HIW Inspections
Overdue actions
(as at 24/11/2023)

Inspection Title	Recommendation	Reference	Action	Date Due	Date Last Updated	Progress Status	Comments/Updates
HIW Bronglais Hospital Maternity Unit unannounced inspecti	The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	MD1/1	Lead Anaesthetist and the Lead Anaesthetist for Obstetrics for BGH have been informed as a priority and have provided assurance that compliance will be met at the earliest opportunity	31/08/2023	08/11/2023	Partially complete (Overdue)	Update 04/09/23 we scheduled two dates for anaesthetic skills update for 8 anaesthetists. I can confirm these completed as planned bar two who were out of the country on leave but whom have been prioritised and scheduled to attend the first PROMPT training dates. I have received the following form our Practice Development Midwives and PROMPT facilitators in relation to this action. On the 18th we had 3 attend and today. On the 24th we had 2 and the welcome addition of an anaesthetic nurse on call that was able to join us. Overall the days have been excellent with good engagement from all participants, we have had interactive learning and discussion throughout the sessions. In particular I noticed the excellent clinical ability of R and D during the PPH scenario which, provided reassurance to the patient actress as well as good clinical leadership. We have 4 anaesthetists that are compliant with PROMPT so this leaves only 2 outstanding (both are out of the country at present) and one is booked to attend the first PROMPT session of the new programme at the end of September.
		MD1/2	PROMPT Wales have been contacted and an additional PROMPT facilitator training place for an Obstetric Anaesthetist from BGH has been confirmed this will increase the number of anaesthetic facilitators available for PROMPT training in BGH.	21/09/2023	08/11/2023	Overdue	
		MD1/3	Given the nature and value of PROMPT training, it is essential that it is MDT and therefore session take place on a monthly basis. The Health Board acknowledges that to achieve the outcomes they must be SMART and therefore, this will take several months to achieve compliance	21/09/2023	09/11/2023	Overdue	Update 09/11/23 the service have advised they are aiming for 31/03/24 as a completion date.
	The health board should review the on call rota process (for midwives) to ensure that appropriately skilled midwives are available to support the obstetric unit in times of increased acuity	MD5/1	Vacancy factor of 1.8wte has been recruited to which will further support the staffing requirements of the service	10/11/2023	08/11/2023	Overdue	Position recruited to, awaiting onboarding prosess for a start date.
		MD5/2	Community midwives support the acute obstetric unit based on the bespoke nature of the service and will respond and support during periods of high acuity only. Community hours are collated monthly to understand usage and impact and shared with the senior midwifery team.	10/11/2023	08/11/2023	Overdue	
		MD5/3	A RAG rated escalation flow chart is in place during high periods of acuity to ensure appropriate escalation for support from the community midwives who have their base on Gwenllian Ward	10/11/2023	08/11/2023	Overdue	
		MD5/4	Community midwives take part in the annual PROMPT training and complete both the community and obstetric PROMPT course to ensure skills and practice supports the low risk and high risk requirements of both clinical areas of practice.	10/11/2023	08/11/2023	Overdue	
		MD5/5	A new programme of skills and drills will include the community midwifery team to support their ongoing need to maintain obstetric skills required to support high acuity and these are scheduled throughout the year.	10/11/2023	09/11/2023	Overdue	
	The health board should review and risk assess the system for on call theatre scrub nurses for obstetric emergencies	SD6/1	1 scrub nurse is on site 24/7, a second scrub nurse on call is operated after 20:00hrs and is called when theatre is required for obstetrics	10/11/2023	09/11/2023	Overdue	
		SD6/2	An options appraisal process and risk assessment was undertaken to ensure the safety and cover for theatres out of hours to support the obstetrics requirements due to emergencies.	10/11/2023	09/11/2023	Overdue	
	The health board should review consultant presence across unit and with a view to increasing visibility and ensuring that all staff and patients feel safe and supported	SD8/1	Monitor using the QR reporting tool consultant representation at daily safety huddle / daily handover meetings	10/11/2023	09/11/2023	Overdue	
		SD8/2	Monitor using the acuity tool the consultant presence on the unit for morning and evening handover and ward rounds	10/11/2023	09/11/2023	Overdue	
		SD8/3	Confirm Consultant base location are available and accessible for direct communication for advice and patient review at all times	10/11/2023	09/11/2023	Overdue	
	The health board should monitor attendance and review and evaluate effectiveness of new Skills and Drills training.	SD11/1	A new programme of skills and drills will include the community midwifery team to support their ongoing need to maintain obstetric skills required to support high acuity and these are scheduled throughout the year.	10/11/2023	09/11/2023	Overdue	

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HIW Bryngofal inspection July 2022	Appropriate and safe curtains are placed in patient bedrooms	MD3/1	Estates to review environment in bedrooms and identify work plan to replace curtains	30/06/2023	24/10/2023	Overdue	Update 05/10/22 Curtains were removed (re anti ligature work) windows tinted, ward manager to confirm what is required, Estates will then facilitate Update 19/04/23 Option costed, to be ordered and risk assessed. Expected to be completed by 30/06. Update 21/07/23 No funds remaining from the original allocation Update 10/08/23 LBG advised that there were no funds available in the original allocation, but we have included in our scope of works for PoL allowance to install reflective one-way privacy film to all bedroom windows. these works are due to start in September 2023 through to February 2024, I cannot be more specific about where in the programme of works the windows will be done Update 21/08/23 advised that work is underway to complete this action, expected end of Sept 2023. Update 16/10/23 expected to retrofit blinds in bedrooms at Bryngofal, request to Estates to assist Update 24/10/23 The blinds for the 17 bedrooms and the 136 suite are on order, and we are awaiting an update for delivery and fitting from EStates
HIW Cadog Ward and Ceri Ward, Glangwili Hospital March	R14: The health board must ensure that oxygen is accurately prescribed and a record of administration maintained on the All Wales Drugs Chart.	MD1/1	Clinical Directors to discuss the need for improved prescribing of oxygen with medical staffing. To provide training for ward staff on the use of oxygen therapy and prescribing.	31/10/2022	14/08/2023	Overdue	Senior Nurse currently working alongside Senior Nurse for Medicines Management to devise training package. Will form part of wider HB approach to addressing training needs for all practitioners in relation to oxygen administration. Suspended due to Covid-19 pandemic. To rearrange for October 2020. 22/01/2021- Hospital HON confirmed she will check with clinical Directors that this was discussed with medical staff and will check training status. 19/02/2021- Hospital HON confirmed she will discuss with Dr. Ward to undertake audit of O2 prescribing. 26/03/2021- update from Consultant Respiratory -'the project should be complete within the next 2 months. Hopefully sooner. It may take a bit longer to organise an educational session, so a rough timescale of 2-3 months'. Revised timescale of June 2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 11/08/2021- The doctors who were doing the oxygen QIP have completed the first cycle, they are handing over to the current team to complete. Hopefully within 2-3 months. 17/01/23 chased for progress with action. No response. 14/08/2023 - Oxygen audit has been completed and uploaded for reference. The audit result showed an improvement % from previous reviews though continued work to further improve on this is required. There is a further audit to be undertaken across all GGH areas. Medication Policy (268) and reference to emergency oxygen and its prescribing link sent out to all Medical/Surgical and Speciality Dr's for reference. e-learning package re oxygen is pending (John Harries Pharmacy Lead is looking at this).
HIW GGH IRMER Inspection Nov 2022	The health board is required to provide HIW with details of the action taken to improve the print quality of appointment letters sent to patients	MD2/1	Create a working group to standardise the letter format for radiology using the HB guidelines	30/09/2023	23/11/2023	Partially complete (Overdue)	Update 23/11/23 Due to RISP project the development of new leaflets needs to be delayed until the new RIS system installed (early 2025). However all leaflets have been reviewed and only printed not photocopied copies are used to improve quality to patients (example uploaded)
	The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: 1) for those practitioners entitled to justify exposures to carers and comforters 2) for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner	MD13/3	Introduce a process to establish dose constraints and add to Employer Procedures.	30/06/2023	23/11/2023	Partially complete (Overdue)	Deputy Head of Radiology requested extension to 30th June 2023. EP's updated Update Sept 23 Checking with medical physics as to completion Update 23/11/23 med physics chased 23/11/23
	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	MD15/2	To source a document control system.	30/09/2023	23/11/2023	Overdue	Update 23/11/23 added to risk register

