Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Follow-up Inspection (Unannounced)

Wrexham Maelor Hospital, Betsi Cadwaladr University Health Board, Emergency Department

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced, follow-up inspection of the Emergency Department (ED) at Wrexham Maelor Hospital, within Betsi Cadwaladr University Health Board, on the 06 and 07 August 2019.

Our team, for the inspection comprised of three HIW Inspectors, two clinical peer reviewers and one lay reviewer. The inspection was led by a HIW senior healthcare inspector.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service strived to provide safe and effective care. However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

We found that the health board had implemented and sustained some of the improvements listed in the action plan drawn up, following the last inspection of the department. However, some areas remained in need of improvement, and these are referred to in more detail within the relevant sections of this report.

This is what we found the service did well:

- Staff engagement
- Information for patients
- Designated paediatric section
- Governance and visibility of departmental managers

This is what we recommend the service could improve:

- Waiting times and patient flow
- Overview of patients in corridor
- Medication management
- Storage in Medical Assessment Unit (MAU) and Clinical Decisions Unit (CDU)
- Upgrade shower in MAU
- Care documentation and assessments
- Pressure relieving mattresses on trolleys
- Some aspects of staff training
- Staffing recruitment.

3. What we found

Background of the service

Wrexham Maelor Hospital is the district general hospital for the central area of North Wales. It originally opened in the 19th century, but was re-built in 1986. The hospital serves a population of approximately 195,000 and it has around 603 beds (17-18, Stats Wales), with a full range of specialties.

Wrexham Maelor Hospital is run by the Betsi Cadwaladr University Health Board. The health board provides a full range of primary, community, mental health and acute hospital services, for a population of around 678,000 people across the six counties of north Wales, as well as some parts of mid Wales, Cheshire and Shropshire. There is an allocated budget of £1.3 billion, and a workforce of approximately 16,500 throughout the health board.

HIW last inspected the Emergency Department at Wrexham Maelor Hospital on 05 December 2017. The immediate assurances issued immediately following the previous inspection, and the areas for improvement highlighted, together with the health board's responses, are detailed within the relevant sections of this report.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients spoken with during the course of the inspection expressed satisfaction with the care and treatment received.

We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner.

Staff within the department worked well together, and with other members of the multidisciplinary healthcare team, to provide patients with individualised care according to their assessed needs. However, patients expressed concerns about waiting times.

We found good management and leadership within the department, with staff commenting positively on the support that they received from the department managers.

Dignified care

We found that patients were treated with dignity and respect by the staff team.

We saw good interactions between staff and patients, with staff attending to patients' needs in a discreet and professional manner. Patients we spoke with commented positively on the way staff carried out their duties.

We observed staff being kind and respectful to patients. We saw staff making efforts to protect patients' privacy and dignity when providing assistance with personal care needs. For example, curtains were used around individual bed/treatment areas when care was being delivered. However, we saw that up to six patients were being cared for on trolleys within the main ED corridor area. Although staff were making every effort to maintain patients' privacy and dignity, this area was very busy and was not conducive to the maintenance of dignity and privacy.

Patients told us that staff were kind and that they had received the care they needed. Comments included:

"Treated with respect by everyone."

The environment within the department was clean and tidy, adding to the sense of patients' well-being.

Staying healthy

We found that patients were involved in the planning and provision of care, as far as was possible. Where patients were unable to make decisions for themselves, due to their presenting physical/mental conditions or memory problems, we found that relatives were consulted and encouraged to help make decisions around treatment planning and care provision in accordance with the Health and Care Standards.

We saw good interactions between staff and patients, with staff attending to patients' needs in a calm, discreet and professional manner.

The Butterfly[1] scheme was in operation within the department, whereby butterfly symbols were used to identify patients with a diagnosis of dementia or cognitive impairment, and who required additional support or a different approach to the provision of care. However, we found that the scheme was not being applied consistently.

Improvement needed

The health board must ensure that the Butterfly scheme is implemented consistently within the department.

Patient information

During the last inspection, the following areas for improvement were highlighted:

[1] The Butterfly Scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.

- Evaluate and improve effective methods of communicating waiting times for patients
- Improve information resources for patients in the waiting area
- Evaluate leaflets in utilisation within the health board, to ensure Welsh NHS / Public Health Wales resources are utilised as a primary source whenever available
- The health board must improve and develop Welsh language resources available, and ensures it receives the same level of attention as that of the English language.

The health board committed to take the following actions in their improvement plan dated 02 February 2018:

- Head of Nursing for Medicine met with ED Matron on 20th December 2018
- Evaluation of existing patient information has taken place
- Meeting with Matron for ED on 17 January 2018, and arrangements to be made for all Information posters to be translated into Welsh
- Visitor Waiting Time Information Screens have now been placed on order
- Deputy Department General Manager for Medicine in conjunction with Band 6 ED staff member, to undertake patient survey to elicit what information patients would like to see on the system.

