies are required to follow a procedure when the duty if candour is triggered. The Act also requires NHS providers to report annually about when the duty has come into effect, how often the duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence. Triggering the duty does not mean an NHS body accepts any fault or blame.

Triggering the Duty of Candour

The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:

- The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome;
- The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome.

For the purpose of the first condition, a service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal.

The Duty of Candour Statutory Guidance 2023 prescribe the actions that must be taken and supports the existing processes for 'Putting Things Right' (the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) with updates made to the Putting Things Right' (PTR) Regulations to include the Candour Guidance.

Preparing for implementation of the Duty

Prior to the introduction of the Duty of Candour, the health board prepared for the roll out of the Duty. As well as joining national implementation groups, an internal quality and engagement act implementation group was established by the Director of Nursing, Quality and Patient Experience. The implantation group considered what training and education, communication and engagement was required before the duty was rolled out.

Every opportunity was used by the Quality, Assurance and Safety Team to raise awareness regarding the duty of candour. Training sessions were also delivered either face to face or via MS Teams. A dedicated SharePoint site was published, and the site

is updated as required to ensure that staff have helpful information readily available to them. Monthly Duty of Candour drop-in sessions were arranged, and these continue to allow staff to discuss scenario's where it is not as clear if the duty has triggered. The senior members of the Quality Assurance and Safety Team are also available outside of these drop-in sessions to discuss any cases that cannot wait until the scheduled meeting.

The incident functionality within Datix Cymru has been revised to ensure that the consideration of the Duty can be captured, and monitoring and reporting can be undertaken. Under the duty the health board, including primary care contractors, are required to capture and report on occasions where the Duty of Candour is triggered. Primary Care providers must notify the Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under contract.

Training, Governance and Risks

Funding for additional resource to comply with the Duty of Candour has not been made available by Welsh Government. There is a known staffing requirement for administration / co-ordination / support to comply with the Duty of Candour and in turn provide the board with assurance. Across NHS Wales the issue of resources was raised and reported back to Welsh Government. The Health Board recognises this risk and continues to look at alternative ways of working to support the implementation Duty and how work can be streamlined.

Local training has been delivered and continues. Welsh Government have also developed an e-learning training package for staff which is available via the ESR platform / Digital Learning Wales (annex two). Local ESR data has shown that 1052 have logged onto the ESR system and requested the Duty of Candour training. Going forward in 2024/25 staff will be encouraged to access the Candour training via the ESR platform.

The health board recognises the critical role that learning and development plays in fostering growth, progress and also the delivery of high-quality services to patients. We are at our best when we learn from others and share skills and knowledge through continuous learning and development and, through continuous learning and development, we can achieve personal and organisational growth whilst ensuring safe and effective practices. We continue to ensure our workforce are equipped to address current and future demands and continue to develop a culture within the health board to align with the Duty of Candour

The Duty of Candour does have some implications for the 'National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. A full review of the 'Putting Things Right' process has been committed to by the Minister for Health and Social Services and is currently under a consultation process.

Operationalisation

Each directorate and service have processes to manage patient safety incidents which, following an initial management review of harm, is recorded as moderate or above. If a patient safety incident is categorised as moderate or above, the Duty of Candour is

triggered, and the procedure must be followed. The Datix Cymru system should be used to record all activity relating to the patient safety incident including key dates relating to the Duty of Candour.

Dashboards are available within the Datix Cymru system for each directorate and service to ensure the Candour procedure is followed and performance indicators are met.

Candour performance is validated by the Quality Assurance and Safety Team and is reported through the Directorate Improving Together meetings.

We would like to take this opportunity to thank our staff who strive for improvements to the quality of care provided to our patients, who continue to be open and honest and learn from concerns when things do not go as well as we would wish. Staff have embraced the Duty of Candour and are aware of the processes to comply with the requirements of the Act. There is further work to do to support staff to comply in a timelier manner with the reviews and responses to concerns, and we are committed to make improvements in this area.

Health Board Performance

During 2023/2024[1], 2,933 patient safety incidents were graded by the reporter of the incident as moderate or above. Following Manager's Interim Harm Assessment, 2, 311 patient safety incidents were downgraded to low harm, no harm or the incident occurred prior to the introduction of the Duty. This shows an 79% downgrade rate across the health board.

During the reporting period, Datix Cymru is reporting as showing 69 patient safety incidents graded by the reporter as no or low harm which, following 'Manager's Interim Harm Assessment', were re-graded as moderate harm or above.

This data suggests further work is required to ensure staff are aware of the classification of harm to be record when reporting an incident.

Duty of Candour Triggered

During 2023/24, both conditions[2] were met and the duty of candour was triggered in 51 patient safety incidents.

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[1] *Patient safety incidents reported 01.04.23-31.03.24 as moderate or above*

[2] *The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:*

- *The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome;*
- *The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome*

Of the 51 patient safety incidents which triggered the duty, 42 incidents have been closed. Post investigation harm assessment shows that 13 (31%) of patient safety incidents reported did not cause moderate harm or above as a result of healthcare.

Severity of Incident on closure	Manager's Interim Harm Assessment			
	Moderate	Severe	Catastrophic / Death	Total
None	1	0	0	1
Low	10	2	0	12
Moderate	26	1	0	27
Severe	0	1	1	2
Catastrophic / Death	0	0	0	0
Total	37	4	1	42

To date, of the patient safety incidents reported in 2023/24, 1% of patient safety incidents reported within the health board triggered the Duty of Candour during 2023/24.

Top themes triggering the Duty of Candour include:

- In-patient slips, trip or fall (33%)
- Pressure Damage developed or worsened whilst receiving healthcare (31%)
- Treatment / Procedural issues (12%)

Of the patient safety incidents closed at the time of writing this report, whereby patients are recorded on Datix Cymru as having sustained more than minimal harm as a result of healthcare provided, themes as a learning outcome include:

- Ensuring development or review of processes and policies;
- Improvement needed in communication;
- Ensuring review of previous history including risk history;
- Improvement needed in completion / adherence to documentation; and
- Ensuring timely assessments / review of investigations / monitoring

Contracted Services – Primary Care

Contractors within the Primary Care setting, which includes Community Pharmacists, General Medical Practitioners, General Dental Practitioners and Optometrists, are required to submit data to the health board relating to the Duty of Candour in September 2024.

Concerns Management

High quality, safe and compassionate care is at the heart of health care being delivered by our staff. Despite these intentions, inevitably from time to time our patients may suffer harm due to challenging and / or complex situations. When harm does occur, being open and honest should feel like the right thing to do.

Dealing with these situations quickly, sensitively and openly is of great importance and can make a difference to a patient's ongoing relationship with the health board.