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HIW Glangwili A&E Inspection	The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	MD5/1	To arrange provision of new information screens for the department.	31/08/2023	31/10/2023	Partially complete (Overdue)	Update 12/07/23 Senior Nurse Manager updated due date to end Aug 23. Update from Deputy Head of Nursing 30/10/23 Action Complete. Regular notifications of waiting times etc provided by Staff . E-mail sent to all A&E staff, both Medical and Nursing as well as to Specialties reminding of the need to update patients/carers regarding their care and treatment. At times of extreme demand, PALS colleagues do support with information giving and sharing
	The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	MD6/1	To engage with the estates and the Mental Health Teams regarding creating a safe space to review Mental Health patients in the department	31/08/2023	31/10/2023	Partially complete (Overdue)	Update 12/07/23 Senior Nurse Manager extended due date to 31/08/23 Update 30/10/23 from Deputy Head of NursingThis is an on-going challenge. Open and collegiate working relationship with Mental Health colleagues and high-risk patients escalated. Significant numbers of MH patients requiring A&E input have complex medical needs necessitating medical input. Meeting arranged with Senior MH Colleagues to discuss these issues across both GGH & PPH.
	The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	MD7/2	To facilitate working with '2 Wish' charity regarding the refurbishment of relatives/viewing room	30/09/2023	31/10/2023	Partially complete (Overdue)	Changed the due date from 29th Sept to 30th Sept as this is what is on the document. Update 30/10/23 from Deputy Head of Nursing Awaiting quotation from Estates for refurbishment of staff facilities and seeking Charitable Funds support to fund the refurbishment.
	The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit	MD8/1	To ensure work alongside estates to review refurbishing staff changing rooms, shower facilities and toilet	29/09/2023	31/10/2023	Partially complete (Overdue)	Update 30/10/23 from Deputy Head of Nursing Awaiting quotation from Estates for refurbishment of staff facilities and seeking Charitable Funds support to fund the refurbishment.
	The health board is required to provide HIW with details of the action taken to ensure audit activity in the unit is fully completed in accordance with the health board's policy.	MD12/2	To ensure that medical staff within the department are supported to and undertake regular clinical audit.	30/04/2023	10/08/2023	Overdue	Senior Nurse Manager updated timescale to 30th June Update 12/07/23 NL extended completion date to 31/08/23.
HIW Improvement Plan – adapted from the CTMUHB Menta	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	MD1/1	a)Development of standards for physical health screening to be incorporated into Service Specifications.	29/09/2023	22/11/2023	Overdue	Update 10/10/23 Multi disciplinary Task and Finish group established to develop standards for physical health screening across MH/LD Directorate. Physical health assessment requirements formulated based on national guidance. Baseline audit planned to confirm current practices against requirements in order to inform implementation plan. Revised timescale for completion 31/01/24. Update 22/11/23. Physical Health Standards finalised for inpatient pathway and baseline audit underway. Physical Health Checklist developed an awaiting approval for initial implementation on paper from Jan 24.
	The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	MD4/1	d)All teams to compile evidence folders for certification against Investors in Carers standards by a September 2023 and commence implementation of an annual review process.	29/09/2023	22/11/2023	Overdue	Update 10/10/23 All teams across MH/LD directorate are now engaged with Investors in Carers. A full position statement is to be presented to MH/LD QSEG in December through an Investors in Carers Agenda Item agenda item. Timescale for completion revised to 31/12/23.
	The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	MD6/1	e)Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	29/09/2023	22/11/2023	Overdue	Multi disciplinary Task and Finish Group established to coproduce standards for Ward Review process. Update 10/10/23 Multi disciplinary Task and Finish group established. Previous published work by Hywel Dda on service user perceptions and AIMS standards to be used as a reference point. Timescale revised to 31/01/24 to enable full engagement of service users and carers.
	The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	MD7/1	f)Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53).	29/09/2023	22/11/2023	Overdue	Multi disciplinary Discharge Review Task and Finish Group established. Training provided to the group by the Clinical Effectiveness Team on the process of benchmarking and use of the AMaT system to record, track and monitor benchmarking work. Initial scoping undertaken of NG 53. Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity. Contributors to benchmarking identified and process set up to engage and obtain information from them. Update 10/10/23 Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity however now impacted by long term absence in team. Revised timescale 31/01/24.
		MD7/2	g)And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated.	29/09/2023	22/11/2023	Overdue	Update 10/10/23 Review of Health Board Policy #370 Discharge and Transfer of Care underway however detailed input from mental health services incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore delayed. Revised timescale for completion 28/02/24.
	The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	MD8/1	h)Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	31/10/2023	22/11/2023	Overdue	Development of a training resource is incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore progress delayed. Revised timescale 01/04/24.

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	The health board must ensure that adequate administrative support is available within inpatient mental health units.	MD10/1	i)Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	30/09/2023	22/11/2023	Overdue	Update 10/10/23 Ward clerk cover in place for all wards (1 WTE admin available to all units as a minimum through a variety of roles) meeting the MH Principles for safe staffing. Band Ward PA Job Description revised on feedback from ward managers, now job matched, engagement in place with staff side in order to launch an organisational change process. Revised target date of 31/01/24 to have people in all Ward PA roles.
	The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	MD18/2	l)Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	30/09/2023	23/11/2023	Overdue	Update 10/10/23 Full transition to paper free clinical records incumbent on national direction. Focus of action therefore revised to: Scope digital priorities and smarter working practices to support shift to digital across MH/LD Directorate (eg use of digital dictation) through a digital workshop led. Revised timescale 31/01/24. Update 21/11/23 Initial presentation on HB Digital Strategy presented to BPPAG on 28.09.23. Date being sought for directorate wide workshop. by Innovation and Digital Transformation Team. Update 23/11/23 Discussion held at BPPAG with input from the HB Digital Director. Date for directorate wide workshop revised to 30/04/24.
	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	MD25/2	o)Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	30/09/2023	22/11/2023	Overdue	Update 10/10/23 Mental Health Safe Staffing Principles and Welsh Levels of Care (version 3) remain in draft and unpublished. A review of establishment for inpatient assessment and treatment services is underway. The above draft documents are being used to inform the review. The timescale for completion has been affected by limited capacity within the finance and nurse staffing team. 31/12/23 is the revised target date for completion of the review.
	The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	MD26/2	s)Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	30/09/2023	22/11/2023	Overdue	Update 10/10/23 Work is being led by the Assistant Director for Mental Health and Learning Disabilities. Timescale for completion revised to 31/12/23.
	The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.	MD27/1	t)Resolve CRHT access to space within all emergency departments.	31/07/2023	22/11/2023	Overdue	Update 10/10/23 EED departments currently under significant pressures and are unable to ring-fence identified rooms for mental health assessment only. This challenge has been flagged through Operational Planning and Delivery Programme (04/10/23). Solutions continue to be sought through local discussions. 31 March 2024 set as a revised timescale for implementation.
	The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	MD38/1	dd)Review options for enabling Social Workers who provide a service on behalf of the health board to have direct access to DATIX, establish a process to implement this which includes routine access to DATIX for all new Social Workers joining mental health teams and processes to amend access when moving or leaving the team. Identity existing Social Workers to set up system access and training to enable full use of DATIX and feedback mechanisms within the system.	31/07/2023	22/11/2023	Overdue	Update 10/10/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. Revised timescale for completion 31/11/23. Update 22/11/23 Details of existing Social Workers have been gathered and Datix accounts have been requested.
HIW National Review of MH Crisis Prevention March 2022	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	MD1/3	This is now incorporated in the service specification for the CRHT /CMHT- which is due to be finalised in March via Written Control Document Group	24/07/2023	06/09/2023	Partially complete (Overdue)	Update 5th April 2023 - Service specification to be taken to written control in July as service specification is being developed in conjunction with local co-occurring framework. Co-occurring framework is now complete. Update 6th June 2023 - Service spec is dependant on advice from CHC on whether to engage or consult on proposed changes regarding 7 day working. Update 27th June 2023 - Unable to move forward until CHC decision is made. Update 4th August 2023 decision to be taken by Board / Committee level as to is this is being taken forward Update 6th September- Service specification now being submitted to WCDM in November 2023 for approval
HIW Prince Philip Hospital Minor Injuries Unit 26.06.23	Whilst efforts were made to improve the comfort of patient on trollies for extended periods. Surge patients are kept, for the most part, on trollies with limited pressure relieving equipment available. By the nature of these patients being generally older and acutely unwell, they are more susceptible to pressure damage, as well as falls, when on this equipment for longer stays	MD1/4	All nursing staff including HCSW to receive update training on pressure damage management. Training to be provided by the TVN service and records of attendance to be kept by the Senior Sister.	30/09/2023	05/10/2023	Overdue	Update Oct 23 there have been training sessions on pressure damage management that has been delivered by the TVN service. They have trained 31% staff so far and there is further training booked for November awaiting to confirm the date. Aiming for completion by 01/12/23
	Whilst HIW acknowledges the national flow pressures, we were concerned with the lengths of stay these patients experienced on the Unit. We noted stays of up to 5 days	MD9/6	To develop an MIU escalation SOP which will include the escalation and transfer of patients.	30/09/2023	05/10/2023	Partially complete (Overdue)	Update 01/09/23 Escalation flow chart completed and submitted to Head Nurse PPH 05/10/23 aiming for completion by 31/12/23
	The health board must review this staff feedback in the context of these findings. It must continue to provide a platform to listen to staff and must take robust and sustained actions where appropriate to do so	MD17/1	Liaising with Mental Health colleagues to review management of MH patients presenting to MIU	01/11/2023	05/10/2023	Overdue	