During this inspection we found that patients were informed of waiting times by means of a hand written board in the main reception waiting area. The information on this board was not updated regularly and did not accurately reflect waiting times.

We found that the general provision of information to patients within the department had improved, with notice boards placed in prominent areas within the department, to display audit results. However, further work was needed to improve the provision of information within the waiting area and the provision of information through the medium of Welsh.

Improvement needed

The health board must ensure that:

- Waiting times are accurately communicated
- Patient information is made available through the medium of Welsh.

Communicating effectively

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner.

All patients who completed a questionnaire said they had been able to use their preferred language and agreed that staff were always polite, both to them and to their friends and family.

Patients told us that staff had talked to them about their medical conditions and helped them to understand them. However, some patients told us that they found the use of abbreviations, by staff, to describe the various areas within the department confusing. We therefore recommended that staff be discouraged from using abbreviations when speaking with patients and visitors.

Some patients told us that they had arrived at the department by ambulance. All of those arriving by ambulance said the crew had been reassuring and treated them with respect. All said the crew had explained what was happening and helped them understand.

Nearly all patients told us that staff referred to them by their preferred name.

A hearing loop system was available for people with hearing difficulties.

Improvement needed

The health board must discourage staff from using abbreviations when speaking with patients and visitors.

Timely care

Staff worked well with other members of the multidisciplinary healthcare team, to provide patients with individualised care according to their assessed needs.

However, patients expressed concerns about the waiting times. Around half of patients who completed questionnaires said they had been waiting for less than four hours. A fifth said they had been waiting for four to eight hours, and few said they had been waiting more than eight hours. Some comments included:

> *"Waiting seems long three hours."*
>
> *"Waiting times too busy. Poor communication."*
>
> *"Last Saturday left coughing blood in waiting room seven hours."*

The department was very busy on both days of the inspection, with patients having to wait some considerable time to be admitted to the necessary wards within the hospital. However, we observed all patients who were waiting to be admitted, being cared for and treated in a professional manner. There were no delays observed during the day of our visit in offloading patients from ambulances into the department.

Improvement needed

The health board must continue to monitor waiting times and implement further strategies to improve patient flow through the department.

Individual care

Planning care to promote independence

We found that there were generally good care planning processes in place, which took account of patients' views on how they wished to be cared for. Care plans were generic in format and more needs to be done to make them person centred.

Through our conversations with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their care needs.

Overall, patients' records were completed to a satisfactory standard and were generally clear and concise. Care files were tidy and easy to navigate.

There was relevant, up to date information available throughout the department on the importance of the early recognition of sepsis[2].

Improvement needed

The health board must ensure that care plans are person centred.

People's rights

We saw that staff provided care in a way to promote and protect patients' rights.

We found that Mental Capacity assessment and Deprivation of Liberty Safeguards (DoLS)[3] assessments were being conducted on patients with diagnosed mental health needs. However, such assessments were not being conducted for patients presenting with other conditions such as dementia, head injury or general confusion.

Improvement needed

The health board must ensure that DoLS assessments are routinely conducted on patients presenting with conditions such as dementia, head injury or general confusion.

Listening and learning from feedback

During the last inspection, the following area for improvement was highlighted:

[2] Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.

[3] DOLS are a part of the Mental Capacity Act 2005 that provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm.

- The health board must ensure that information is freely available to all patients on the NHS Wales process for raising a concern / complaint Putting Things Right[4].

The health board committed to take the following actions in their improvement plan dated 02 February 2018:

- Patient feedback kiosk available in ED entrance/exit
- Five Putting Things Right information posters have been placed around the department
- Putting Things Right information leaflets have been provided to ED in both Welsh and English, and information on making a complaint to the health board has been compiled and is currently being translated into Welsh.

During this inspection we found that Putting Things Right information was available within the department. In addition, patients and their representatives had opportunities to provide feedback on their experience of services provided, through face to face discussions with staff. There were good systems in place for managing complaints and we were told by staff that the number of complaints received about the service were low.

There was a formal complaints procedure in place which was compliant with Putting Things Right.

[4] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed “Concerns”. This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We found that the staff team were committed to providing patients with safe and effective care.

There were formal medication management processes in place. However, we found that some elements of medication management required improvement.

We identified potential risks to patient safety, in relation to the care of patients who were waiting on trolleys in the corridor area.

Safe care

During the last inspection, the following area for improvement was highlighted:

- The health board to provide HIW with an action plan detailing how it intends to address the current practice, whereby patients have to wait on chairs outside the Clinical Decisions' Unit (CDU) for care and treatment, when beds are not available
- The health board to implement standardised protocols across all appropriate sites, in regards to the standardised consistent assessment and care of patients unable to be offloaded from ambulances, due to the unavailability of beds within the hospitals
- The health board to evaluate the current systems for referring patients to the Out of Hours (OOH) GP service, and take action as necessary to promote the timely assessment of other patients at the triage phase.