Throughout 2023/24 at our Board meetings, we have reported how we are improving people's experience which includes our concerns management and patient experience survey data. An example from the Board meeting in July 2023, can be found through the following link hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-27-july-2023/board-agenda-and-papers-27-july-2023/item-4-3-improving-service-user-experience-report-pdf/

We recognise that there are times when we do not get our concerns management right and patients and families request assistance from the Public Services Ombudsman for Wales.

Public Services Ombudsman for Wales

During 2023/24, 23 final investigation reports were received from the Public Services Ombudsman for Wales (PSOW). Of the 23 final investigation reports, 3 were upheld and 16 were partially upheld. The table below provides a summary of the numbers.

Final Investigation Reports received	23
Upheld	3
Partly Upheld	16
Not Upheld	4

Cases where financial redress was recommended by PSOW	8
Total Value	£5100.00
Value Range	£250 - £1500

The themes within the reports received from the PSOW included:

- Care/treatment not following appropriate guidance;
- Lack of reasonable adjustments;
- Medication;
- Communication;
- Documentation / poor record keeping;
- Failures in relation to treatments, test, diagnosis;
- Discharge issues;
- Nutrition / hydration; and
- Complaint handling.

Further detail is provided within Appendix 1 of this report.

In response to the recommendations from the PSOW, we have undertaken further pieces of improvement work including:

- Carrying out an audit of arterial cannula management to ensure nursing staff in the ITU are reviewing arterial cannulas at the intervals specified in the Workbook and documenting them accurately and provide evidence that it has done so.
- Ensuring that the PSOW recommendations are shared to facilitate learning across services and across the Health Board e.g. sharing the PSOW findings at a consultant forum to ensure wider learning from the complaint, noting in particular the record keeping requirements around counselling for treatment and the accuracy of the terminology used in the records.
- Reminding relevant staff of the benefit of recording in patient notes the availability of the SPCT, including out of hours, so it is visible to clinicians.
- Arranging for the nursing team to have a discussion on the alternatives to oral analgesia for patients with chronic pain and not able to tolerate oral medication.
- Reviewing how we support individuals with a hearing impairment, including ensuring their hearing aid is available, and how this is documented in a patient's notes.

- Introducing a lower threshold for decisions on whether to initiate “conscious sedation” during trans oesophageal echocardiography (TOE) procedures and endeavour to obtain the patient’s agreement to receive sedation prior to the passage of the trans oesophageal probe
- Reminding nursing clinicians of the WAASP guidance and what it says regarding patients at moderate and high risk of malnutrition.
- Developing local guidelines for independent inter-hospital transfer

Listening and Learning Sub-Committee

The Listening and Learning Sub-Committee is a sub-committee of the Health Board’s Quality, Safety and Experience Committee. The sub-committee provides clinical teams across the Health Board with a forum to share and scrutinise learning from concerns (incidents, complaints, and claims) and other quality areas such as external inspections, and to share innovation and good practice.

During 2023/24, the Listening and Learning Sub-Committee considered:

- Palliative care
- Reports received from the PSOW;
- The learning identified through the nosocomial COVID review programme; and
- The themes arising from inspections undertaken by Healthcare Inspectorate Wales.

Meeting the Duty of Quality: how we are ensuring we provide quality services

The health board recognise the importance of the Duty of Quality in meeting service standards and in ensuring we provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

The duty means that we must think and act differently by applying the concept of "quality" across all our services. We are required to have quality-driven decision-making and planning, which ultimately delivers better outcomes for all people who require health services. We are required to involve people in decisions that affect them, balancing short-term needs with planning for the longer-term, with action to prevent problems occurring or getting worse.

Quality Management System

In preparation for implementation of the duty, we developed our quality management system strategic framework which was approved by Board in March 2023.

The overarching aim of the quality management system (QMS) strategic framework is to provide a system-wide approach to achieving quality of care in a way that secures continuous improvement. The strategic framework sets out our approach, structure and tools to empower staff to lead and deliver services that meet quality and safety expectations and standards.

Putting people who use our services, patients, and carers at the centre of everything we do is important, working together as one Hywel Dda team, ensuring we have the data, resources, engagement, and support required to deliver on a quality service through our system. Our QMS framework and the board strategic objectives act as an enabler to this.

Quality Planning

Throughout the year, we have worked on understanding our priorities for improvement, understanding the need from the population perspective, identifying the gaps in what is provided and identify the priorities for redesign and continuous improvement.

The board have set 6 strategic objectives with clear outcome measures.

The board is committed to reshaping pathways based on outcomes and is using Value Based Health Care to take this forward. To ensure that quality is considered in all strategic decisions, a Quality Impact Assessment Tool has been introduced. Each assessment is considered by the Quality Impact Assessment Panel which ensures that there is clinical oversight of the decisions being requested.

Quality Control

We aim to provide safe and timely care for our patients. To help achieve this we have identified some key areas where we want to make improvements. In addition, we have identified areas where we are performing well and want to maintain this or, where possible, make further improvements.

During 2023/24, we have reported our progress against our strategic objectives at our Board meetings. Each month we produce a performance report, in the format of a dashboard, to show our progress in these key areas. The report is examined by our Board and Committee members.

A quality dashboard is also available for services and directorates so that they can monitor their performance in relation to the strategic objectives set by the Board.

Quality Improvement

In 2018, we made an investment to build its capacity and capability for Quality improvement (QI). In March 2023, the Board approved the updated Quality Improvement Strategic Framework. Our Enabling Quality Improvement in Practice (EQIiP) Programme provides teams with the arena to:

- Come together to agree and prioritise the areas they want to improve;
- Meet regularly to review data and feedback, discuss issues, review progress, and agree actions;
- Agree key improvement measures and making data easily accessible to aid decision making;
- Work on improvement projects aligned to the team's priorities utilising QI skills and tools and engaging in EQIiP for more complex multi-disciplinary improvement; and
- Share good ideas across the Health Board to help others.

As well as the improvement projects being undertaken through EQIiP, the Quality Improvement and Service Transformation (QIST) team supports services with designing and implementing improvement projects in response to national and local initiatives and priorities.

Using the Health and Care Quality Standards, examples of some of the improvements we have made are outlined below.

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The Health and Care Quality Standards

To understand what good quality means and how we can ensure quality is considered across a number of areas, twelve Health and Care Quality Standards have been developed. The Standards comprise of six domains of quality and six quality enablers.

Safe – how we ensure that we provide high quality, highly reliable and safe care that avoids preventable harm, maximising the things that go right and learning form when things go wrong to prevent them occurring again.

Timely – how we ensure that our patients have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time.

Effective– how we ensure decision-making, care and treatment reflects evidence-based best practice, to ensure that our patients receive the right care to achieve the best outcomes possible for them.

Efficient – how we make take a value-based approach to improve outcomes that matter most to our patients in a way that is as sustainable as possible and avoid waste.

Equitable – the arrangements we have to ensure that people in Hywel Dda are provided with an equal opportunity to attain their full potential for a healthy life.

Person Centred – how we meet the needs of our patients, ensuring that their preference and values guide our decision making and that we treat everyone with kindness, empathy and compassion, respecting their privacy, dignity and human rights.

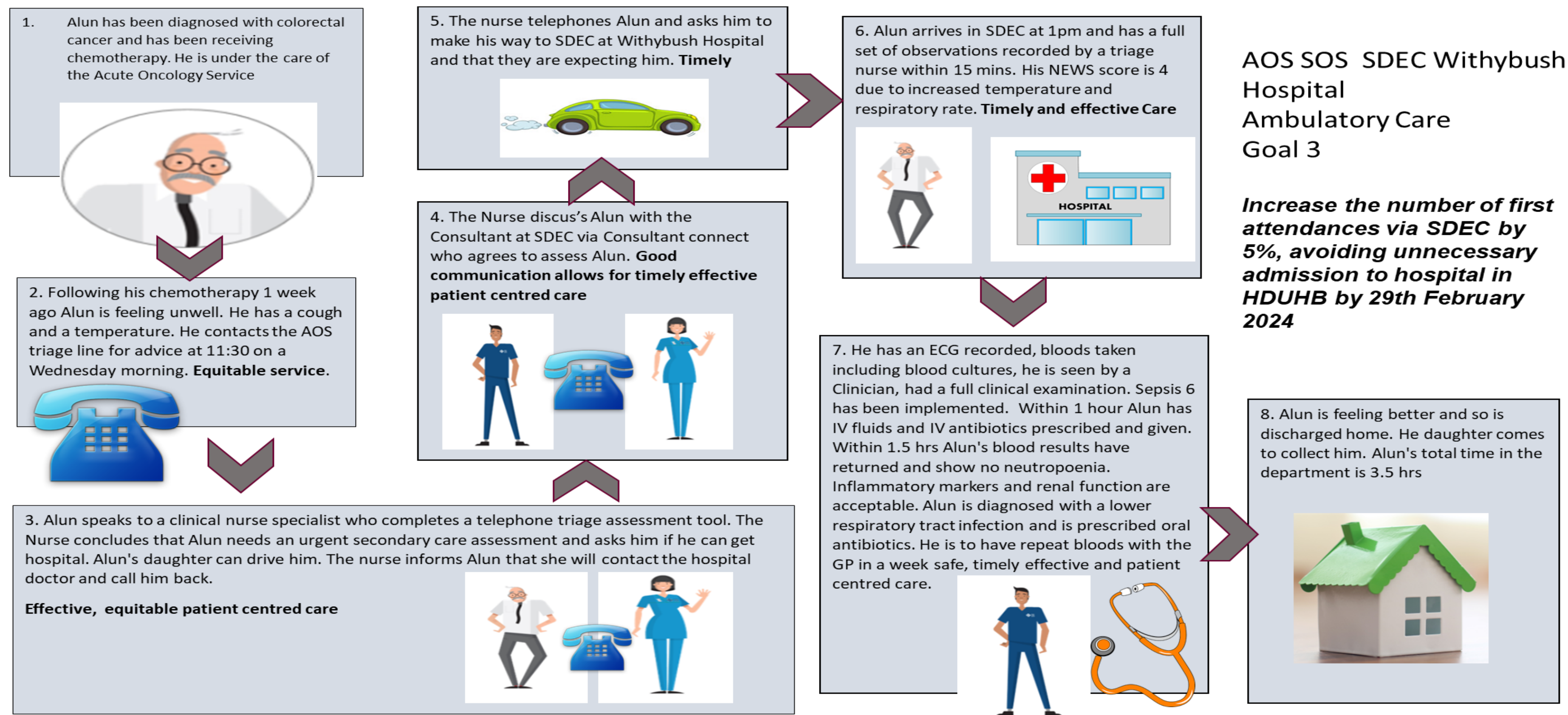
The quality standards are supported by six quality enablers: leadership, workforce, culture, information, learning, improvement and research, and whole-system perspective.

Our quality improvements during 2023/24

Acute Oncology Service (AOS) SOS

Patients actively receiving systemic anticancer treatment and who are assessed as requiring urgent or emergency care by the Acute Oncology (AOS) Triage line were signposted to the A&E Department at Withybush General Hospital which resulted in long waits. A change in the referral pathway was implemented with an aim of increasing the utilisation of the Same Day Emergency Care (SDEC) service reducing avoidable hospital admissions by improving internal pathways and communication both within primary and secondary care to ensure patients receive the right care, in the right place, the first time.

The experience of patients and staff was greatly improved through this change.



AOS SOS SDEC Withybush Hospital
Ambulatory Care
Goal 3

Increase the number of first attendances via SDEC by 5%, avoiding unnecessary admission to hospital in HDUHB by 29th February 2024

"As a cancer patient undergoing a years' worth of treatment to include weekly chemotherapy & immunotherapy, along the way I have had to be seen urgently in Glangwilli Hospital for treatment, for adverse side effects. The first visit, I had to go to A&E and then to MAU (Medical Assessment Unit), I was very unwell, and sat on a chair in a room full of other patients all day. I was very exposed to other patients coughing and this was not a safe environment for me when I am extremely vulnerable. Not being able to lie down or sit in a comfortable chair was also difficult when you are feeling that unwell.

The second time I had to contact the hospital due to needing an urgent MRI scan, I was directed to the SDEC unit. This was an absolutely far better experience from beginning to end. The staff were fantastic, the chairs were comfortable, and there are screens in-between patients, which made me feel safer in terms of catching infections.

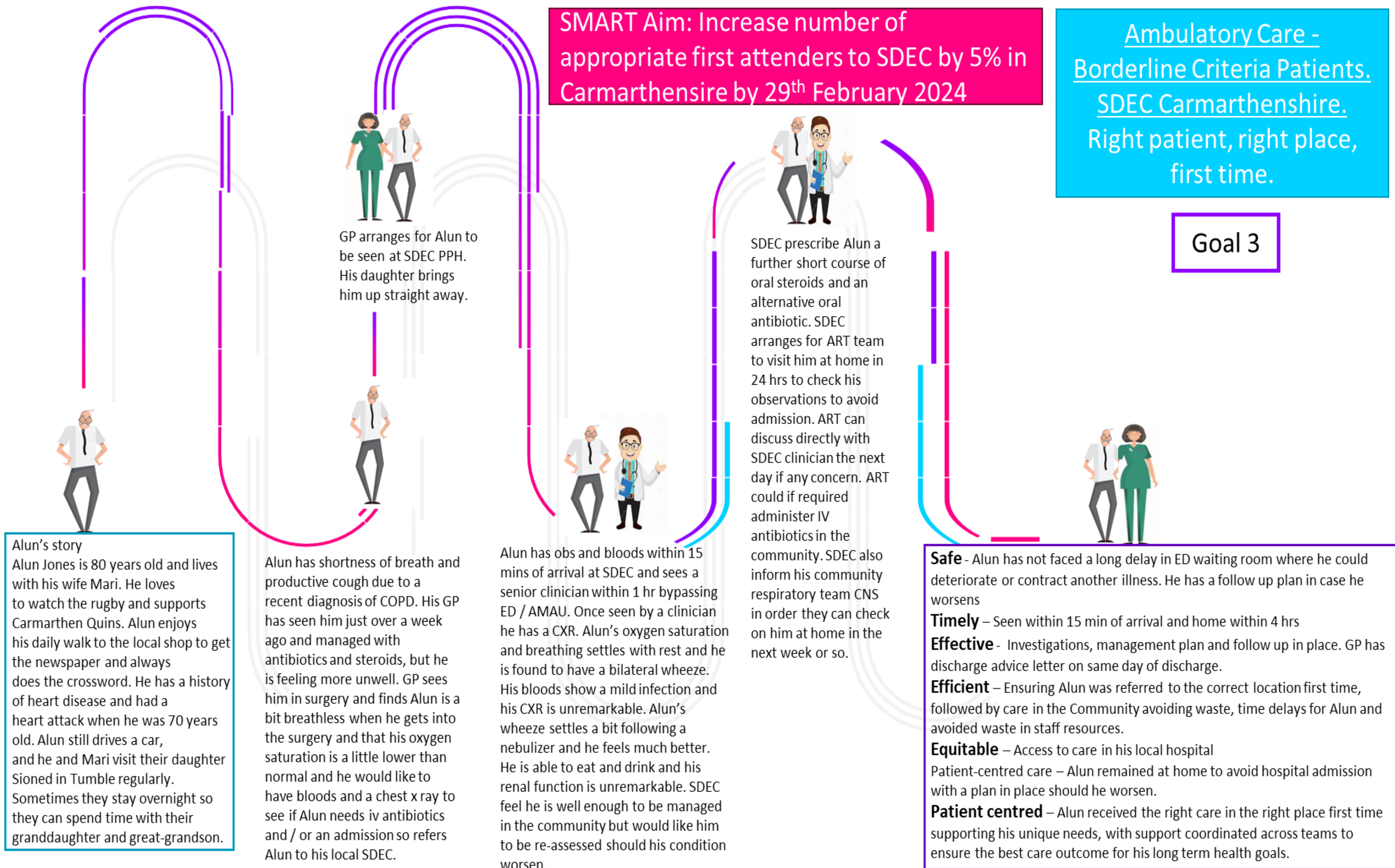
Another visit, I was again directed to SDEC, who had been informed I was on my way via the chemo unit. This in itself made the process seamless, and I was seen to straight away, where it was decided I needed an urgent blood transfusion. Again, I was in a clean room by myself. I felt my care was far better overall having gone straight to SDEC and that this system is better for cancer patients, both physically and mentally. As opposed to going to A&E"

"When referring patients, the AOS team also forward on the relevant guidelines which has also been very very useful".

"Attending SDEC team meetings has been invaluable. It's given me the opportunity to get to know and feel part of the SDEC team."

"It's really helped me feel like we're working together as a team to improve the service we give to all of our patients."

Same Day Emergency Care in Carmarthenshire



Alternative Welsh Ambulance Services Trust Pathways

Alternative WAST Pathways

Project Aim:

To develop localised pathways which enable WAST to refer directly into community services for rapid access to appropriate intervention and support for individuals where conveyance to hospital is not clinically indicated

Sioned Jones

- Sioned works part time. She is also a student, and a carer for both her ageing parents, and her grandson.
- Sioned wants healthcare pathways tailored to the current and future needs of her family.
- Sioned wants her family to be able to access the right care, in the right place, first time.
- Sioned wants her family to be able access care closer to home, with them being at the heart of all decisions.
- Sioned is concerned that if either of her elderly parents go into hospital, they will contract an infection. She would like the Ambulance Service to arrange alternative healthcare and support services to enable her parents to remain together at home.

Mari & Alun Jones

- Mari and Alun rely on their daughter to care for them.
- Mari gets confused and sometimes gets lost. She is scared about going to hospital and wants to stay at home with her husband.
- Alun wants to live well with his wife at home. He would like the Ambulance Service to seek alternatives to going into hospital as he is worried how Mari would manage without him being there.

Mari's Story

Mari has fallen whilst walking to the bathroom toilet. She doesn't appear to be seriously injured however is having difficulty getting up from floor. Alun calls his daughter Sioned for assistance, who is looking after her grandson Ben whilst daughter Lianne attends an antenatal appointment.

Sioned advises her dad to call for an ambulance, and once Lianne returns Sioned heads over to her parents' house. By this time Alun has been able to assist Mari into her armchair and is making her comfortable whilst waiting for the ambulance to arrive.

Mari is clinically assessed by the Paramedic who establishes that she has sustained minor injuries from the fall. They are concerned about Mari's increasing frailty and the fact that this is the second time she has fallen in the past three months.

Treatment options are discussed with Mari, Alun, and their daughter Sioned whom all agree that taking Mari into hospital to be further assessed and treated isn't in her best interests, particularly as the busy hospital environment can cause Mari to become disorientated and distressed.

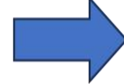
Using the locality directory of community health services, the Paramedic refers Mari to the local Same Day Urgent Care (SDUC) service who arrange to visit later that day to assess her needs. A request for Mari to be reviewed by the community therapy team is also made.

Mari is able to remain and receive the care that she needs at home, supported by Alan and her family.

Message in a Bottle

Goal 4 Message In a Bottle- Improve communication by ensuring 80% of patients on 1 DN caseload who have palliative or end of life care needs are offered statement of wishes by April 2024.

Rhys, is 52 years old, a long-distance lorry driver, who lives in Tumble, near Llanelli. Rhys lives with his wife Sioned, 19 year old daughter Lianne and 3 year old grand-son Ben. Rhys needs orthopaedic surgery on his knee, which has been giving him lots of trouble and reducing his mobility. The operation has been postponed a couple of times due to emergencies and staffing issues. Unfortunately, before having his operation, he had a new diagnosis of prostate cancer with bone and liver metastasis, which is incurable.



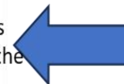
Rhys was given a prognosis of six months; he declined palliative chemotherapy as he wanted quality of time with his family as opposed to quantity of time. Consent was given for a referral to the palliative care team. Due to his poor mobility and long periods of time in bed Rhys consented for a referral to the District Nursing team for pressure damage prevention and equipment assessment. Rhys was admitted onto the district nursing caseload.

Rhys was suffering with nausea and pain, which was being regularly reviewed by the District Nursing team. During subsequent routine visits, providing advice and support a good rapport developed with Rhys, Sioned and the family. On each visit support and advice was offered not for just Rhys but for the whole family. A carer assessment was offered but was declined by Sioned and for Leanne and Ben were referred to Palliative Care Psychological Support. This in turn gave the District Nurse an opportunity to discuss a Statement of Wishes (SOW) with the family.

A sensitive conversation was had with Rhys and Sioned who wanted more information on a SOW. The Nurse explained that a statement of wishes is a written statement that sets down your preferences, wishes, beliefs and values regarding your future care. The aim is to provide a guide to anyone who might have to make decisions in your best interest if you have lost the ability to make or communicate decisions.

Rhys had the discussion with Sioned and the nurse and explained he wanted to be buried in his Welsh rugby jersey holding his family photo in his hand. He also requested that his end-of-life care needs should be met at home with his family present. He also wanted his favourite rugby song "Yma o hyd" played in his final moments.

After completing the SOW a copy was put into a yellow file and placed into the left draw in the dresser with the district nursing file. A copy was given to Rhys's GP and recorded onto the Civica Scheduling system to inform all healthcare professionals that a SOW is in place. It was then recorded into the message in a bottle to indicate that a SOW is in place also and where to find this information.
A message in a bottle is a simple but effective way for people to keep their basic personal and medical details safely and can be found in an emergency or deteriorating situation in a common location such as a fridge.



After a few weeks Rhys deteriorated at night. Sioned contacted the OOH's GP who in turn contacted WAST for conveyance to hospital. Sioned also contacted the Acute Response Team (ART) to request a visit for symptom control. She informed ART that an Ambulance had also been called. ART were aware of the SOW (due to Civica) and contacted 999 to cancel the ambulance stating that Rhys's end of life care was to be met at home. ART liaised with OOH GP and a syringe driver was commenced for symptom management.

In the morning ART handed Rhys's care back over to the District Nursing team and a fast track was completed for care with the Continuing Care Team. All his care needs were attended to at home in the last days of his life.

Rhys sadly passed away peacefully away at home (as per his SOW) with his family by his side. Yma o Hyd was playing in the background. He was buried in his favourite Welsh Rugby jersey with a photo of him and his family in his hand.

Frailty Matters

Frailty Matters @GGH

'The frailty team will increase the number of discharges of frail patients within 72 hours of arrival by 5% by 29th February 2024'.

02:58 Found following an unwitnessed fall. Family called WAST

04:05 Ambulance arrives at Mari's home. Frailty scored assessed at 6

05:06 Mari is seen in ED Pit Stop, bloods taken, awaiting CT

06:07 Mari is returned to the ambulance following her ED assessment

08:00 Mari is taken for CT head and x-ray pelvis and returned to ambulance

10:11 Mari has a chest x-ray and returned to ambulance

11:31 Mari is reviewed by the nurses, analgesia given and is catheterised

12:04 Mari is returned to the ambulance

12:16 Doctor assessed Mari whilst on the ambulance.

14:23 Nursing staff administer antibiotics whilst on the ambulance for a urine infection

15:00 Mari is taken to the Pit Stop for skin check s and is taken into ED

15:30 Reviewed by the Frailty Team and to be transferred to Cadog Ward when bed available

23:07 Mari is transferred to the Clinical Decisions Unit and then to Cadog Ward at 09:30.

11:00 am Mari is reviewed by the frailty team on Cadog Ward

11:00 am The following day, Mari is discharged home via the discharge lounge following medical and therapy review

Maris is very pleased to be home with her husband and to be nearer her family

DEVELOPING:

- **SAFE:** Early access to specialist Frailty services.
- **TIMELY:** Mari saw the frailty team within ED and the decision was made to transfer Mari to the short stay frailty ward when a bed was available.
- **EFFECTIVE:** Mari was seen by the Frailty Team with the aim to get her home as soon as possible.
- **EFFICIENT:** Mari was able to see the Frailty team as early as possible in her journey and this influenced the ward she was admitted to by implementing a 'positive pull' for frail patients.
- **EQUITABLE:** Mari received care from the team she most needed to achieve getting home safely as soon as possible.
- **PATIENT CENTRED CARE:** Mari saw the MDT who were aware of her aim to get home as soon as she could with the support services she required.

charlie story - frailty.mp3

Reducing Harmful Patient Safety Incidents in A&E at Glangwili General Hospital

Reducing Harmful Incidents in A&E Glangwili Hospital (GGH) - TUEC Goals 5 & 6
Safe and Effective Acute Care – In the **right place,** having the **right care, first time**

To help reduce some of the pressure on his sister Sioned, Gareth takes Sioned's daughter Lianne and grandson Ben to meet up with his family on a trip to Pembrokeshire to enjoy the scenery and some cycling. Unfortunately, on the way home the family were involved in a Road Traffic Collision on the A40 between St Clears and Carmarthen.

Gareth required extraction from the car after being trapped in the drivers seat. He had suspected serious injuries and was pre-alerted to GGH A&E as a trauma call.

GGH had no resus space free and when the trauma call was received they were also asked by WAST to red-release an ambulance to go to this trauma call. As identified in the earlier **safety huddle**, the most appropriate patient was moved from resus to another area in the department to accommodate him and allow the trauma team to prepare for immediate reaction and **timely** treatment on his arrival.

Upon arrival Gareth was met in resus by the trauma team and following a primary survey, he had a poly-trauma CT before returning to Resus. Significant injuries were identified via CT prompting **immediate** discussions with the South Wales Major Trauma Network, resulting in a need to be **transferred** to University Hospital of Wales (UHW) in Cardiff

GGH agreed with WAST a patient swap from an ambulance to allow Gareth to be 'blue lighted' to Cardiff to undergo specialist treatment before being repatriated at the **appropriate point of his care.**

Lianne sustained minor superficial injuries while Ben had a suspected broken arm so both were conveyed to GGH A&E.

In transport to GGH Ben was becoming more distressed, requiring constant reassurance but Lianne appeared quiet and distant.

On arrival to A&E, both Ben and Lianne were triaged and **redirected** to the Minor Injuries Unit (MIU) for treatment.

The Emergency Nurse Practitioner (ENP) in MIU arranged for an X-Ray for Ben but could also see that Lianne was becoming distressed. She raised concerns about her unborn baby and would not accompany Ben to the X-Ray department so the ENP contacted the **Midwifery Led Unit (MLU)** to discuss Lianne's concerns and review her as required while a Registered Nurse and member of the **Play Co-ordinators** from the **Paediatrics** team took Ben for his X-Ray which confirmed the fracture, applied a cast and organised fracture clinic follow up appointments.

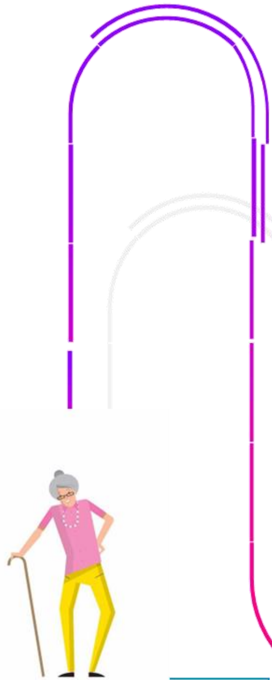
In this time, Lianne's parents arrived and immediately expressed concerns that Lianne has not been coping well looking after Ben and being pregnant and they felt helpless as they have been supporting elderly parents alongside Lianne and Ben. This coupled with Lianne's demeanour led the ENP to contact the **safeguarding** team for advice.

After receiving reassurances from **MLU**, the ENP had a discussion with Lianne and her parents regarding support at home and arrangements were made for the safeguarding team to follow up to identify and address their needs together.

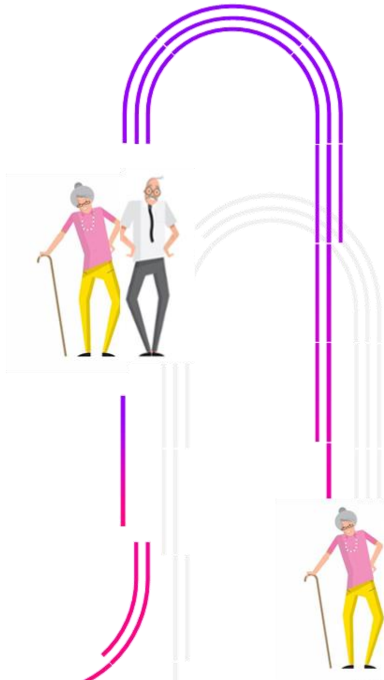
Improving patient safety through collaboration

Hydration and fluid balance – Bronglais General Hospital

Acute Care - Hydration and fluid balance
Bronglais General Hospital
Ceredigion



Mari is 78 years old and lives at homes with Alun, her husband of 50 years. She is a retired teacher and is former President of the local Women's Institute which she still attends. She loves cooking, especially baking cakes. In recent months, Mari has developed mild dementia and has become increasingly frail. She is becoming more confused and has often been found wandering.



Mari has become unwell at home over the past few days and her husband has called for an ambulance as her condition worsened.
The paramedics make an initial assessment and decide Mari needs to be taken to A&E in Bronglais general hospital in Aberystwyth.

Once in A&E the nursing team take handover from the ambulance crew and begin their assessments. Mari has a NEWS score of 4 and a temperature of 38.2
The nurse caring for Mari knows that a NEWS of 3+ and a temperature of over 38 are both triggers for the commencement of a fluid balance chart and start one immediately. After further investigation it is decided that Mari may not have been drinking enough at home due to becoming confused and forgetful. It is decided that some IV fluids should be given, which is an additional trigger for a fluid balance chart.

The team in A&E and CDU in BGH monitor Mari closely over the next 24 hours and with the help of an accurate fluid balance chart are able to establish that as a result of her mild dementia Mari had become dehydrated over a period of days by forgetting to drink enough fluids which has caused a UTI and an elevated temperature.
IV fluids and antibiotics are administered and by closely monitoring her fluid input and output are able to discharge Mari home to her husband after 48 hours.

Safe – Mari was assessed by a nurse who was able to begin a fluid balance chart appropriately by correctly identifying the triggers which indicate one.
Timely – A fluid balance chart was started as soon as it was appropriate to do so.
Effective - By using the accurate data provided by the fluid balance chart further deterioration is prevented.
Efficient – The fluid balance chart was able to be used as a diagnostic tool which enabled a diagnosis to be made.
Equitable – Access to care in her local hospital with patient focused care which meant Mari could be safely discharged to home from the A&E/CDU without an extended stay in hospital.
Patient centred – Mari received the right care in the right place first time supporting her unique needs, Clinicians were able to get the information provided by the appropriate diagnostic tools to make a diagnosis.

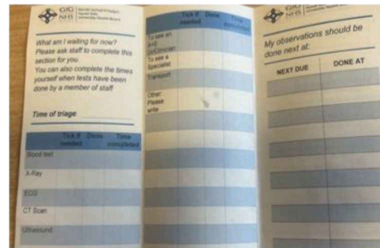
Talk NEWS

Goal 1&2

Talk NEWS- To ensure 100% of patients attending ED in WGH have a NEWS score documented in triage and are escalated appropriately by March 2024.

1. Rhys, aged 52 self- presented to WGH ED on a Wednesday afternoon around 14.00pm. He is a long-distance lorry driver, and he has been feeling generally unwell for 3/7days. He has right leg swelling with redness and tenderness.

2. On booking in at reception Rhys is given his ED Patient Passport with information in relation to waiting times, triage process, what investigations he may be booked for and Observations he may be due. The aim of the ED passport Is to provide **equitable patient centred care**.



3. Rhys is reviewed in triage in a **timely** manner, within 15 minutes and he has observations taken. NEWS score calculated as 3 due to RR of 21, Heart Rate is 94bpm. Triage nurse records observations on NEWS chart, updates Rhys ED passport to manage expectation of planned care and informs allocated HCA for waiting to repeat his observations in 30 minutes. Triage nurse also screens for Sepsis 6 due to NEWS score >3. Rhys had bloods taken, calf measurement and the doctor asked for a WELLS score to be completed.

Due to operational pressures, there is no capacity for Rhys to be admitted into the main ED department and he is placed back in the waiting area.

4. Rhys has his observations repeated in the waiting area by the HCA in the new observation Hub. The hub can ensure the staff provide **Safe patient centred care**. NEWS remains 3, Triage nurse updated, and time prescribed on chart for when observations next due.

A USS was requested for Rhys to rule out a DVT but Radiology have no capacity to do the scan today.

5. Rhys reviewed by medical team with his blood results.

He has a raised Ddimer and all other bloods are normal. WELLS score 2- Moderate risk group for DVT. The team are ? he has a DVT so commence him on treatment dose Tinzaparin.

His repeat observations indicate a NEWS of 2 due to RR 21.

6. Rhys is discharged home from ED and is booked to attend SDEC Thursday AM for his USS & review by the medical team.

7. Rhys had his ED passport copied for him to take home and the master copy given back to reception staff.

Rhys informed the staff he felt informed throughout his visit to the department and **effective** communication throughout.

Cuppa Conversations – Talking Marginalisation

72 MIDWIVES AND OBSTETRICIANS ATTENDED!

LEARNING WAS SHARED VIRTUALLY BY THE MULTI-DISCIPLINARY TEAM THROUGH GROUP SESSIONS LED BY:

Cerian Llewellyn - Lead Risk & Governance Midwife
Sarah Burton - Public Health Midwife
Tipswalo Day - Consultant Obstetrician

SUPPORTED BY:

Elizabeth Rees - Consultant Midwife
Faith Worrall - Clinical Supervisor for Midwives

WHAT DID WE ALL LEARN? HERE IS A SNAPSHOT...

'The lack of funds those seeking asylum get'

'This has given me food for thought in how I treat people'

'Thought provoking, how do we adjust our service to create equity'

'The tiny budgets people are given- to be aware to support women with baby bank, home visits etc'

'It's about caring for the individuals needs not necessarily giving everyone the equal care'

'This was really impactful and insightful'

'The difference between equality and equity.'

'I loved how this presentation was given, it was informative and engaging. I really want to learn more about how to be actively anti-racist in my life and in the healthcare setting'

'Talking about K**** really brings it home about racism and equal opportunities to care'

'Meaning of allostasis'

'Discussion about allostatic load very interesting and I will apply this knowledge to my practice'

'Allostatic load. I will ensure extra visits and continuity in community'

'How allostatic load physically effects the body is mind blowing'

'Allostasis must become part of our every day considerations for all women but especially in support of those women at risk of poorer outcomes because of inequalities including those within ethnicity minority groups'

'Importance of language used and again individualised care for better outcomes'

'CHANGE IS THE END RESULT OF ALL TRUE LEARNING' (ARISTOTLE)

GIG Cymru NHS Wales | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Learning Disabilities and Pregnancy

LEARNING DISABILITIES & PREGNANCY

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1.5 MILLION

People in the UK with a learning disability

2.16%

OF ALL ADULTS IN THE UK HAVE A LEARNING DISABILITY

Pregnant women with learning disabilities are less likely to seek or attend regular antenatal care, and struggle to understand the often text-based antenatal information communicated during pregnancy

Right to an "Ordinary Life"

There has been increased recognition of the rights of people with learning disabilities to 'an ordinary life', including the right to be parents, with people with learning disabilities becoming more likely to develop relationships and form their own families

Associated Risk Factors

- Increased rates of pre-eclampsia
- Venous thromboembolism
- Pre-term birth
- Caesarean birth
- Low birth weight
- Low Apgar scores
- In one UK study combining stillbirths and infant deaths, rates per 1000 were 27.9 for babies of mothers with learning disabilities and 13.4 for other babies

THE MATERNITY PASSPORT

Co-produced by the maternity service, learning disabilities team and Paige's family

The passport aims to improve communication for women with a LD and care providers during pregnancy

Pregnant Women and Birthing People with a Learning Disability Guideline

Development of a local guideline in conjunction with LD services to promote individualised care planning to meet the needs of women and birthing people with a LD

Feedback

"I found that the passport was great, helped me really discuss with the woman what she needed and helped me to understand more about how I could support her. I felt like it strengthen our bond"
Midwife

"XXXX is very happy with the passport and is proud that this was a part of her baby's legacy"
Service user

Additional Information

Scan me

Neurophysiology Improvements

"In the last year we have made a number of changes and improvements to Neurophysiology.

The department has been redecorated and refloored (from very old and dirty carpet to vinyl flooring throughout) which has improved our compliance with infection control. I overheard a patient in the waiting room today comment on how clean and tidy it looked (which of course gives a better impression and better experience).

We have procured the most up to date equipment for all of the tests that we offer - the new EEG equipment is *almost* up and running but reliant on input from IT. Our IT infrastructure is in the process of being updated - this will allow remote log in for our consultants to report on the investigations more promptly and allow automatic uploading of results to Welsh Clinical Portal allowing easier access for clinicians. Both of these measures will help to reduce RTT (Referral to Treatment Times) for our patients' pathways and hopefully improve outcomes.

Laura has recently developed a QR code allowing our patients to complete a feedback questionnaire as our paper leaflets in the waiting room were removed during covid.

She has also set up educational meetings every other month for us to all come together and discuss interesting cases that we have seen and present topics of interest and relevance as part of CPD."

Our commitment for 2024/25: a final message from the Chair and Executive Lead for the Quality, Safety and Experience Committee

As Chair and Executive Lead for the Health Board Quality, Safety and Experience Committee (QSEC) we hope that you have found that this Quality and Engagement Act Annual Report has provided a snapshot of our work, demonstrating our commitment to improve the quality of our services and to meet the needs of our patients across Carmarthenshire, Ceredigion, Pembrokeshire and borders.

In 2024 to 2025, we will endeavour to learn from when things have not gone well, make improvements in areas that matter to our patients, residents and staff, and ensure all our strategic decisions are made through a quality lens.

The QSEC is a statutory committee of the Board. Its primary purpose is to scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board. The full terms of reference for the committee can be found on our website http://www.wales.nhs.uk/sitesplus/862/opendoc/324367 With this primary purpose in mind the QSEC will receive at its meetings throughout 2024 to 2025 updates on the key quality priorities, as part of our commitment to continuous learning and improvement for the benefit of our communities and our staff.

Thank you for taking the time to read our report.

Patient support services (feedback and complaints): Share your experience

Quality drives everything we do and for us to continue to improve we'd like to know about your recent experience of using our services.

You can do this by contacting our patient support services:

Telephone: 0300 0200 159

Email: hdhb.patientsupportservices@wales.nhs.uk

Online: Using our feedback form which can be found on our website https://hduhb.nhs.wales/healthcare/services-and-teams/patient-support-services-complaints-feedback/

Post: Freepost Feedback @ Hywel Dda

If it matters to you - it matters to us.

We are listening.

Appendix 1 - PSOW Final Investigation Reports – 2023/24

Final Investigation Reports received	23
Upheld	3
Partly Upheld	16
Not Upheld	4
Cases where financial redress was recommended by PSOW	8
Total Value	£5100.00
Value Range	£250 - £1500

PSOW Themes

Care/Treatment not following appropriate guidance

NICE Psychosis and schizophrenia in adults: prevention and management 2014

Royal College of Obstetricians and Gynaecologists and British Society for Gynaecological Endoscopy, Green-top Guideline No.67: Management of Endometrial Hyperplasia

NICE guideline NG148 – "Acute kidney injury: prevention, detection and management"

The GMC Guidance - of particular relevance are items 20, 50 and 51, which relate to discussing and documenting decisions on care (November 2020).

NHS Wales model policy for consent to examination or treatment (revised July 2017) - in particular, point 6, which states that "consent can be given in writing or verbally", and that "in all cases it is essential that an adequate record of the consent is maintained for future reference"

Equality Act 2010

National Institute for Health and Care Excellence ("NICE") "Patient Experience" clinical guideline [CG138], Section 1.5 concerns communication and enabling patients to actively participate in their care

Lack of Reasonable Adjustments

No evidence that the Health Board had made any reasonable adjustments, in accordance with the Equality Act 2010, to account for the patients autism and enable her to properly understand and participate in the decisions about her clinical management (including any earlier surgery).

While there was evidence that clinical staff discussed with the patient her care and treatment, there was no evidence staff ensured she was wearing her hearing aids or considered if she required any other adjustments due to her hearing impairment.

Medication

There was a delay in the patient receiving pain relief when she attended the ED WGH.

Delays in administering pain medication to the patient in ED GGH

Patient had been given an inappropriately high dose of pain-relieving medication and that the management of her vomiting was avoidably made more difficult by this error.

There was a 7-day delay in the patient receiving anti-TB treatment, although unlikely to prevent the patient's deterioration, admission, and subsequent death, the 7-day delay led to uncertainty and caused distress for the family.

Communication

A drug error was not reported to the family until after the patient's death

Although the patient received appropriate treatment and interventions, communication was poor with her family, national guidelines were not followed and there was confusion as to why certain decisions were made.

The Ombudsman found that there were missed opportunities for the SPCT to be involved in the patient's care, and to support her family.

It was reasonable that the patient was discharged from the service, however the way that this was communicated to him was not appropriate and he was not fully informed of the decision to discharge him.

The complaint that the communication with the patient was poor was partly upheld in relation to the lack of opportunity to discuss his concerns after his surgery.

Communication between services and with the family and need for close collaboration between teams

Documentation/Poor record keeping

RCOG Guideline recommend that persistent bleeding would point to hysterectomy as a preferred treatment, no evidence in records that this was considered or discussed with the patient in 2019. The Health Board acknowledged that record keeping was not of the expected standard.

It was not possible to determine if the patient suffered a fall, but poor record keeping and a failure to document vital observations meant that her risk of falls was not appropriately assessed.

The decision to place the patient in an induced coma was medically appropriate. However, due to a lack of documented discussion, it could not be concluded that he made an informed decision to proceed, or that his consent was properly obtained.

Nursing care and treatment fell below standard because there was a failure to fully record the treatment prescribed to the patient, failure to note a pain score and, as a result, failure to fully assess the patient's needs.

Inadequate clinical evidence that patients longstanding urinary dysfunction had been explored sufficiently leading to uncertainty about whether the patient's condition required urgent intervention at the time.

The patient's risk of blood clots had been managed appropriately before her cardiac arrest, however the unavailability of relevant clinical records had caused avoidable distress to the patient's family.

Documentary shortcomings in a procedure impacted on communication as well as contributing to shortcomings in complaint handling.

Bote - In a number of these cases the PSOW found that issues with documentation and poor record keeping led to uncertainty and distress for patients/families.

Failures in relation to treatments, test, diagnosis

Patient abdominal aortic aneurysm was visible on a scan that the patient underwent and should have been noted and reported on at the time. This was a failure by the Health Board and an injustice to the patient who was unaware that he was suffering from a potentially serious condition.

Patient's symptoms should have warranted an admission to hospital in order to administer antibiotics and management of his kidney injury. The Ombudsman said that it is not possible to know with confidence whether admission to hospital would have prevented the patient's death, but this uncertainty was a significant injustice to the family.

The initial investigation and treatment of the patients shoulder problem was appropriate. However more detailed imaging could have been obtained before carrying a subsequent operation, and the decision made at that operation to carry out a hemiarthroplasty (half-joint replacement) was unlikely to have led to the best outcome.

There was a delay in the patient having bowel surgery

Failure to diagnose patients iron deficiency anaemia

Failure to stop patients vaginal bleeding for a period of 11 months. Although treatments to medically manage the symptoms were provided, these were unsuccessful. RCOG Guideline recommend that persistent bleeding would point to hysterectomy as a preferred treatment, the Ombudsman could not see that this was considered or discussed with the patient in 2019.

Failure to arrange appropriate investigations and a review to confirm or exclude a blocked biliary stent. As a result the patient was deprived of the opportunity for appropriate investigations which potentially could have identified the problem sooner and given her a better chance of avoiding an infection.

There was a delay in organising an ECG for the patient in September 2021, despite requests being made as early as December 2020. Additionally, the patient was prescribed and had started taking medication that should only have been commenced after an ECG had been performed.

There was inadequate clinical evidence that patients longstanding urinary dysfunction was explored sufficiently. The Ombudsman considered that, whilst it is not now possible to determine with certainty whether the patient had Cauda Equina Syndrome that needed urgent intervention at the time, had there been sufficient exploration at the time of the consultation this uncertainty might have been avoided.

Discharge issues

The patients discharge home during the early hours of the morning was not appropriate and put her, staff and her family at risk

Patient should have had observations taken prior to transferring independently to GGH, to ensure it was safe for her to do so, and she should have been given the option of waiting for an ambulance to transfer her.

Nutrition/Hydration

Patients nutrition was not person-centred, and her cultural needs were not considered as a trigger for her poor nutritional intake. Food intake was not documented from admission and therefore her poor intake was not identified in a timely manner.

Significant failings in the assessment and management of patient's nutritional needs. A delay in him being screened using the WAASP, which was not repeated at the appropriate frequency, there was a delay in being referred to Dietetics with incorrect information on the referral form, no weight measurements or suitable alternatives were taken, and there was a delay in prescribing Pabrinex.

Complaint Handling

Complaint handling failings which included delays added to the families' distress.

Complaint handling partly upheld to the extent that the response omitted to address one issue.