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HIW St Caradog ward, Withybush Hospital	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	MD1/1	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	30/07/2023	23/11/2023	Partially complete (Overdue)	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022. Update 24/04/23 Significant fire improvement works underway new completion date July 23 update 03/10/23 all of the outstanding work, the estates works have been delayed considerably due to the issues in that are being faced in Withybush hospital, am in regular contact with the team there, although I have been unable to get a concrete plan from them for when the list of works is likely to be started, let alone completed. The Fire safety work is coming to an end, with a few doors left to be installed, however there have been some delays in this. Once we have these works completed, we will look to get the ward repainted to comply with IPC. Update 10/11/23 the date of completion is end of Nov 23. Estates have been informed that there's only a few specialist MH doors remaining and they were slightly delayed in the manufacturing stage.
	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	MD2/1	Interior walls to be repainted where necessary to comply with IPC. Timescale 3 months, November 2021.	27/08/2023	03/10/2023	Overdue	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. Update 24/04/23 fire improvement works underway, painting to be competed thereafter, new date for completion. Update 03/10/23 from service all of the outstanding work, the estates works have been delayed considerably due to the issues in that are being faced in Withybush hospital, however am in regular contact with the team there, although I have been unable to get a concrete plan from them for when the list of works is likely to be started, let alone completed. The Fire safety work is coming to an end, with a few doors left to be installed, however there have been some delays in this. Once we have these works completed, we will look to get the ward repainted to comply with IPC.
HIW Withybush A&E unannounced inspection (August 2023)	Ensure that IPC practises within the department are strengthened and environmental issues escalated to ensure that the risks to patients, staff and visitors are mitigated	MD1/1	Issue related to roof/gutter temporarily rectified by Estates, but requiring further maintenance to resolve.	27/09/2023	21/09/2023	Overdue	
	Increase the frequency of audits, walkaround and / or spot check activity related to IPC to ensure that improvements are implemented and sustained.	MD2/1	Results to be discussed at monthly Health & Care Standards meetings and departmental meetings	27/09/2023	03/10/2023	Overdue	
		MD2/2	Observational weekly spot checks audits commenced to be undertaken by ED Senior Sister for six weeks to ensure compliance.	20/10/2023	03/10/2023	Partially complete (Overdue)	Update from service evidence of initial audits.
		MD2/7	Ensure that hotel facilities audits are undertaken once a month, in the company of a senior sister.	31/10/2023	21/09/2023	Overdue	
		MD2/8	Use of green 'I'm clean' tape for commodes already in use, to be strengthened by the use of 'I'm clean' labels to be piloted	20/10/2023	21/09/2023	Overdue	
	Provide HIW with details of the action taken to demonstrate suitable daily checks of emergency equipment and the recording of this	MD3/1	Emergency equipment checklist updated to meet standard.	20/10/2023	03/10/2023	Partially complete (Overdue)	03/10/23 audit evidence presented
		MD3/2	Observational weekly spot checks to be undertaken for six weeks to ensure daily compliance by Senior Sisters with feedback through Health & Care Standards meeting	20/10/2023	03/10/2023	Overdue	03/10/23 senior sister audits provided for upload
	Increase the frequency of audits / spot check activity related to emergency trolley checks to ensure that improvements are implemented and sustained.	MD4/1	Observational daily spot checks commenced to be undertaken for six weeks, with reducing frequency thereafter according to compliance. Feedback on findings through bi-monthly directorate Quality & Governance meetings.	20/10/2023	17/10/2023	Overdue	Next meeting due November 23. Evidence of checks uploaded
	The health board must continue to focus on and review the privacy and dignity needs of patients as changes to use of surge areas are implemented	MD7/1	Curtains rails to be erected in cubicle areas where "doubling up" is necessary to support surge patient flow demand	24/11/2023	23/11/2023	Overdue	
		MD7/2	SBAR ED internal escalation plan to be presented at Governance meeting including Risk assessment to identify risks and mitigations taken to support areas accommodating surge.	24/11/2023	23/11/2023	Overdue	
	The health board must ensure that communication with patients in relation to their care is strengthened.	MD8/2	Memo to be sent to Navigator team to take responsibility for updating reception staff to update waiting display timing information.	24/11/2023	23/11/2023	Overdue	
		MD8/4	Memo issued to remind staff to record in diary to maintain log of communication with waiting area and spot checks carried out weekly for 6 weeks to monitor compliance.	24/11/2023	23/11/2023	Overdue	
	The health board must ensure that all delayed transfers are recorded as required and in a timely manner	MD9/1	Delays & escalation of offsite transfers are reported to the CSM to escalate to the point of contact manager in hours and off site manager out of hours. This is also reported at the safety site meetings	24/11/2023	23/11/2023	Overdue	
	The health board must ensure that there is a suitable mental health assessment room available within the ED, which is subject to a risk assessment prior to use.	MD13/1	To ring fence the designated mental health room to support availability of suitable ligature free environment as part of SBAR.	24/11/2023	23/11/2023	Overdue	
		MD13/2	L - Risk Assessment to be completed for environment.	24/11/2023	23/11/2023	Overdue	

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(as at 24/11/2023)

Inspection Title	Recommendation	Reference	Action	Date Due	Date Last Updated	Progress Status	Comments/Updates
HIW: Quality Inspection (Ty Bryn)	HIW requires details of how the health board will ensure the building is property maintained in order to prevent the risk of harm to patients and staff.	MD5/1	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	30/06/2022	23/11/2023	Partially complete (Overdue)	21/12/2021 - A detailed action log has been developed: remaining works: Replacement doors, delivery est 8-10 weeks, completion date end Feb 22 Emergency lighting has been reviewed and minor works costed to be completed end Feb 22 Assessment of Trees – new fence will come inside of the tree line, so preventing access by patients. Additional works: New sink and cladding to shower in bathroom Guttering has been repaired/replaced as required. 26/01/2022 - updated fire assessment completed. 27/01/2022 - Works are ongoing, with completion expected by March 2022 Update Sept 23, site being considered for use, plans re patient care being reviewed.
	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice.	MD6/1	A full training needs analysis will be completed once the inpatient model has been developed and approved. This work is currently ongoing.	01/07/2022	23/11/2023	Partially complete (Overdue)	21/12/2021 - Workshop held to scope new service model, further work ongoing to develop a service specification, workforce plan and training needs analysis. 20/01/2022 - Draft service specification for approval at writen control group 25th January 2022 (approved). 26/01/2022 - All staff in work completed fire training and dedicated time to be secured for returning staff. Staff training plan in place currently booking speakers will commence mid February. 27/01/2022 - Training needs analysis has been drafted and currently out for consultation with staff. Update Sept 23, site being considered for patient use, action being revisited.
	The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being	MD9/1	Staff wellbeing are developing a structured programme of support for the staff ongoing, these will be in the form of reflect and act sessions. These are opportunities	24/08/2022	23/11/2023	Partially complete (Overdue)	Update Sept 23 site being considered for patient use, action being revisited
	HIW requires assurance from the health board that every effort is made to gather patient voice data on their views of the service provided by the setting	MD12/1	Develop an Easy Read version of the Patient Experience Questionnaire, linked to the friends and family test	17/08/2022	23/11/2023	Partially complete (Overdue)	Update Sept 23, as site is being considered for use, action being revisited Update 23/11/23 service user experience questionnaire in place and ready to use. Development of an Easy read underway. Copy uploaded.

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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Quality and Safety Assurance Report

Quality, Safety and Experience Committee (QSEC)

December 2023

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

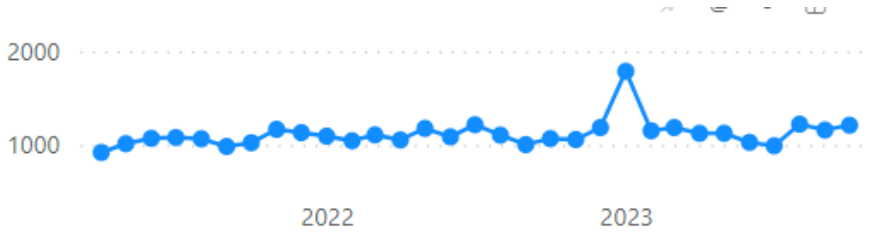
This report provides information on:

- Patient safety incidents including nationally reported patient safety incidents
- Duty of Candour
- Infection control
- The nosocomial COVID-19 review programme
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- WalkRounds

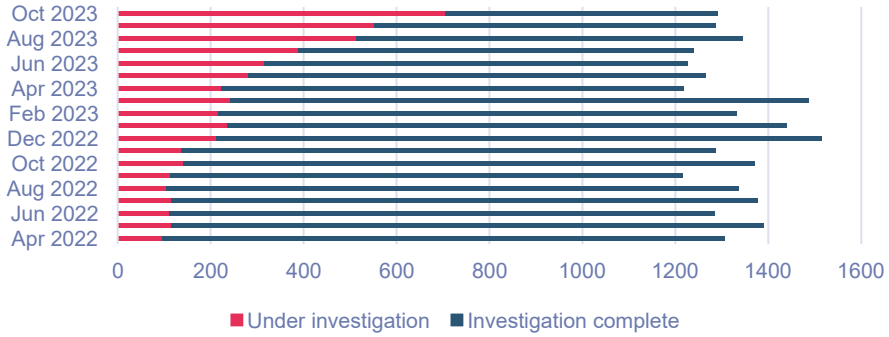
Patient Safety Incident Reporting

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

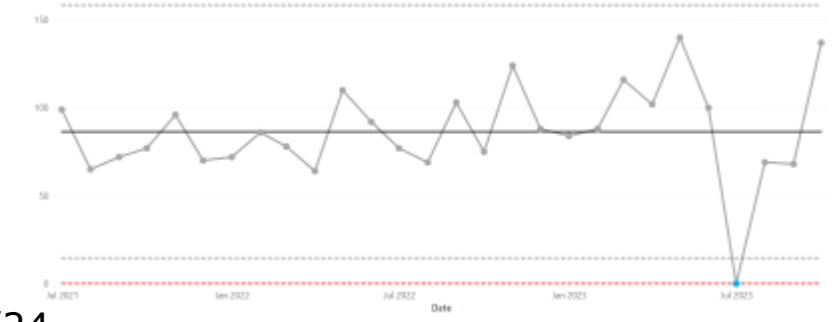
Patient Safety Incidents by month reported



Patient Safety Incident - investigation progress



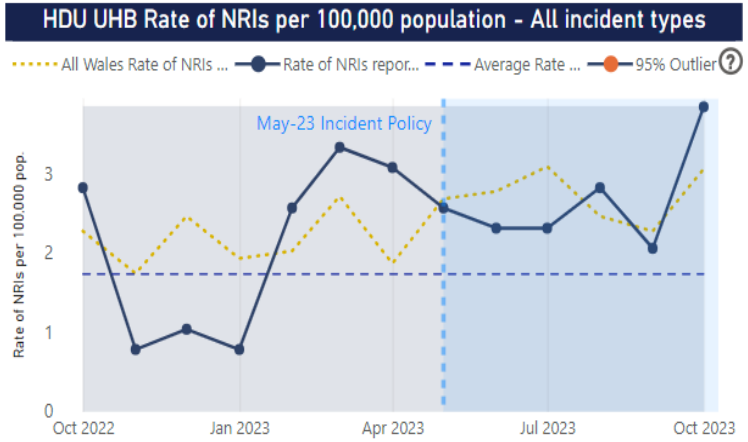
Investigated incidents causing moderate or worse harm

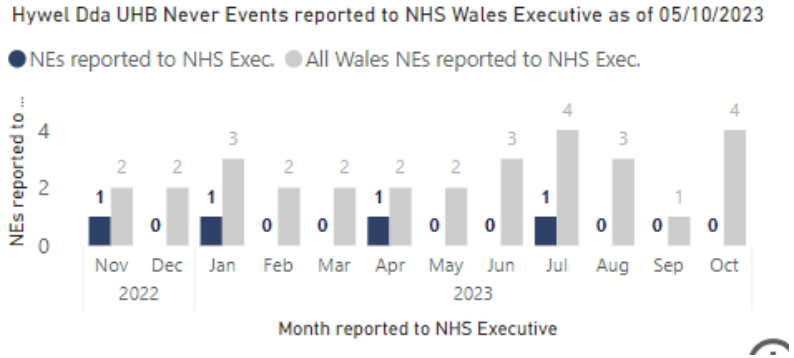


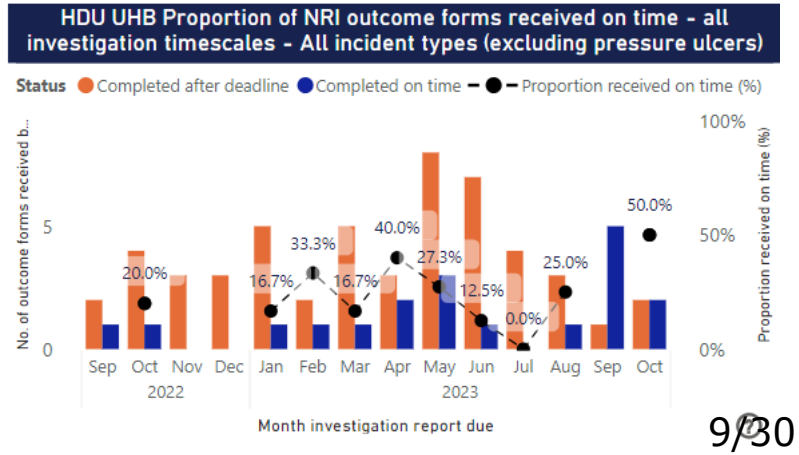
There were 16,655 Patient Safety Incidents reported on Datix Cymru in Hywel Dda UHB between 1 November 2022– 31 October 2023.

Of the 16,655 patient safety incidents reported, 10,909 have been closed. 5% were closed as moderate, severe or catastrophic harm.

Work continues to remind investigators that the grade/severity of an incident should reflect whether the investigation identified any acts or inactions by the Health Board that led to a negative outcome for the person affected e.g. an expected death in the community was closed as catastrophic by the service and on review no acts or inactions were identified.





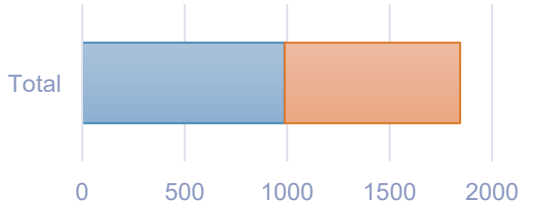


Patient Safety Incident Reporting: Pressure damage

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Pressure damage incidents

(incident date 1 April 2023 to 31 October 2023)



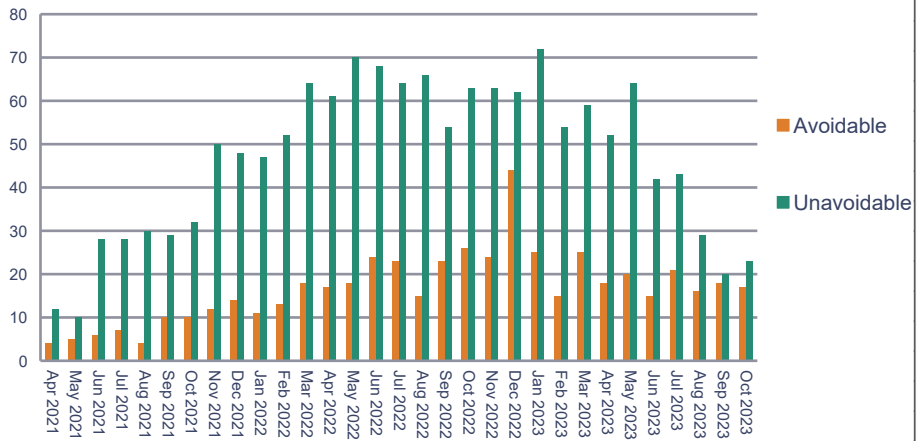
	Total
Present on admission	988
Developed or worsened during clinical care	856

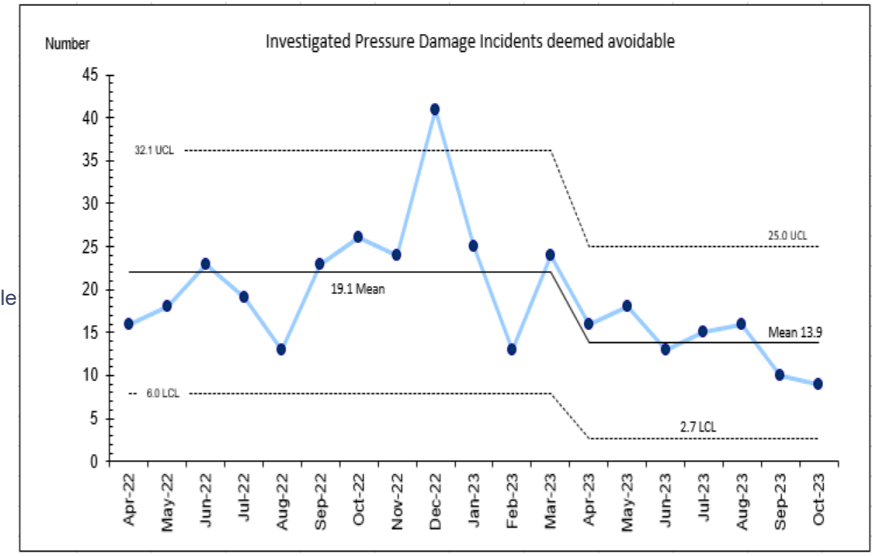
Incidents reporting pressure damage on admission

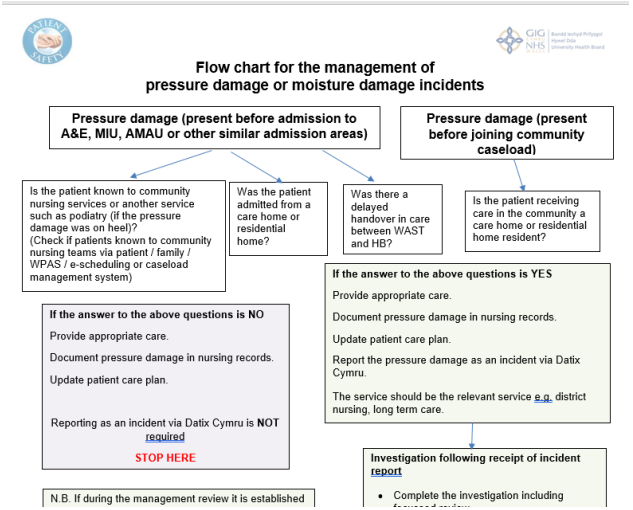
The number of pressure or moisture damage on admission incidents where there has been no involvement from healthcare prior to admission is increasing. Reporting of these incidents is impacting on timely review of pressure damage incidents where there is potential for quality improvement e.g. whilst there is a reduction from the investigated pressure damage incidents in the Statistical Process Control (SPC) chart below, this may not be the case as there are incidents open incidents under investigation.

From 1 December, a pilot will be undertaken in Accident & Emergency (A&E), Acute Medical Assessment Unit (AMAU) and Community Nursing which will change the focus to documenting in the clinical records pressure damage on admission incidents. There are three exceptions: (1) patient known to community services, (2) patient admitted from a care/nursing home, (3) delayed transfer of care from ambulance to A&E).

Pressure damage - developed or worsened during clinical care (by incident date)







Flow chart for the management of pressure damage or moisture damage incidents

Pressure damage (present before admission to A&E, MIU, AMAU or other similar admission areas)

Pressure damage (present before joining community caseload)

Is the patient known to community nursing services or another service such as podiatry (if the pressure damage was on heel)? (Check if patients known to community nursing teams via patient / family / WPAS / e-scheduling or caseload management system)

Was the patient admitted from a care home or residential home?

Was there a delayed handover in care between WAST and HB?

Is the patient receiving care in the community a care home or residential home resident?

If the answer to the above questions is NO

Provide appropriate care.

Document pressure damage in nursing records.

Update patient care plan.

Reporting as an incident via Datix Cymru is NOT required

STOP HERE

If the answer to the above questions is YES

Provide appropriate care.

Document pressure damage in nursing records.

Update patient care plan.

Report the pressure damage as an incident via Datix Cymru.

The service should be the relevant service e.g. district nursing, long term care.

Investigation following receipt of incident report

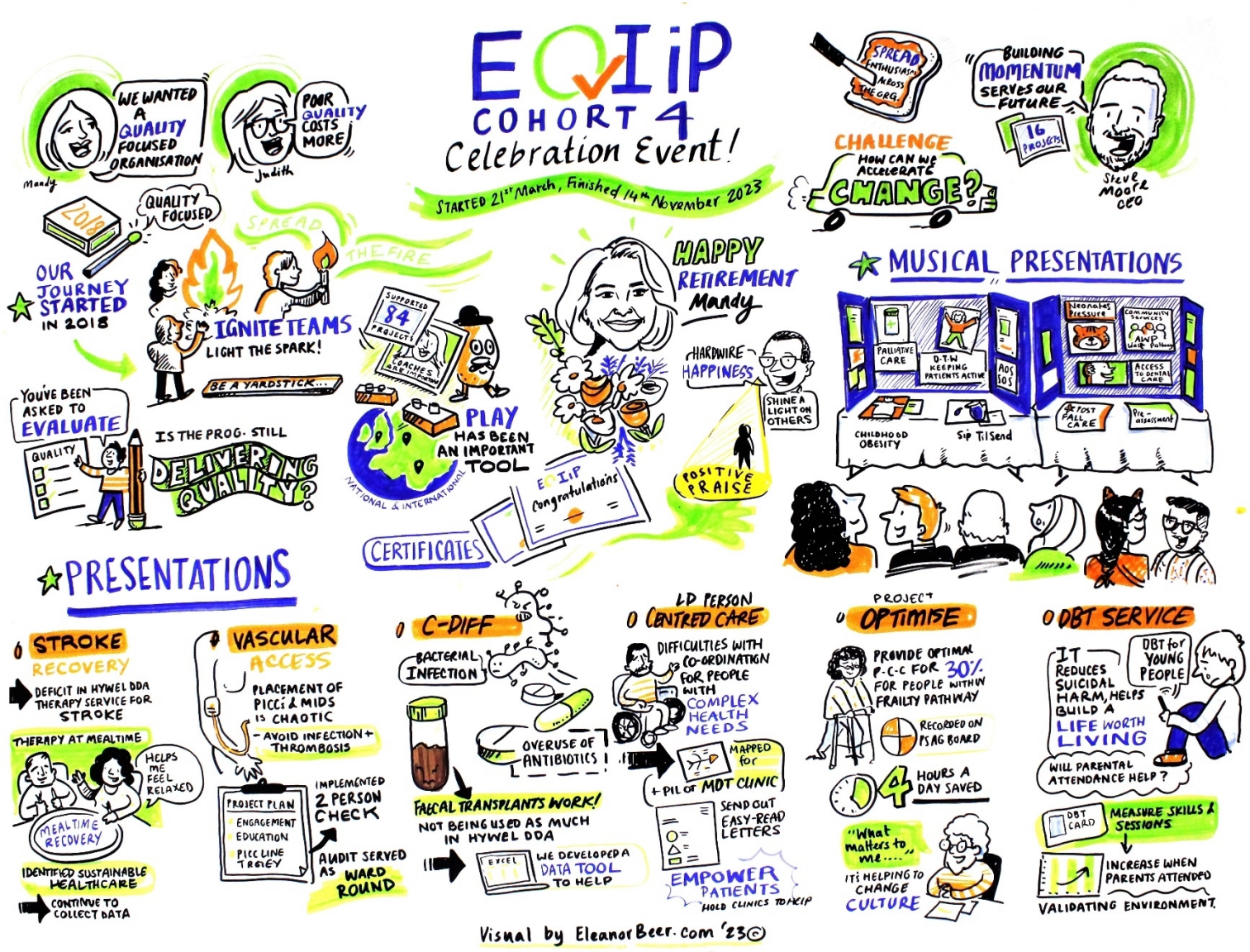
- Complete the investigation including

N.B. If during the management review it is established

EQIiP Cohort 4

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Stroke
- Urgent Dental
- Neonates Pressure Damage
- Learning Disability Person Centred Care
- Childhood Obesity
- C.Diff
- Vascular Access
- Preassessment



- DBT Service
- SipTilSend
- AOS SOS
- Teifi Deconditioning Patient
- Project Optimise
- Palliative Communication Improvement
- Falls Prevention
- WAST Community Discharge

EQIiP
Galluogi Gwella Ansawdd yn Ymarferol
Enabling Quality Improvement in Practice

Team	Project outline
Stroke Therapies Improvement	Improve and agree common approach across professions and counties for stroke rehabilitation, i.e., different locations- acute/community beds / home. This would support discharge pathways including early supported discharge.
Development and expansion of an urgent dental service	Develop urgent access to dental services to improve accessibility to timely urgent care for patients.
Preventing pressure damage due to O2 saturation monitors in neonates and children	Reduce pressure damage in paediatrics from oxygen saturation probe monitors in acute and community settings.
Learning Disability person centred care	To develop a multidisciplinary complex needs clinic for adults with a learning disability.
Childhood obesity	Improve the management of obesity in the early years by working with third sector and local authority to create and deliver innovative programmes that support healthy lifestyles for families.
Improvement of C-Diff rates	To look at implementing a nurse-led FMT service for Hywel Dda. Also looking at improving our current RCA document in order to get better engagement from ward managers and medical teams in completing this.
Vascular access service	To introduce a funded vascular access service for the Health Board.
Pre-assessment services	Rationalisation and standardisation of Pre-assessment services across the Health Board.
Dialectical Behavioural Therapy services	To work more collaboratively with each locality service. Looking at if having extra young people in DBT group who aren't in the full DBT service is helpful to wider service and risk. Consideration to be given as to whether referrals at primary care are appropriate as no intervention has taken place prior to referring to an intense therapy service.
Nutrition & Hydration Improvements – sip-to-send	Improvement to the Health Board's current fasting policy to allow patients (elective & emergency) to remain hydrated up to the time that they are advised that Theatres are ready to undertake their procedure.
AOS SOS	To improve access, outcomes and experience for cancer patients who need emergency or urgent care as a consequence of their non-surgical cancer treatment or complications of their malignancy.
Deconditioning patients	Development of an environment within Teifi dayroom, which is used to prevent patient deconditioning and improve wellbeing. This area should be utilised by reablement staff, HCSW and therapy staff with patients, to provide an environment where patients can be encouraged to be more physically and mentally active.
Project optimise	A formal change of emphasis and approach for clinically optimised patients within medicine for the elderly wards (Pilot wards 3 and 12 Withybush).
Palliative care	Supporting people with palliative and end of life care needs to remain at home or die in their preferred place of death.
Falls prevention	To reduce the number of falls from harm across all admission units within the Health Board.
WAST community referrals	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 indicted.

EQIiP
Galluogi Gwella Ansawdd yn Ymarferol
Enabling Quality Improvement in Practice

GIG CYMRU NHS WALES
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Cash Releasing

- Reduction in costs of care
- Reduction in travel time for staff and patients
- Impact on claims from reductions in harm from care
- Reductions in LOS and unnecessary admissions

Non-Cash Releasing

- Increase in clinic capacity
- Reduction in need for unnecessary care
- More efficient and effective use of resources
- Release of clinical time
- Reduction in waste and duplication

Patient Experience

- Increase in amount and quality of care
- Co-production and skills share
- Peer support/self-management
- Return to normal routines
- Patients voice and empowerment
- Confidence in care
- Reduction in stress and anxiety
- Early intervention

Clinical

- Reduction of risks
- Timeliness of care/Earlier discharge
- Consistency of care/Reduction in health inequalities
- MDT/holistic approach
- Crisis prevention

Workforce

- Professional development
- First in Wales
- Increased job satisfaction
- Increased staff retention
- Collaboration
- Increased knowledge and confidence
- Networking

Process Improvement

- Improved decision making
- Maximising existing initiatives
- Optimising bed turnover
- Increased capacity at the front door
- Reduction in missed appointments/referrals
- Reduced investigations
- Reinvestment of time saved

Statutory or policy requirement

- Duty of Quality and Duty of Candour
- Improved compliance with NICE guideline
- NHS Wales Cancer Improvement Plan
- Transforming Urgent and Emergency Care Goals
- Learning Disabilities Service Delivery Plan
- Welsh Government Targets

Strategic Goal

Duty of Candour

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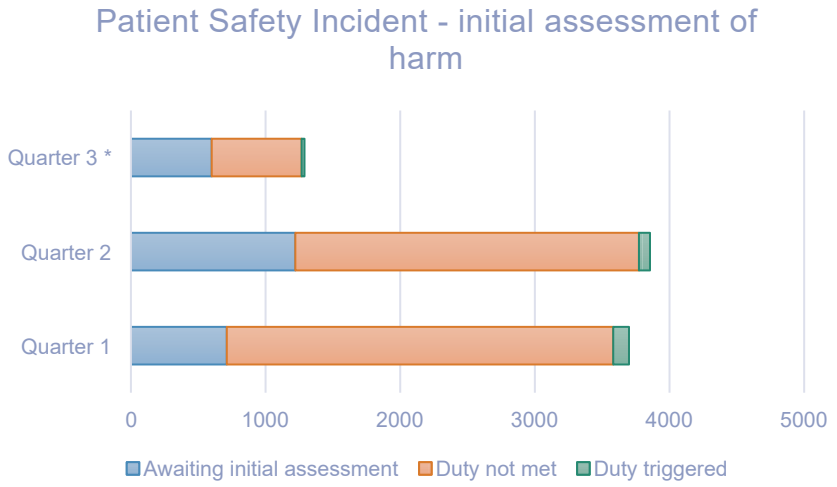
From the daily review of the Datix records in relation to incidents with a more than minimal report of harm, further work across the Health Board is needed relating to accuracy of reporting actual harm.

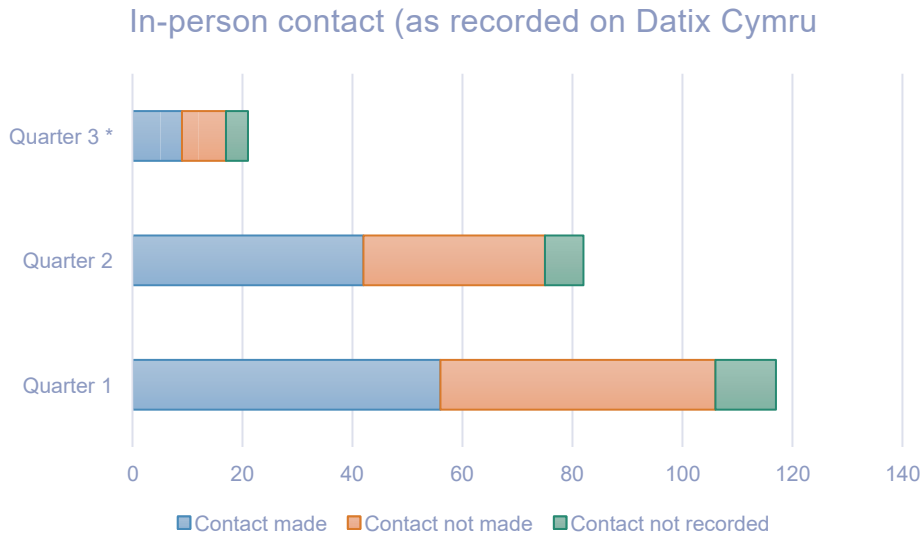
A Duty of Candour Scrutiny Panel has been scheduled as a resource for services as a forum staff who can bring and discuss cases that may trigger the Duty or to discuss particularly complex cases.

Having undertaken a random review of some records where the service consider that Duty of Candour has triggered, it is clear that further training is required regarding the conditions to be met for the Duty to trigger:

(1) 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.

(2) 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.





Nosocomial COVID Review Programme

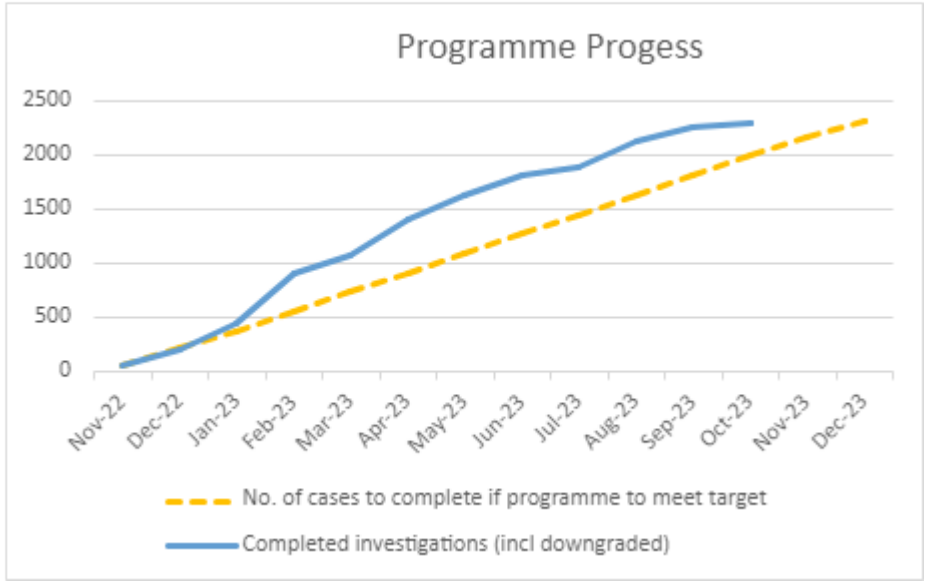
The COVID Programme Review Team and Quality Assurance and Safety Team continue to make good progress with completion of the reviews where it is suspected that the patient had nosocomial COVID infection during Waves 1 to 4 of the pandemic.

The Corporate Assurance Nosocomial COVID Scrutiny Panel and the Corporate Assurance Nosocomial COVID Strategic Oversight Group continue to meet.

A programme closure report will be prepared and shared with QSEC at the end of the programme (March 2024).

One area of new learning has been identified since the last report to QSEC. This relates to appropriate prescription and administration of oxygen for patients with chronic obstructive pulmonary disease. An audit of prescription and administration of oxygen will be undertaken.

For learning reported to previous QSEC meetings please see appendices.



Position as at 01/11/2023

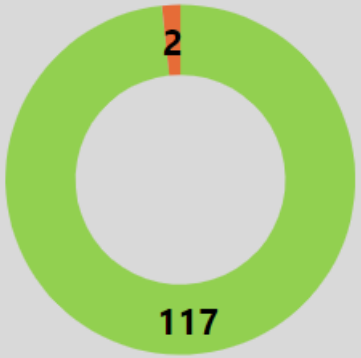
	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022)	**Total (01/11/2023)**	Position As at 01/09/2023
Total number of suspected hospital acquired COVID included in the review	119	1043	355	802	**2320**	**2320**
Total not started / under investigation	0	1	0	0	**2**	**143**
Total review complete (awaiting decision for panel)	0	0	0	1	**1**	**17**
Downgraded	17	174	82	86	**359**	**330**
Total referred to panel (not closed)	2	4	1	0	**7**	**18**
Total completed investigations	100	864	273	714	**1951**	**1812**

NNCP Data - Hywel Dda UHB

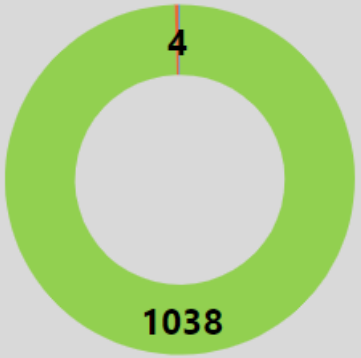
Position, as at the end of October 2023

National Nosocomial COVID-19 Programme

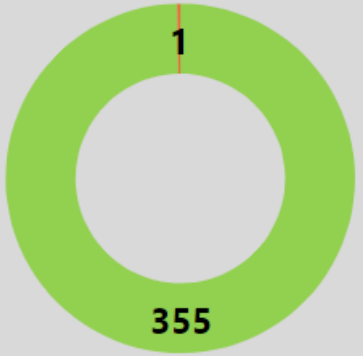
Wave 1



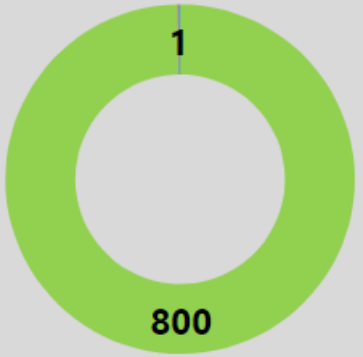
Wave 2



Wave 3



Wave 4



Status Completed In Progress Not Started

Wave 1 | Wave 2 | Wave 3 | Wave 4 | **Reset**

Total Cases

2320	0
Latest	Change

In Progress

8	-48
Latest	Change

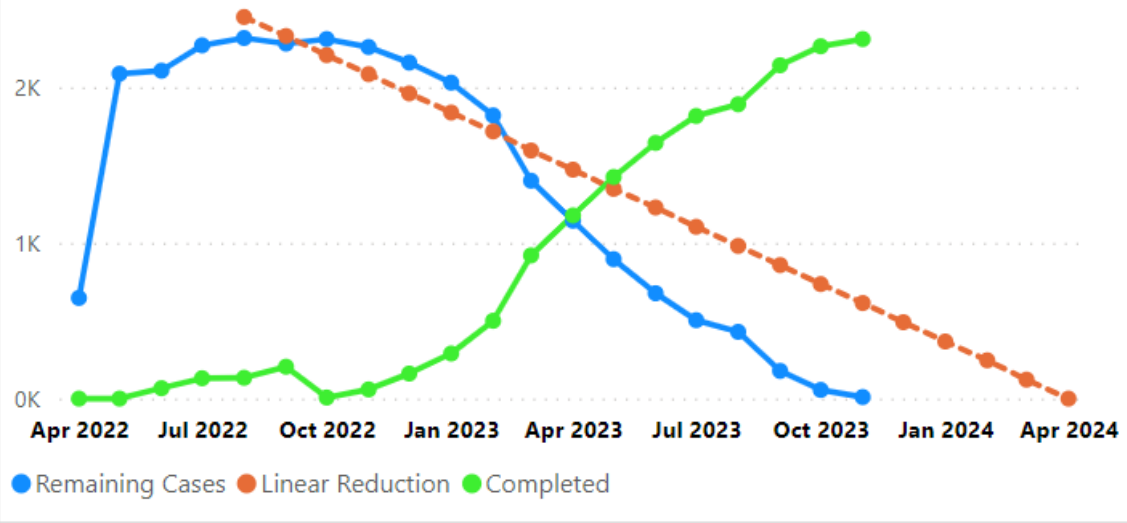
Completed

2310	46	99.57%
Latest	Change	%

Not Started

2	2
Latest	Change

Required Trajectory



Infection Prevention & Control:
HCAI Comparative data across HB's

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Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Oct 23

Additional filters for Table 1.

Select month or FY: Current FY

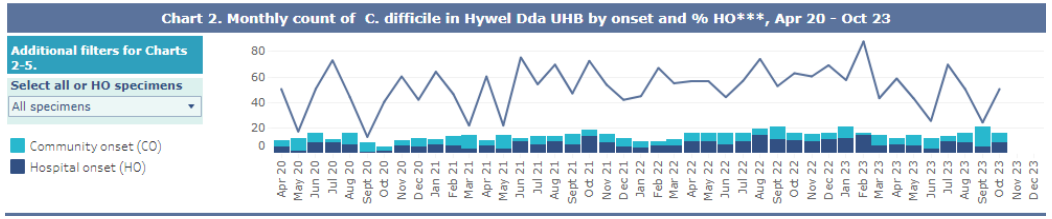
Select organism group: All organisms

< than same period last FY
= same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	35.17	0.86	17.73	57.75	23.73	3.43
Betsi Cadwaladr UHB	39.63	0.97	22.13	78.05	22.37	6.32
Cardiff and Vale UHB	23.05	2.37	29.15	66.78	24.41	5.09
Cwm Taf Morgannwg UHB	30.42	1.9	31.94	90.87	26.61	4.56
Hywel Dda UHB	45.64	3.07	25.01	106.64	25.45	8.34
Powys THB	18	0	0	2.57	0	0
Swansea Bay UHB	56.87	2.62	35	69.56	24.06	6.12
Velindre NHST						
Wales	36.91	1.78	24.82	73.76	23.47	5.29

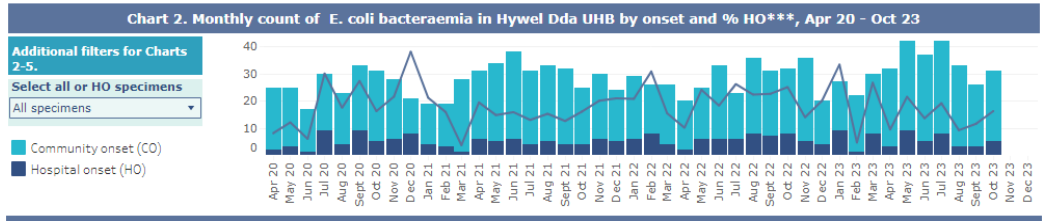
Chart 1. Cumulative monthly rate per 100,000 population of C. difficile in Wales, 2023/24 compared to previous FY

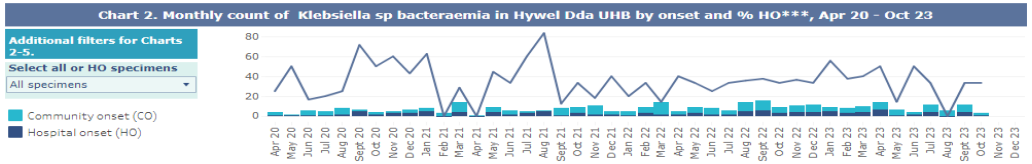
Infection Prevention and Control: Overview



CDI – We remain 5th out of 6 (last year we were consistently 6th/6th), and 3 cases above our 20% reduction trajectory, but improvement over last year with 27 less cases for equivalent period. For month of Sept there were 21 cases of which 76% were community onset, for October the community/hospital split is 50/50. Environmental and rural factors are potentially confounding factors and these areas (including water) are being explored on an All Wales basis.

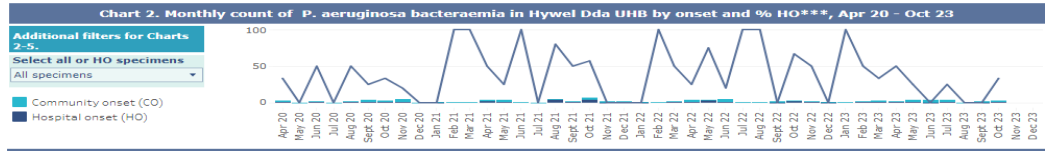
E.coli – Continual battle with community burden for this year to date at 85% (higher than the national average of 78%). Working with PHW team in HD to look at wider public messaging through health promotion using media of varying forms, promotional leaflet (awaiting updated version from Sue then shall translate). Vaccination team have been helping through the summer with ANTT in ED's, this work shall continue when the vaccinations decrease. Public awareness campaigns that have occurred on a small case during the summer months need to be stepped up to increase the public awareness with simple direct messaging. Domiciliary carers now attend out mandatory training sessions which will prove beneficial in 'Every Moment Counts' messaging. A greater/wider public health message is still required, and I shall continue to raise and challenge at every opportunity.

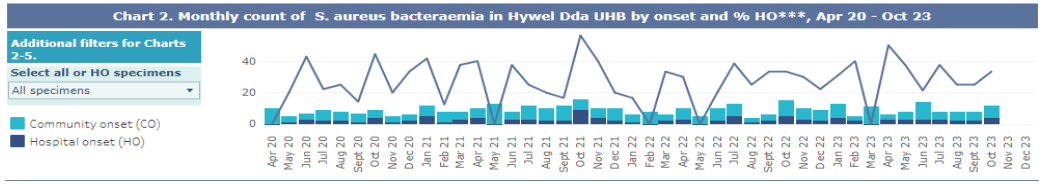




Klebsiella – 2nd lowest for this Gram negative, and as you state Sharon, was originally used as a HAI indicator but the community burden is averaging at 68% for this year. Urinary and hepatobiliary feature highly among the source for this one.

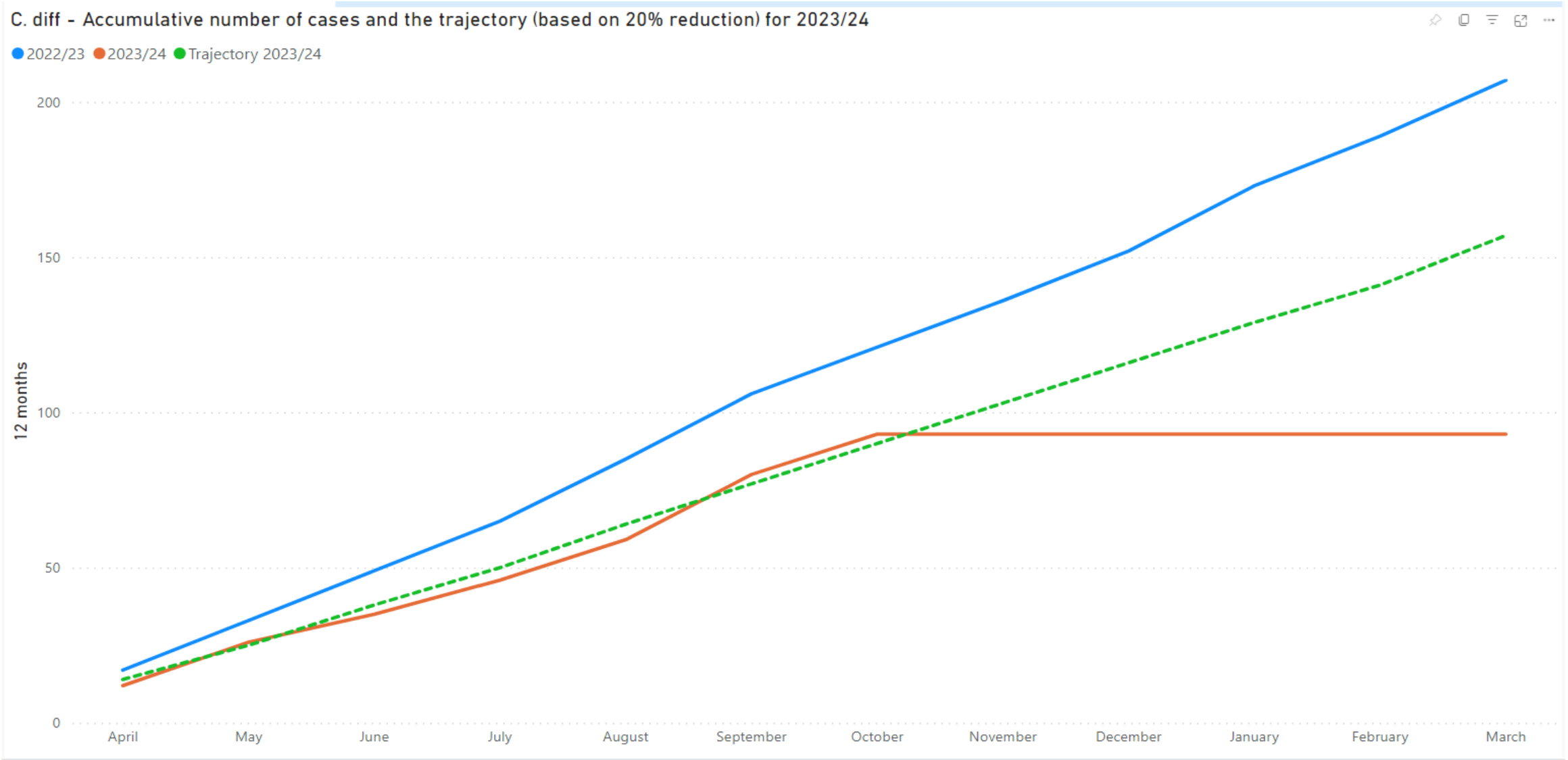
Pseudomonas – Often difficult to determine the source, again urinary but respiratory and SST feature regularly. Numbers remain relatively low but we are 5th out of 6 but slight improvement over last year. CO is 79% for the year to date.





S.aur – we are 3rd which is disappointing as our numbers had been low, we saw 12 cases in October, 67% CO (community onset), SST is the predominant source, however we are seeing a vast range of sources including malignancy, liver abscess, urinary and even a dog bite considered to be a causal factor. Increased emphasis on ANTT in care homes, GP surgeries and across the acute sites is one of the actions that is currently being pushed.

C.*diff* reduction trajectory for 2023/24



Infection Prevention and Control: Overview

Focused work-streams are yielding positive results in reducing hospital acquired infections, however, there continues to remain a large community burden.

The C.*difficile* Strategic Plan for Wales recognises the growth in Clostridioides *difficile* infection (CDI) cases within our communities and Primary Care and the increasing necessity to concentrate efforts outside of Secondary Care.

The Health Board Healthcare Acquired Infection (HCAI) Improvement Plan aligns with the national Strategic Plan in identifying the need to combine IP&C energies in both sectors to drive improvement. While the historic focus has been primarily on reduction of healthcare acquired infection, we now need to focus attention on a reduction strategy within the community setting, including household infection prevention practice.

This includes collaborative working with PHW and local authority partners to develop a strategy to spread and scale our current community work-stream including:

- Patient facing campaigns and focus groups to highlight infection prevention methods
- Providing education on good health for skin, oral care, gut health and UTI prevention
- Working with PHW team to improve communication methods such as local media, utilising technology such as QR codes
- Developing leaflets for patients in GP surgeries and those on waiting lists across the HD area informing of recognition and prevention of infections
- Developing closer relationships with our GP partners to help drive improvement in antimicrobial resistance
- Teaching programme in place for care home staff, domiciliary care staff

Healthcare Inspectorate Wales (HIW) inspection activity themes: 5 Inspections 1 March 2023 to 31 August 2023

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Leadership
19 recommendations including
- The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge
- Reminder to radiology staff to be vigilant when checking demographics and history. And a reminder to referrers to be vigilant when attaching addressograph labels to radiology request forms. The referrer has been spoken to personally to remind them of their duties under IR(ME)R. The referrer has and will be more cautious in future and is aware of the implications of such errors

Person centred
3 recommendations including
- The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits and informed patient consent should be gained

Equitable
2 recommendations
- The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.

Workforce
8 recommendations including
- The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards

Efficient
7 recommendations including
- The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process
- The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.

Safe
29 recommendations including
- The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance
- The health board should review the clinical governance arrangements related to the neonatal stabilisation room to ensure that the service and staff that provide care are appropriately led, governed and supported
- Whilst the risk assessments for MIU patients were suitable, shortened risk assessments, e.g. falls, nutrition etc, for longer stay surge patients were not clinically appropriate

Effective
7 recommendations including
- The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.

Collation of the recommendations made by HIW under the individual Health and Care Quality Standards is a new approach.
For each recommendation made by HIW, the directorate develops an appropriate action(s) to address the issues raised. The overdue actions are detailed in the appendix. To ensure that there is wider learning across the Health Board, the themes collated have been shared with all directorates for dissemination via the Quality and Safety Governance meetings.

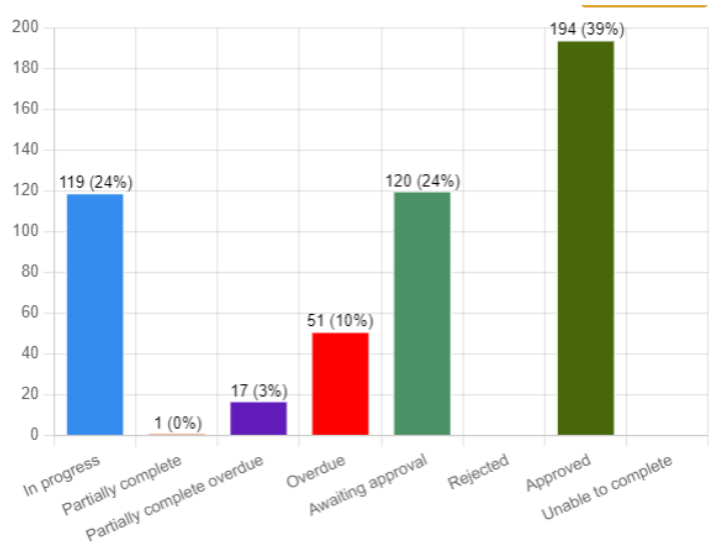
HIW Quality Checks/Inspections: Recent reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Open HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
16	57/260 (22%)	0/21 (0%)	0	0	119	1	17	51	0	120	0	157

See appendix for list of overdue actions



Completed HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
10	33/33 (100%)	0	0	0	0	0	0	0	0	0	0	41

Source: AMAT 27/11/2023

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Title	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
HIW Bronglais Hospital Maternity Unit unannounced inspection June 2023	0/6 (0%)	0/5 (0%)	0	0	14	0	1	13	0	0	0	0
HIW Bryngofal inspection July 2022	0/19 (0%)	0	0	0	0	0	0	1	0	18	0	0
HIW Cadog Ward and Ceri Ward, Glangwili Hospital March 2019	0/1 (0%)	0	0	0	0	0	0	1	0	0	0	0
HIW Clinical Review into the Death of a Service User in HMP Parc	0/1 (0%)	0	0	0	0	0	0	2	0	0	0	0
HIW GGH IRMER Inspection Nov 2022	17/21 (81%)	0	0	0	0	0	2	1	0	1	0	31
HIW Glangwili A&E Inspection	7/27 (26%)	0	0	0	0	0	4	1	0	49	0	39
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	2/40 (5%)	0	0	0	13	0	0	12	0	2	0	5
HIW IRMER GGH 0725 report	0/1 (0%)	0	0	0	0	0	0	0	0	1	0	0
HIW National Review of MH Crisis Prevention March 2022	11/19 (58%)	0	0	0	0	0	1	0	0	9	0	29

HIW Quality Checks/Inspections: Open reviews and inspections (cont)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Title	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
	(58%)											
HIW National Review of Patient Flow (Stroke Pathway)	0/34 (0%)	0/12 (0%)	0	0	50	1	0	0	0	2	0	0
HIW National Review: Maternity Services 2020	0/32 (0%)	0	0	0	0	0	0	0	0	31	0	0
HIW Prince Philip Hospital Minor Injuries Unit 26.06.23	11/18 (61%)	0	0	0	5	0	1	3	0	0	0	42
HIW St Caradog ward, Withybush Hospital	0/2 (0%)	0	0	0	0	0	1	1	0	0	0	1
HIW WAST inspection 2021 /2022	0/4 (0%)	0	0	0	0	0	1	3	0	0	0	0
HIW Withybush A&E unannounced inspection (August 2023)	0/20 (0%)	0/4 (0%)	0	0	37	0	2	13	0	5	0	2
HIW: Quality Inspection (Ty Bryn)	9/15 (60%)	0	0	0	0	0	4	0	0	2	0	8

Safety WalkRounds:
23 WalkRounds between 01/05/2023 to 31/10/2023

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Leadership
4 recommendations including
- Celebrating our model wards

Person centred
16 recommendations including
- Stocking of vending machines
- Availability of birthing pool
- Availability of games, puzzles etc for patients
- Dedicated space for breaking bad news
- Facilities for staff and relatives
- Palliative care suite in community hospitals

Safe
25 recommendations including
- Posters not laminated
- Ageing estate including peeling paintwork, damage to wall, floor levels
- Temporary estate work – signage required
- Storage of O_2 cylinders
- Ward cleanliness
- Bare below the elbow

Workforce
15 recommendations including
- Availability of the right workforce for task e.g. hotel service staff for mealtime service, ward administrator, portering staff in community hospitals, grounds maintenance staff

Whole-system perspective
5 recommendations including
- Admission to hospital policy in care homes following fall
- Shared outpatient facilities impacting on room for specialists
- Purchasing of fire doors (where cost sits)

Equitable
1 recommendations
- Variations across sites e.g. no dedicated physio space in BGH

Timely
4 recommendations including
- Difficulty meeting waiting times
- Patient flow – theatre to ward and ward to theatre

Culture
2 recommendations including
- Staffing levels leading to demoralised staff

Effective
3 recommendations including
- Regular consultant ward rounds

Learning, improvement and research
3 recommendations including
- Simulation training
- Funding for courses

Efficient
10 recommendations including
- Outpatient bookings – reduced DNA when patient phoned to arrange appointment
- Shortage of linen

Information
3 recommendations
- Discharge arrangements when power of attorney is in place
- Up to date information on display boards

Collation of the issues identified arising from WalkRounds under the individual Health and Care Quality Standards is a new approach.
For each issue, the directorate will ensure that there is an appropriate action(s) to address the issues raised. The actions, going forward, will be recorded using Audit Management and Tracking (AMAT) system. To ensure that there is wider learning across the Health Board, the themes collated have been shared with all directorates for dissemination via the Quality and Safety Governance meetings.

Recommendations

The Quality, Safety and Experience Committee is asked to take assurance that processes, including the Listening and Learning Sub Committee, are in place to review, manage and monitor:

- Patient safety incidents including a focus on pressure damage care planning and incident reporting
- Nationally reported patient safety incidents
- Duty of Candour
- Infection control including hand hygiene
- The nosocomial COVID-19 review programme
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

Appendix 1a: COVID Learning identified
(reported August 2023)

The COVID Programme Review Team and Quality Assurance and Safety Team have seen a number of important local themes coming through these reviews and they should be considered alongside the national learning coming from all Health Boards during this review process. Hywel Dda themes are listed below:

- The ageing estate and lack of side rooms for vulnerable patients e.g. those undergoing cancer treatment or shielding patients
- The reasons documented in notes for a patient undergoing a swab – this has not always been noted in records, e.g. a contact, the ward suffering a potential outbreak for example
- Communications with family once a result from a swab is known. In some cases the communication with family was very good, but not so in all cases
- The reasons documented in notes as to why a patient was isolated
- Delays in discharge – the review has seen a large number of patient's who were medically fit for discharge (MFFD) but their route to discharge was blocked for a reason such as a) the nursing home destination was closed to admissions due to an outbreak; b) a vulnerable relative at home c) awaiting a package of care and the associated delays getting that in place during the pandemic

Sadly, in a number of cases, some patients who were MFFD remained in hospital, caught COVID and passed away whilst in the hospital ‘s care.

Appendix 1b: COVID Learning identified
(reported January 2023)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Good practice

- Timely DNACPR decisions with rationale and discussions documented
- Ceilings of care being agreed and documented
- Regular medical reviews (well documented)
- Use of technology for communication between patient and family
- Documentation of bed location and rationale for moving patients
- Family members visits being facilitated when end of life
- Documentation of PPE usage when patient being visited by relatives

(Note – the above is not consistent across wards and sites)

Areas for Improvement

- Medically fit for discharge patients becoming COVID positive whilst waiting for package of care or nursing home placement
- Increase the use of technology for communication between patient and family when visiting restricted
- Documentation of bed location and rationale for moving patients
- Symptomatic patients – reliance on one diagnosis rather than potential differential of COVID

Appendix 1c: COVID Learning identified
(reported to QSEC February 2022)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Areas for improvement

- Timely discussions regarding ceilings of care (sometimes more than 5 days after COVID-19 positive test)
- Documentation that video call / contact with family has happened
- Timely communication from community to hospital e.g. care home closed due to outbreak, ward informed 3 days after care home closed

Good practice

- Ceiling of care discussion with patient and family documented
- Do not attempt cardio pulmonary resuscitation (DNACPR) discussions with patient and family documented
- Initiation of end of life pathway where appropriate
- Regular COVID-19 testing following any symptoms

Observations from outbreak reviews

- We may be unable to categorically answer how patients became nosocomial COVID-19 positive e.g. staff contact / other patient contact / visitor contact

Early wave 3 outbreaks observation

- It would appear that outbreaks are being contained to bays or parts of wards rather than the whole ward being affected

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Hywel Dda
University Health Board

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND