Healthcare Inspectorate Wales (HIW)
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Issue 6

CONTINUOUS IMPROVEMENT NEWSLETTER

Healthcare Inspectorate Wales (HIW) regulate and inspect NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. Staff can access inspection reports/improvement plans and find out more about HIW https://**hiw**.org.uk

This newsletter provides an overview of the inspections carried out in 2018/19 and the learning/improvements made.

External Inspections can be an anxious time for staff, and we need to support staff during these times while fully engaging in the process to improve the services we provide.

Number of HIW Inspections 2018-2019

Dental Practices	GP Surgeries	Acute Hospitals	Mental Health	Total
13	3	2	2	20

Dental & GP Practices

The Learning from the Practice inspections has been shared with other practices across the Health Board.

Main issues identified by HIW included:

- gaps in checking emergency trollies;
- safety certificates and training certificates were not always available for inspection or in date; and
- the record of maintenance of equipment was not always available for review.

Action has been taken to learn from the inspections. The Primary Care & Community Services Unit Quality Assurance visiting program has been revised to support practices more ahead of inspections.

Dental

We Inspected 13 Practices

☑	☒
Patients reported a friendly, professional and patient-focussed service in 10 out of 13 practices	Improvements need to me made in clinical record keeping in most practices – recording of medical histories, allergies, health promotion advice, treatment justification, consent and cancer screening
Good leadership in 8 pf the 13 practices visited	Gaps in staff training in safeguarding, resuscitation training, and fire safety
Safe use of x-rays in 5 practices	Improvements needed in the management if equipment including emergency equipment
A good suite of policies and procedures in five practices	

Mental Health Inspection

Two mental health inspections were carried out, one in Cefn Coed Hospital and the other in Community Mental Health Team Service which resulted in an immediate improvement notice.

The improvement notice related to the availability of risk assessments. Immediate action was taken which strengthened the completion and sharing/discussions of the risk assessments within the Community Teams.

Mental Health

We Inspected the Tawe Clinic at Cefn Coed Hospital

☑	☒
Patients were treated with kindness and compassion	No call system for patients in bedrooms
Information about advocacy was prominently displayed	Lack of furniture in bedrooms
Efforts had been made to make the entrance and outside areas pleasant for patients to use	Inadequate checking of emergency equipment
Good compliance with Health Board Mandatory Training	Information about how to raise a concern should be clearly visible
Visible and supportive leadership	Care and treatment plans need to be in line with the Mental Health (Wales) measure

Community Mental Health

We Inspected the Tawe Clinic at Cefn Coed Hospital

☑	☒
Dedicated staff	Environmental risks such as ligature points (the service received an immediate assurance letter in relation to the environmental risks)
Patients treated with dignity and respect	Poor culture of incident reporting
Evidence of supportive treatment plans for patients	Discord between leaders leading to a poor culture at senior level

Do you know where your Ward/Department/ Service/Practice Risk Assessments are and do you discuss them with your team and take action to manage the risk?

Acute Hospitals

Two inspections were carried out, one in Minor Injuries Unit (MIU) in Neath Port Talbot Hospital and the other in Surgical Services in Morriston Hospital. Both inspections resulted in immediate improvement notices being issued relating to:

MIU

- **Resuscitation equipment/medication checks to be consistently undertaken;**
- **Portable electrical equipment to be routinely tested for safety; and**
- **Delay in routine referral for patients to fracture clinic.**

Immediate action was taken in respect of the above findings

Surgical Services

HIW were not assured that a safe and consistent approach to Venous Thromboembolism "VTE" risk assessment and associated prophylaxis was being used by medical and nursing staff.

All Units have been reminded of the standard risk assessment to be used for VTE.

Hospitals

We conducted an inspection at the Neath Port Talbot Minor Injuries Unit and a surgical services inspection at Morriston Hospital

- ✓ Patients were treated with dignity and respect in both hospital inspections
- ✓ Good infection control procedures
- ✓ Good systems in place to promote patient safety
- ✓ Good management of controlled drugs

- ✗ Timely management of trauma and orthopaedic patients
- ✗ Concerns about the management of theatre lists at the unit were expressed by staff
- ✗ Safety checks in theatre need strengthening
- ✗ Concerns over the number of never events
- ✗ Key equipment, resuscitation checks and audit arrangements need to be improved (NPT). These issues have been found in the minor injuries unit on previous visits
- ✗ Risk assessments for blood clots (Morriston)

Are your safety checks being carried out in your Ward/Department/ Service/Practice?

Have you read the VTE Policy and are you familiar with the risk assessment to be used? If not the policy and form can be found here LINK TO COIN

MIU have completed a Patient/Staff Story following the inspection and the improvement made which was shared with the Quality & Safety Committee and demonstrated the improvements made as a result of which, no formal complaints were received for the service during April – June 2019

Review of the Handling of the Employment of Kris Wade

HIW published their review of the former Abertawe Bro Morgannwg University Health Board's handling of the employment and 3 allegations of sexual assault. HIW considered a wide range of evidence and concluded that there was nothing in Mr Wade's training, supervision or occupational Health records which would have indicated he was unsuitable to work in a care setting.

24 recommendation were made from the report which mainly related to safeguarding and HR processes. The Health Board developed an improvement plan and out of the 74 individual actions 67 have been completed with plans on target to complete the remaining 7.

HIW raised an all-Wales issue for Welsh Government to consider in relation to how the renewal of Disclosure and Barring services (DBS) checks for NHS staff can be facilitated across Wales as an important part of Safeguarding.