The health board committed to take the following actions in their improvement plan dated 02 February 2018:

- Business case in draft in respect of accommodating GP admissions in Medical Assessment Unit
- Local Escalation Action Process (LEAP) document used across BCUHB to provide ability to surge patients to place in holding areas during times of extreme pressure

- Meeting planned system and process to be redesigned with the view that OOH staff will collect and transfer patients to appropriate area
- Monthly meeting to be put in place between ED matron and OOH matron

During this inspection we found that every effort was being made to reduce the numbers of patients waiting on chairs outside CDU. However, this will need to be monitored to ensure further improvement. This should be done as part of the overall monitoring of patient flow through the department.

We were not alerted to any on-going issues with regards referrals to the OOH GP service.

There was good communication with ambulance crews. Emphasis was on moving patients off ambulances into the department as soon as possible to free up the vehicles.

There was an Escalation Policy in place to manage patient flow through the department and to manage patients treated on trolleys in corridor areas. However, it was identified that patients who were waiting on trolleys in the corridor were not receiving appropriate and timely care. Members of the inspection team had to intervene on three separate occasions, with the care of patients waiting on trolleys in the main corridor within ED:

- We had to alert the nurse responsible for the patients in the ED corridor, to a patient who was experiencing increased chest pain
- We had to alert the nurse responsible for the patients in the ED corridor, to a patient who had been incontinent of urine. In addition, the patient concerned had been discussed at the 1.00pm patient flow meeting, and was due to be discharged. However, on further examination by doctors within the ED, the patient was found to have an urinary tract infection and was dehydrated. The patient was subsequently moved to the Medical Assessment Unit for treatment and not discharged
- We observed the nurse responsible for patients in the ED corridor, undertaking observations on a patient. The nurse was not using a timer when counting the patient's respirations. We checked the patient's records, and found that the nurse had documented a respiratory rate for the patient, that may therefore have been inaccurate

- During the inspection, we found that there were no pressure relieving mattresses available for any patients, who were waiting on trolleys within the ED

- We found the use of patient identification (ID) wrist bands to be inconsistent. On the first day of the inspection, we saw patients undergoing diagnostic investigations and treatment who were not wearing ID wrist bands. This was escalated to the shift manager who reminded staff of the need to ensure that all such patients must be issued with and wearing a wrist band. However, during the second day of the inspection, we saw a patient on an intravenous infusion who was not wearing an ID wrist band.

We considered the above practices to be unsafe and increased the risk of harm to patients. As a consequence, an immediate assurance was issued to the health board. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvement plan can be found in Appendix B.

Managing risk and promoting health and safety

During the last inspection, the following areas for improvement were highlighted:

- Leaking cistern requires fixing.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Emergency Department Matron has reported fault to estates in December / January 2018 (remedial repairs). Cistern is working but on time has a repeated fault and estates reviewing with regarding to full replacement.

- Review of Portering Wheelchair Cleaning Procedure Undertaken. Amendment of Procedure to be made by 31January 2018 to include:

    - Checking for damage

    - Removing from use immediately

    - Labelling ‘do not use’ and stating the damage

    - Where to store

    - Who to report damage to

During this inspection, we found that general environmental audits and risk assessments were being undertaken on a regular basis, in order to reduce the risk of harm to patients and staff. These were being formally reported to senior managers and displayed within the department for patients and visitors to see. However, we found that there was a lack of storage within the MAU. Wheelchairs and commodes were stored in front of the fire escape. This was brought to the attention of the nurse in charge of the ward, who took immediate action to have the items removed.

We found issues with the flooring within the shower room on MAU which presented a trip hazard to patients and staff. We were informed that this matter had been passed to the maintenance department for action. We also found that there were holes in the wall coverings within the shower room and broken shower fittings which allowed water to pool thus increasing the risk of cross infection.

We also found that some food items, for use by patients, were being stored with clinical equipment on both MAU and CDU.

Improvement needed

The health board must ensure that:

- The shower room on MAU is refurbished
- Food items are not stored with clinical equipment on both MAU and CDU.

Preventing pressure and tissue damage

We saw that staff on MAU consistently assessed patients regarding their risk of developing pressure damage to their skin, and that suitable pressure relieving mattresses were available on beds. However, some patients within the majors[5] area of the main ED, did not have formal pressure area risk assessments completed. In addition, as previously mentioned, suitable pressure relieving mattresses were not readily available for use on trolleys, for those patients waiting more than four hours for a bed.

[5] The area of the ED where patients with more serious injuries or medical needs are cared for.

Improvement needed

The health board must ensure that pressure area risk assessments are routinely undertaken and that suitable pressure relieving mattresses are available for use on trolleys.

Falls prevention

From reviewing a sample of individual care files, we found little evidence to show that risk assessments were undertaken in a timely fashion, to reduce the risk of falls.

Improvement needed

The health board must ensure that falls risk assessments are undertaken in a timely fashion.

Infection prevention and control

During the last inspection, the following areas for improvement were highlighted:

- All commodes to clearly identify that they have been decontaminated following use
- Linen bins to be emptied in timely manner
- All wheelchairs in use to be fit for purpose.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Cleaning schedule for monitoring the sluice by house keeper to be put in place on a daily basis
- New Cleaning Standards policy launched January 2018 being embedded into practice
- Head of nursing met with ED matron on 20 December 2017 clearly outlining expectations and standards.

During this inspection we found that there was a comprehensive infection control policy in place, and we found that regular audits were being undertaken to ensure that staff were adhering to the policy and good practice principles. As previously

mentioned, notice boards had recently been provided to display infection control audit outcomes in prominent positions within the department.

Staff had access to, and were using, personal protective equipment, such as disposable gloves and aprons to reduce cross infection. Hand washing and drying facilities were available. We also saw hand sanitising stations strategically placed near entrances/exits for staff and visitors to use, to reduce the risk of cross infection.

During the first day of the inspection, we found some areas of the department that required cleaning. However, on the second day of the inspection we found the situation to have improved.

Nutrition and hydration

We looked at a sample of care records and found that patients' eating and drinking needs were not consistently assessed, and nutrition and hydration monitoring charts were not always being used where required. In addition, there was little documented evidence of the use of the All Wales Nutritional Care Pathway[6].

We saw staff providing encouragement and support to patients to eat independently. Red Cross staff were also seen assisting patients to eat and drink. This was done in a dignified and unhurried manner.

The meals served to patients appeared well presented and appetising. Patients told us that the food was good.

Improvement needed

The health board must ensure that patients' eating and drinking needs are consistently assessed and nutrition and hydration monitoring charts are completed as required.

[6] The All Wales Nutrition Care Pathway for hospitals was introduced in 2009, and details the pathway for the nutrition screening of patients on admission and the nutritional care throughout their hospital stay.

Medicines management

During the last inspection the following Immediate Assurance issues were highlighted:

- The health board is required to provide HIW with details of the action taken to ensure that medicines are safely stored in the ED, and on other wards and departments across the health board
- Consideration must be given to following Patient Safety Notices (PSN):

  PSN 015 / July 2015 The storage of medicines: Refrigerators

  PSN 030 / April 2016 The safe storage of medicines: Cupboards

The health board confirmed the following in response:

- All three emergency departments have appropriate facilities for the secure storage of hospital medicines
- Staff immediately reminded that patient's own medicines must be placed in a locked cupboard
- Weekly spot check audit on compliance for a further month in Wrexham Maelor ED
- All ward /departments reminded through daily safety huddles and ward safety briefs for the next week, of the requirements for the correct procedure for the management of patients own medication.
- Matron's spot check each ward / department within 48 hours to ensure that staff are aware of the correct procedure and that the procedural requirements of PSN 15 and PSN 030 are met.
- Project plan to address structural requirements (for example, lighting and temperature) identified following comprehensive medicines storage walkabouts in October and November across all sites to be completed.

During the last inspection, the following areas for improvement were highlighted:

- The health board must ensure that all fridges containing medication throughout the health board sites are locked when not in direct usage by staff

- Health board must ensure that oxygen be prescribed appropriately within patients records, and inputted on the patients medication administration records

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Fridges with integral locks on order for minors and majors area
- In the interim re-location to resuscitation area
- Prescribing is appropriate in clinical areas – Oxygen prescribing on cas. card (which is an appropriate mechanism) where there is a decision to admit the patient, the inpatient treatment sheet will be utilised for patients – agenda item for the ED Governance meeting in Feb 2018
- Audit of compliance with PSN 015 and PSN 030 in progress across secondary care inpatient areas
- Weekly review of medication stored within the department utilising approved BCU medicines management safe storage audit tool
- Hospital Board wide review of medication storage facilities including fridges undertaken and new standards introduced.

During this inspection we confirmed that the majority of the areas for improvement highlighted during the previous inspection had been addressed.

We observed medication being administered to patients, and saw staff approaching the administration of medication activity in an unhurried way, taking time to ensure that patients were able to take their medication, without becoming anxious or distressed. However, as previously mentioned, we saw some patients without identification wrist bands. As a consequence, an immediate assurance was issued to the health board. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvement plan can be found in Appendix B.

We reviewed a sample of medication administration records and we found that these were, on the whole, completed to a satisfactory standard. However, there were some missed signatures within the controlled drug registers and evidence that the controlled drugs were not being checked routinely every day.

As was the case during the previous inspection, we found that some patients were administered oxygen without it being formally prescribed.

A pharmacist was available within the ED from 9.00am until 3.00pm, Monday to Friday, to audit medication and offer staff guidance and advice.

Improvement needed

The health board must ensure that:

- Controlled drugs are checked on a daily basis
- Staff sign controlled drug registers at point of checking and/or administration
- Oxygen is only administered when formally prescribed with the exception of emergencies.

Safeguarding children and adults at risk

There were written safeguarding policies and procedures in place, and the majority of staff had undertaken appropriate training on this subject.

There was a separate waiting and treatment area for children with a key pad operated door at the entrance. However, we found the door to be propped open with no staff in attendance.

Improvement needed

The health board must ensure that the door to the paediatric area is locked when staff are not in attendance.

Blood management

We found that there were robust systems in place for the management of blood transfusions and was supported by formal written policies and protocols.

Staff involved in the administration of blood transfusions had received training in the process. Once training has been completed then staff are permitted unique scan access to the blood storage fridge. The fridge is stocked by pathology department staff.

Medical devices, equipment and diagnostic systems

During the last inspection, the following areas for improvement were highlighted:

- The health board to ensure that emergency resuscitation trolleys are checked daily and staff document this accordingly.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Audit in place to monitor compliance and accurate checking of trolleys
- Weekly audit of crash trolley checking in ED has demonstrated improvement – however, inconsistencies on occasion with daily checks. Maintenance of checking compliance weekly.
- BCUHB CPR policy states frequency of checks and responsibilities of staff. The Resuscitation Team complete audits across BCUHB to ensure compliance of trolley checks, if area non-compliant, audits frequency is increased.

During this inspection we checked the resuscitation trolleys in use within the department. We found that the trolleys was well stocked and had sufficient equipment to deal with an emergency. However, we found that the trolleys were not being checked on a regular basis.

Medical electronics department responsible for checking and maintaining all the equipment within ED. We found all safety checks to be in date.

Improvement needed

The health board must ensure that the resuscitation trolleys are checked on a regular basis as per policy.

Effective care

Safe and clinically effective care

Areas for improvement identified at last inspection included the following:

- We recommend the health board remind all staff of the importance of undertaking pain assessments and repeating these assessments following intervention or analgesia.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Revised vital signs observation charts to be implemented following awareness training – pain monitoring form part of the overall patient assessment

During this inspection we found evidence of good multidisciplinary working between the nursing and medical staff.

There were comprehensive policies and procedures in place to support staff in their work.

We found that pain relief was being administered as required. However, this was not always reflected in formal assessment documentation, and there was little evidence of review of the effectiveness of the pain relief.

Improvement needed

The health board must ensure that patients are assessed for pain relief and that the effectiveness of the pain relief is reviewed and documented.

Information governance and communications technology

There was an information governance framework in place, and staff we spoke with were aware of their responsibilities in respect of record keeping and maintenance of confidentiality. However, on the first day of the inspection, we found a trolley containing patients' care notes left open with no staff in attendance within the main ED. In addition, we found a computer screen left unlocked with no staff in attendance within the paediatric area of the department.

Improvement needed

The health board must ensure that:

- Trolleys containing patients' care notes are locked when staff are not in attendance
- Computer screens are locked when not in use.

Record keeping

During the last inspection, the following areas for improvement were highlighted:

- The health board to remind staff to include times of inputs in patients' records and introduce appropriate strategies to monitor this area of record keeping ensuring robust and comprehensive practice.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Documentation audit to be completed (Monthly) to establish baseline with communication and improvement - to continue until standard improved, then move to 6 monthly

During this inspection we viewed a sample of patients' care notes and found them to be generally well maintained and relatively easy to navigate. However, as previously mentioned, we found evidence of inconsistencies in the completion of some care documentation, such as fluid and nutrition charts, pain assessments, falls and pressure area risk assessments.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the Health and Care Standards.

Overall, we found good management and leadership within the department, with staff commenting positively on the support that they received from the department managers.

Staff told us that they were treated fairly at work and that an open and supportive culture existed. Staff also told us that they were aware of the senior management structure within the organisation, and that the communication between senior management and staff was generally effective

Senior nurses and other managers were working diligently in order to promote the safe and effective care and treatment of patients attending the department.

Governance, leadership and accountability

We found that there were well defined systems and processes in place to ensure that the health board focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and established governance structures which enabled nominated members of staff to meet regularly, to discuss clinical outcomes associated with the delivery of patient care.

Key staff from the department and senior hospital managers met regularly during the day to discuss the prevailing situation within the department, with a view to preventing any emerging issues before they escalated. Staff reported that this process was effective in managing the pressures on the department and patient flow.

During discussions with staff, we were told that there was good communication within the department and good informal, day to day staff supervision and support processes in place.

Staff and resources

Workforce

Areas for improvement identified at last inspection included the following:

- The health board must provide HIW with an action plan clearly evaluating how it intends to address staffing shortfalls within the ED of Wrexham Maelor hospital.
- The health board must ensure all staff receive timely annual appraisals.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- This is 7.2 whole time equivalent registered nurse vacancies and others are on maternity leave
- Bespoke Wrexham Maelor recruitment and retention advertising campaign acute site. Retention strategy includes:
    - Preceptorship programme
    - Intra venous and pump agency training for agency registered nurse (to include Aseptic Non Touch Technique)
    - Undergraduate interviews undertaken twice yearly to appoint specific requests for ED appointments
    - Task and finish group held on fortnightly basis
    - Reconfiguring and completing establishment review to appoint specific roles with prepared advert for Emergency Nurse Practitioner in Emergency Department
- Compliance with Performance and Development Review (PADR) currently 67% within the Emergency Department.
- Programme in place for completion of PADR

During this inspection we found that there was sufficient staff on duty across the department. However, there was some reliance on agency staff to cover vacancies and sickness.

There was generally a good skill mix of staff. However, we were informed that there were not enough qualified children's nurses to cover every shift.

Figures presented showed that 83% of staff working in ED and 98% of staff working in MAU had received a performance and development review/annual appraisals within the past 12 months.

We distributed HIW questionnaires to staff to find out what the working conditions are like and to obtain their views on the standard of care.

We received 11 completed questionnaires from a range of staff.

Most staff indicated in the questionnaires that they had undertaken learning and development, in areas such as health and safety, fire safety and infection control while at the hospital, in the last 12 months.

A majority of staff had undertaken training for advanced life / paediatric life support and Deprivation of Liberty in the last twelve months. However, only a minority said they had undertaken training on dementia and de-escalation and privacy and respect in the last 12 months.

The majority of staff who completed a questionnaire said that the training or learning and development they complete helps them to do their job more effectively, and most said it helps them to stay up to date with professional requirements and ensures that they deliver a better experience for patients.

Nearly all staff members who completed a questionnaire told us that they had an appraisal, annual review or development review of their work in the last 12 months.

The majority of respondents said that they were able to make suggestions to improve patient care although a minority said they felt involved in decisions that were made that affected them.

Around half of the respondents said that they are usually able to meet all the conflicting demands on their time at work, and that they often do not have adequate materials, supplies and equipment to do their work. Comments included:

> *"Not nearly enough equipment, which leads to poor care"*

> *"Limited facilities, require further equipment."*

Some staff who completed a questionnaire felt there were not enough staff within the organisation to enable them to do their job properly. Comments included:

> *"The ED is under-staffed and under-resourced from a nursing, medical and pharmacy perspective. I sympathise with my ED*

colleagues who cannot deliver the standard of care they wish to patients or to the standard the patient needs. However, they do the best with the resources available. Delays are common from clerking, to patient care to medicines administration."

"The current environment in the ED borders on unsafe. Whilst individually each patient is kept as safe as possible, collectively the crowding leads to high risk environment."

The majority of the staff who completed a questionnaire, however felt that they were satisfied with the quality of care they are able to give to patients. Although only half agreed that the privacy and dignity of patients is maintained and that patient independence is promoted.

The majority of staff who completed a questionnaire thought that the organisation encourages teamwork. However, only a minority felt that the organisation was supportive, and that front line professionals who deal with patients are empowered to speak up and take action when issues arise.

Around half of the staff said there was a culture of openness and learning within the health board that supports staff to identify and solve problems. The majority of respondents thought that the health board has access to the right information to monitor the quality of care across all clinical interventions.

The majority of staff who completed a questionnaire agreed that the care of patients is the organisation's top priority, and nearly all agreed that the organisation acts on concerns raised by patients. Around half of the staff agreed they would recommend the organisation as a place to work, and most said that they would be happy with the standard of care provided by the organisation, if a friend or relative needed treatment. Comments included:

"When I have raised concerns … senior management are very receptive and we have improved … as a result. However, it remains very much a work in progress."

"…people who provide frontline service are fantastic and dedicated, but are at breakpoint and burn out."

All of the staff members who completed a questionnaire told us that patient experience feedback, such as patient surveys, was collected. Around half told us that they received regular updates on the patient experience feedback, and most felt that patient experience feedback is used to make informed decisions within their directorate or department.

Staff were asked in the questionnaire about their immediate manager, and the feedback received was positive. Comments included:

> *"Our management team are very helpful and very approachable. They listen and understand if there is anything which needs addressing."*

The majority of staff agreed that their manager encourages them to work as a team, can be counted on to help them with a difficult task at work, gives feedback, and is supportive in a personal crisis. Comments included:

> *"Any concerns I have raised have been addressed in a timely manner."*

> *"My line manager is fantastic - very enthusiastic, supportive and understanding of the pressures in ED. In my role, I could be in ED 24/7 to ensure everybody gets the same standard of pharmaceutical care however, she's taught me to do my best in the time…."*

A majority of staff who replied felt that their managers ask for their opinion before decisions were made that affect their work, and can be counted on to help them with a difficult task at work.

A majority of staff who completed a questionnaire reported that they knew who the senior managers were in the organisation. Around half said there is effective communication between senior management and staff, and the majority said that senior managers regularly involve staff in important decisions, with half saying that management act on staff feedback. Comments included:

> *"I feel we have a fantastic senior team of managers who are always very supportive and very helpful."*

A majority of staff said that senior managers are committed to patient care and that they have sight of new guidance, patient safety alerts and medical device alerts, and that they are supported to ensure implementation of those.

Around half of respondents agreed that their immediate manager takes a positive interest in their health and well-being. However, a third disagreed that their organisation takes positive action on health and well-being, and that they were offered full support in challenging situations. Most said they were aware of the Occupational Health support available to them, and that their working pattern allows for a good work life balance.

Around half of the staff told us in the questionnaires that they had seen errors, near misses or incidents in the last month that could have hurt staff, and around two thirds said they had seen errors, near misses or incidents that could have hurt patients. All staff who had seen an error, near miss or incident had reported it. Comments included:

> *"Medication safety is the mainstay of my role. I Datix all serious and life threatening errors and document all medication related admissions for review … and improve patient care - especially at the care interface such as the ED. I am confident approaching nursing and medical staff if I observe them making a medicines related error and educating them."*

All staff said they were aware of the incident reporting system and a majority said they had adequate training on this system.

A third of staff told us that the organisation treats staff who are involved in an error, near miss or incident fairly, and most agreed that their organisation encourages them to report errors, near misses or incidents.

A majority of staff indicated that they felt the organisation would treat any error, near miss or incident that is reported confidentially, and few felt that the organisation would blame or punish the people who are involved in such incidents. A majority of responses agreed action would be taken on incidents identified.

Around half of the staff agreed that they are informed about errors, near misses and incidents that happen in the organisation, and around half said they were given feedback about changes made in response to reported errors, near misses and incidents. Comments included:

> *"…the situation in ED is less transparent and I'm not aware of staff being told of recent errors/near misses etc and how to prevent them."*

Staff told us that they knew how to report unsafe clinical practice and that they would feel secure about raising such concerns.

Most staff members who completed a questionnaire felt that their organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Improvement needed

The health board must:

- Continue to monitor staff levels and skill mix within the department
- Ensure that all staff have access to training in order to ensure that they have the right skills and competencies
- Reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.

4. What next?

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

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

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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

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

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

5. How we conduct follow-up inspections

Follow-up inspections can be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels. We will also highlight any outstanding areas of improvement that need to be made.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified during this inspection.			

Appendix B – Immediate improvement plan

Service: Wrexham Maelor Hospital, Emergency Department

Date of inspection: 06 and 07 August 2019

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take, to ensure that patients who are waiting on trolleys in the corridor receive appropriate and timely care.	2.1, 3.1, 3.5 and 5.1	Formal risk assessment to be completed with clear mitigation and controls for the use of corridor for all patients. The formal risk assessment will be a part of the BCUHB escalation framework (likely risk score above 16 and will be part corporate risk register). Immediate corrective action of clinical teams to incorporate patient's nursed in the corridor as a part of ED safety huddle and document all the actions taken. Matron and Heads of Nursing to	Head of Nursing (HON) – Emergency Care (EC) Shift Leader and Lead Consultant – Emergency Department (ED)	30th August 2019 (Immediate) 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		perform daily random audit to gain assurance with compliance. The practice has been reinforced with all nursing staff about the use of the SHINE document at time of initial assessment. All agency workers will receive an effective induction for the Emergency Department and clinical supervision will be provided to ensure compliance with policies. The clinical staff will complete the National Emergency Warning (NEWS) Score according to the policy and will escalate to the Shift Leaders and doctor in-charge as required. If the patient's clinical condition deteriorated, the staff have been instructed to re-triage the patients and inform the senior clinician as suggested by the triage category.	HON- EC Shift Leader – ED. Shift Leader – ED. Shift Leader – ED	12th August 2019 (Immediate) 12th August 2019 (Immediate) 12th August 2019 (Immediate) 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Patients to receive an apology letter whilst waiting in the ED corridor from the Managing Director during overcrowding within the ED. The use of the multipurpose room is reinforced to all the staff to provide appropriate and dignified care at all times to the corridor patients. Develop and implement the Standard Operating Procedure (SOP) to ensure there is a clear escalation process for all the staff to ensure appropriate and timely care provision for the corridor patients. This would be further supported by internal ED escalation policy. Reinforce the Health Board's Escalation Policy to escalate corridor patients to the Hospital Management Team (HMT) lead through daily bed meetings to gain specialty support to maintain patient safety.	Directorate General Manager- EC Shift Leader- Emergency Care. HON- EC HON- EC Matron- ED	30th August 2019 (Immediate) 12th August 2019 (Immediate) 30th August 2019 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The departmental Matron (in hours) and Shift Leader (out of hours) to ensure the opportunity of completing the patient experience survey is offered to all the patients within the ED corridor. This action plan will be monitored at the weekly Unscheduled care meeting and the department will establish a task and finish group to monitor this action plan locally. A weekly audit is performed to gain assurance of compliance for the above actions and to drive further improvement.	Matron- ED Shift Leader- ED Triumvirate – EC Matron- ED HON- EC	19th August 2019 (immediate) September 2019 19th August 2019 (Immediate)
The health board must provide HIW with details of the action it will take to ensure that suitable pressure relieving mattresses are readily available for use on trolleys within the ED.	2.2	The importance of appropriate skin checks (at admission and as required) has been reinforced to the staff. Staff have also been informed about the importance of pressure ulcer prevention & care as per policy for the patients nursed on ED trolley	Matron- ED	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		mattresses. This includes the patients being nursed in the corridor. All staff to ensure that the Maelor score is completed as per policy and actions taken accordingly. In case of patient's further clinical and physical deterioration, staff have been reminded about the importance of re-checking the Maelor score and acting accordingly. All patients within the department are placed on the profile bed with appropriate air mattress as indicated by the Maelor Score. The current trolley mattress within ED to be reviewed and the Huntleigh (trolley provider within ED) to be contacted to ensure we are using the trolley mattresses for	Matron- ED Shift Leader- ED Matron- ED	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		our patients as per their recommendations. The ED trolley mattress audit performance is sustained as per policy. Harm reviews are currently undertaken to review the hospital acquired harms for long trolley waits. The ED Matron is to present the findings of any harm reviews in local Hospital Acquired Pressure Ulcer (HAPU). This action plan will be monitored at the weekly unscheduled care meeting, and the department will establish task and finish group to monitor this action plan locally.	Shift Leader- ED Matron- ED Triumvirate- EC	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		A weekly audit is performed to gain assurance of compliance for the above actions and to drive learning and further improvement.	Matron- ED	
The health board must provide HIW with details of the action it will take to ensure that patients are issued with ID wrist bands at an early stage in their care pathway within the ED.	2.1 and 3.1	The Triage, Majors and Resuscitation areas now have the electronic printers installed. This is now being used to issue printed ID wrist bands across all areas. Ensure weekly audit is performed to gain assurance with compliance of ID wrist bands. This action plan will be monitored at the weekly unscheduled care meeting the department will establish task and finish group to monitor this action plan locally. A weekly audit is performed to gain assurance of compliance for the	Matron- ED Matron- ED Triumvirate- EC Matron- EC	9th August 2019 (Immediate) 12th August 2019 (Immediate) September 2019 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		above actions and to drive further improvement.		

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

Service representative:

Name (print): Kate Clarke

Job role: Secondary Care Medical Director

Date: 13 August 2019

Appendix C – Improvement plan

Service: Wrexham Maelor Hospital, Emergency Department

Date of inspection: 06 and 07 August 2019

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the Butterfly scheme is implemented consistently within the department.	1.1 Health promotion, protection and improvement			
The health board must ensure that waiting times are accurately communicated.	4.2 Patient Information			
The health board must ensure that patient information is made available through the medium of Welsh.				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must discourage staff from using abbreviations when speaking with patients and visitors.	3.2 Communicating effectively			
The health board must continue to monitor waiting times and implement further strategies to improve patient flow through the department.	5.1 Timely access			
The health board must ensure that care plans are person centred.	6.1 Planning Care to promote independence			
The health board must ensure that DoLS assessments are routinely conducted on patients presenting with conditions such as dementia, head injury or general confusion.	6.2 Peoples rights			
Delivery of safe and effective care				
The health board must ensure that the shower room on MAU is refurbished.				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that food items are not stored with clinical equipment on both MAU and CDU.	2.1 Managing risk and promoting health and safety			
The health board must ensure that pressure area risk assessments are routinely undertaken and that suitable pressure relieving mattresses are available for use on trolleys.	2.2 Preventing pressure and tissue damage			
The health board must ensure that falls risk assessments are undertaken in a timely fashion.	2.3 Falls Prevention			
The health board must ensure that patients' eating and drinking needs are consistently assessed and nutrition and hydration monitoring charts are completed as required.	2.5 Nutrition and Hydration			
The health board must ensure that controlled drugs are checked on a daily basis.	2.6 Medicines Management			
The health board must ensure that staff sign controlled drug registers at point of checking and/or administration.				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that Oxygen is only administered when formally prescribed.				
The health board must ensure that the door to the paediatric are is locked when staff are not in attendance.	2.7 Safeguarding children and adults at risk			
The health board must ensure that the resuscitation trolleys are checked on a regular basis as per policy.	2.9 Medical devices, equipment and diagnostic systems			
The health board must ensure that patients are assessed for pain relief and that the effectiveness of the effectiveness of the pain relief in reviewed and documented.	3.1 Safe and Clinically Effective care			
The health board must ensure that trolleys containing patients' care notes are locked when not in use.	3.4 Information Governance and Communications Technology			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that computer screens are locked when staff are not in attendance.				
Quality of management and leadership				
The health board must continue to monitor staff levels and skill mix within the department.	7.1 Workforce			
The health board must ensure that all staff have access to training in order to ensure that they have the right skills and competencies.				
The health board must reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.				

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

Service representative

Name (print):

Job role:

Date: