Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

The Emergency Department, The Grange University Hospital, Aneurin Bevan University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department at The Grange University Hospital, Aneurin Bevan University Health Board between 1 – 3 August 2022. The following areas were reviewed during this inspection:

- Ambulance Bay and waiting Room
- Triage
- Resuscitation (resus) - This department has 8 resuscitation bays for those patients who were critically ill
- Majors – This is an area containing 20 bays for patients to have their assessments, care and treatments
- Assessment & Sub Wait - This area has a dedicated ECG room and 4 cubicles to assist with assessments and care of the patients in the waiting room. This area also includes an area outside the majors office where patients need to be monitored and they sit on chairs, to await a bed space or discharge and is referred to in this report as the rapid assessment unit (RAU)
- Covid Assessment Zone (CAZ) - Patients were streamed to the appropriate triage area from outside the department depending on their answer to set COVID-19 related questions. The patients who entered via the COVID entrance would be triaged in the A1 Corridor outside the Children's Emergency Assessment Unit (CEAU).

Our team, for the inspection comprised of two HIW Inspectors, three clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

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

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patients were happy with the way that staff interacted with them and were complimentary about the staff dedication and care provided. However, patients were critical of waiting times. We observed all staff striving to deliver good quality, safe and effective care to patients, within very busy units. During the inspection we found that some patients had been waiting on uncomfortable chairs and in the back of an ambulance for over 15 hours.

The waiting area was very small and cramped and unfit for purpose. Staff acknowledged this and told us they needed a bigger waiting area. A large portacabin style building has been built in the area immediately to the front of the CEAU. This was marked as a possible building for another waiting room. However, it is not operational and in its current location would present a significant risk to patient safety if not staffed and monitored sufficiently.

Until the flow of patients into and through the ED can be improved, the health board may find it difficult to address a number of our concerns.

We saw staff speaking with patients and their relatives in a polite, professional and dignified manner. However, we found that the dignity of some patients was affected by either lengthy waits within the department or as a result of where and how patients had been accommodated whilst awaiting further review or treatment. Staff made active efforts to move patients to more appropriate areas of the department where possible.

This is what we recommend the service can improve:

- Manage the overcrowding in the waiting room and the RAU that are not conducive to providing dignified care
- Ensure that there is an area available to facilitate red release calls at all times
- Not requiring patients to wait on chairs overnight in the RAU

- Continue to put processes in place as part of a system wide solution to poor flow and overcrowding at the ED waiting rooms

- Regularly review patients in ambulances, the waiting room and the RAU to ensure that patients receive appropriate and timely pain relief and treatment.

This is what the service did well:

- Patients and their carers that we spoke with were mainly complimentary of the care overall with positive comments on staff

- Staff were observed trying to maintain the best dignified care they could to patients

- Staff were seen to be discreet in communicating personal information with patients

- There were large flow diagrams displayed showing the patient journey through the department, in both Welsh and English.

Safe and Effective Care

Overall summary:

We were not assured that all the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of safe and effective care. This was despite all the efforts of staff who were working hard, under pressure from the number of patients presenting at the ED.

We had a number of immediate concerns relating to the safe care of patients, and these were dealt with under our immediate assurance process.

Patient notes we checked were clear and easy to navigate, with a structured rapid assessment pathway. There were aspects of medicines management which were noted as positive.

Immediate assurances:

HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff. Please note this list is not exhaustive and full details are contained in Appendix B:

- The risk of cross contamination in the area known as the COVID corridor
- The resuscitation equipment had not always been checked daily
- The resuscitation trolley contained two ampoules of out-of-date medication. These were immediately replaced
- The temperatures of medication fridges had not been regularly checked
- The controlled drugs register had not been checked on a daily basis
- There were several areas of the department where substances which could be harmful to health were freely accessible to patients and members of the public, these included medication and prescription pads.

This is what we recommend the service can improve:

- Staff awareness of the Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances
- Give due consideration to staff comments in relation to the lack of availability of some equipment
- Give due consideration to staff comments in relation to the manning and risk associated with patients in the waiting room and the RAU.

This is what the service did well:

- The nurses in the RAU area, who were also responsible for the waiting room had very good oversight of patients
- Patients we spoke with praised those involved, including staff and the Red Cross volunteers for the care and nutrition provided
- Medication charts were completed correctly and medicines administered within time limits
- Nursing and medical documentation was comprehensive and easy to locate and understand
- The patient safety at a glance board allowed good oversight information of the whole waiting room and RAU

- Staff working hard to mitigate risks associated with holding people on hard chairs in the RAU and waiting room.

Quality of Management and Leadership

Overall summary:

We spoke with a cross-section of staff working in the ED. Many told us that they were struggling with the high demands of the department and they could not provide the care to patients they deserved in a timely manner. Staff felt supported by their line managers.

Senior managers were aware of the issues in the department and trying to put arrangements in place to manage this situation. However, the department was experiencing high demands on the service.

We were assured that there was a supportive culture in place which promoted accountability and patient care and that the management and leadership was focused and robust.

This is what we recommend the service can improve:

- Implementing a robust process to ensure the impact of the workload on staff wellbeing is managed
- Continue with its efforts to recruit permanent staff
- Action is taken to improve compliance with staff appraisals.

This is what the service did well:

- The department was well led with clear lines of responsibility and systems in place to monitor and respond to service needs
- We noted that triage staff were resilient and worked hard in a difficult working environment balancing the risk to patients in the waiting room and in the ambulance bay
- The nurse in charge was clearly identifiable and visible in all areas. Staff told us that the senior staff in ED were supportive and visible

- Mandatory training records provided showed that compliance was generally good

- Staff told us of the monthly wellbeing sessions that were in place that had received good feedback.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

HIW issued both paper and online questionnaires to obtain patient views on the Emergency Department (ED) at The Grange University Hospital. In total, we received 11 responses. Patient comments included the following:

> *"Staff were clearly doing their best but up against it and under-staffed and clear lack of beds for number of patients."*

> *"Overall, very disappointed [waiting time] post-surgery severe pain and waiting on cold bench for fourteen hours"*

> *"Friendly staff"*

> *"Just very, very good."*

Responses from patients about their care were mixed, including negative comments about waiting times and PPE, but positive comments about staff. The main issues raised by patients, attracting the most negative comments, were waiting times at the ED and patient checks. Over half the respondents said they had waited for more than four hours before receiving treatment or being referred on. In addition, only a quarter said staff checked on them while they were waiting.

A total of six respondents rated the service they received as 'very good' or 'good', but five rated it as 'poor' or 'very poor'. We asked patients how the setting could improve the service it provides. They told us:

> *"Waiting over sixteen hours with a prolapsed disc and suspected stroke…not very comfortable chair…no bed…stuck in a busy hallway in chair with very little offer of pain relief."*

> *"Have a bigger waiting room, some patients were sitting outside."*

> *"Using PPE correctly using hand gel/washing, more monitoring of patients while waiting."*

Staff Feedback

HIW issued an online survey to obtain staff views on the ED. In total, we received 13 responses from staff at the setting. Responses and comments from staff were generally negative, with the main issues being:

- Lack of space and assessment areas which was impacting on patient safety
- Poor patient flow
- Inadequate staffing levels
- Lack of appropriate training.

Despite this, around two-thirds of staff who responded were satisfied with the quality of care they gave to patients and would recommend their organisation as a place to work.

Positively, all but one member of staff had received an appraisal, annual review or development review of their work within the last 12 months and the majority felt able to make suggestions to improve the work of their team. All staff also believed that patients were adequately informed and were involved in decisions about their care.

Staying Healthy

Health Protection and Improvement

There was information displayed highlighting the appropriate use of the ED and signposting to other services. These were seen on the COVID-19 screening portacabins and in several areas throughout the ED. Posters were also displayed explaining that the hospital was a smoke-free environment. This also extended to the use of vapour or e-cigarettes. We witnessed patients smoking outside the main reception and from the numbers of cigarettes butts on the floor, this area had clearly been used as a smoking area.

Dignified care

Dignified care

Staff were observed trying to maintain the best dignified care they could to patients in an unsuitable and noisy environment in parts of the ED. These overcrowded and gridlocked areas were not conducive to providing dignified care as patients were sat near each other on chairs overnight that did not provide adequate rest and personal care for the patients.

We spoke with 12 patients during the inspection, generally they were very satisfied with the care, but they were frustrated and sometimes angry with the waiting times. The majority were very complimentary about the staff working in the department and in the ambulances. They said they were kind, respectful and helpful. Whilst many patients were unhappy with the waiting times for care and treatment, they recognised that this was not the fault of the staff.

All patients bar one who completed the questionnaire agreed that staff treated them with dignity and respect and that measures were taken to protect their privacy during assessment or treatment.

We observed staff speaking to patients with respect and kindness, and one patient commented on how kind staff were and that they would go ‘above and beyond’ what was required.

Patients in beds or trolleys looked generally comfortable, those in chairs in the RAU and the waiting room looked less comfortable and, in some cases, looked very uncomfortable.

Patients’ dignity could not be maintained in the RAU. Chairs were placed very close together with clinical interventions taking place such as venepuncture and intra-venous (IV) drug administration. They were visible to not just the nursing staff but the whole of majors and anyone passing through. Curtains and doors were closed in majors and resus when delivering personal care.

We noted one particular positive incident of note where an agitated patient in a cubicle was being monitored and supported by a team of security officers. The staff were careful to maintain the privacy and dignity of the patient by not being too intrusive whilst supervising their safety.

We also noted bereavement support being delivered in a timely way and undertaken in a sensitive and compassionate manner. Bereavement information seen was comprehensive including access to support services and a practical guide.

We asked staff in their questionnaire about maintaining patient dignity, whilst five of the eleven staff who answered this question agreed that patients' privacy and dignity was maintained, six disagreed.

Communicating effectively

Staff were seen to be discreet in communicating personal information with patients as well as being kind and considerate to patients and their family and carers. Curtains were drawn when necessary for patients in cubicles. However, maintaining confidentiality in the RAU could be difficult to achieve due to the lack of space.

We observed most staff speaking with patients about their care and treatment in a way that they understood. One of the conversations we heard involved a nurse on triage explaining the waiting time and arranging an appointment with urgent care and primary care as an alternative treatment plan. Patients were moved to private rooms for their examination and assessment by medical staff.

The patient safety at a glance board behind the wall in the RAU facilitated good communication between staff as patient information was recorded and easily available. The board assisted in maintaining safety in a busy overcrowded area. The details on the board included when observations were next due, as well as information on bloods, electro-cardiographs (ECG), X-ray and treatments given or next due.

Patients we spoke with had mixed comments about how staff communicated with them. Five patients were positive or did not have issues. One had poor eyesight and staff were aware they needed to keep their drink topped up frequently. Almost all patients we spoke with said that the staff listened to them and took the time to explain their care and treatment in a way that they could understand.

We asked patients a series of questions about their experiences relating to their healthcare. A total of eight patients who answered the question agreed that staff listened to them, but two disagreed. Of the nine patients who answered the question, six agreed they were involved as much as they wanted to be in decisions about their healthcare. Seven of the nine patients agreed they were provided enough information to help them understand their healthcare.

We noted two members of staff wearing the Welsh speaking logo, to make patients aware that they could speak to them in Welsh. However, we did not see any evidence of staff being able to make an 'Active Offer'.

There was a voice activated communication system used within the hospital that staff were able to wear on a lanyard.

We were advised by staff that there was a working hearing loop in reception and the additional speaker on the reception desk was used when needed. However, they stated that the microphone in the desk was still not working properly.

In resus we observed a number of medical rounds and both medical and nursing staff were always discreet in their communications about personal information. Patients were also spoken to by medical staff at level that allowed the patient to understand their care and treatment. It was noticeable that staff, although busy, took the time to ensure patients understood what they said and that this was given in a reassuring way. We also observed a member of medical staff repeating information to a patient to ensure that the patient understood the conversation. Of the staff who answered this question, nine agreed that sufficient information was provided to patients but two disagreed.

Patient information

There were large flow diagrams displayed showing the patient journey through the department, in both Welsh and English. There were also permanent smaller bilingual signs describing where the patient was in the department and explaining what the area was, for example explaining the triage process in simple terms for patients.

Directions to the ED were clearly displayed outside the hospital. Once inside each unit, there were signs directing patients to the toilets, exits and also the emergency exits.

Timely care

Timely Access

Most patients we spoke with were happy with the care and treatment they received. Those who had entered the ED via the waiting room felt that the waiting times were far too long. They said that the chairs were uncomfortable, and not knowing how much longer they would be waiting created anxiety and frustration. All patients acknowledged that it was not the fault of the staff, whom patients were very positive about, but criticised what they believed to be the policies and management of emergency healthcare services locally. Those who were admitted by ambulance were very pleased with the treatment they had received, both in the ambulance and after entering the ED. This was also the case when they had been waiting in the ambulance for a lengthy period.

In the survey, four patients who answered this question arrived by ambulance. Of these, two said that, on arrival at the hospital, they waited in the ambulance for less than 15 minutes before being admitted into the ED. The other two patients waited between 15 and 30 minutes. All the patients who answered said that they were regularly checked on by hospital staff whilst waiting in the ambulance, and both said they felt safe and cared for whilst in the ambulance.

On the afternoon of our arrival at the hospital, there were 14 ambulances waiting in the ambulance bay and we were told there were major delays in offloading with average offload times being over four hours. This included one patient who had been waiting 18 hours due to an infection control risk.

Care of patients on ambulances was the joint responsibility of hospital staff and the Welsh Ambulance Service Trust (WAST) staff. Paramedics were responsible for patient observations and reporting to hospital staff if the patient deteriorated or if WAST staff had concerns regarding clinical progress. Then the triage nurse and Hospital Ambulance Liaison Officer (HALO) would be informed to possibly expedite offload to a more appropriate area. We noted a close liaison between the deployed HALO, the triage nurse and the nurse in charge of the ED, regarding patient care.

Patients would either be triaged on board the ambulances or offloaded and triaged in the ambulance triage area. They would then be returned to the ambulance or admitted to the department where possible. Ideally patients would be offloaded to the triage area in order to be turned for a full skin inspection and assessment. Triage staff reported that it was difficult to complete a full skin assessment and continence check on an ambulance trolley.

In our opinion there had been significant and multiple long waits for patients to be offloaded from an ambulance. The clinical risks were mitigated by triage assessment and if the patient required urgent attention they would be offloaded, where possible, to a more clinically appropriate area. Red calls and pre alerts were accommodated by managing patients within both the resus and majors areas of the department.

There was a new policy in place relating to releasing ambulances for red calls in operation at the ED. Normally a designated cubicle was allocated as an empty area to expedite quick offloads to release crews for red calls. However, the cubicle was frequently occupied, due to the lack of space within the department and red release calls were noted as not taking place on two occasions during the inspection as there was no safe area to offload the patient.

We observed one of the four site meetings (these occur at 9am, 12pm, 3pm and 6pm) where the relevant staff provide information to the operations and urgent care team. At the meeting the number of attendances and other statistics were discussed for the ED, medical assessment unit and surgical assessment unit and then clinical priorities and clinical safety concerns were discussed. This aimed to assist in the patient movement and any transfers needed could be managed. Additionally, they would look at patients who had been sitting in chairs for long periods and put actions in to address those issues. The aim being to move patients out of these areas into speciality areas.

We also spoke with staff relating to the management and flow of patients. We were told that the main issue related to medically fit patients occupying beds throughout the health board who could not be discharged. This was due to a number of factors including because there were not appropriate care packages in place outside the hospitals to care for the patients and they therefore could not be discharged. If these patients were able to be discharged, this could then create more space for patients to be discharged from the ED into other wards and hospitals.

Whilst we did hear reception staff advising patients that there was a delay, they did not tell patients how long this was, as it varied depending on the acuity of the patient. On the previous inspection, dated the 1-3 November 2021, we noted that there was not a system in place to inform patients of the average waiting time for patients at the ED. The health board stated that the Royal College of Emergency Medicine did not support systems to display waiting times and that the health board supported this. In reply to our recommendation to introduce an electronic waiting time board the health board stated that they were working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine. This is due to be in place by October 2022.

We were supplied with the 12 month ED metrics as at 2 August 2022. These showed the following:

- Length of stay on ambulance - On average, 40.7% of ambulance handovers are over 1 hour, and 5.1% of ambulance handovers are over 6 hours

- Time from arrival to triage - The average time from arrival to triage was 36 minutes

- Length of stay in waiting room - From arrival to first being seen by a clinician averaged 2.3 hours

- Length of stay in ED - The overall average time that patients spent in ED was 7.4 hours. This varied from on average 6.4 hours for those patients not admitted to 10.7 hours for those admitted

- Waiting time breaches – Over the last six months, the overall compliance against the 4-hour ED performance target averaged 42.3%, against the 12 hour ED performance target this averaged at 83.8%

- ED Never Events - Over the last six months there has been an average of 100 patients a week waiting over 16 hours in the ED.

Significant multiple ambulance offload breaches were observed throughout the inspection, with poor flow observed into, and out of, the department. Patient harm due to delayed treatment of pressure area care and dignity was at an increased risk when elderly / vulnerable patients were delayed on ambulances for a significant amount of time.

Individual care

Planning care to promote independence

The ED workload was not always conducive to encourage patients to mobilise. However, we saw physiotherapists and occupational therapy staff on the ward encouraging patients to move. Some staff in majors reported that the high acuity of patients did not give staff time to mobilise patients as often as they would like. The ED is designed for short term stays, although several elderly patients were in the department for over 24 hours.

The electronic patient record Symphony included a blue forget me not symbol when a patient had a diagnosis of dementia. Additionally, the symbol was used on the manual board in the rapid assessment area to identify patients with dementia. We were told that the unit had recently acquired equipment such as board games for patients with dementia.

Of the patients who answered the question, five agreed that they had access to toilet / washroom facilities but two disagreed. There were a number of toilets for patients in the waiting room and in majors.

All 11 staff who answered the question agreed patients and/or their relatives were involved in decisions about their care. Eight staff said they were satisfied with the quality of care they gave to patients and three disagreed. A staff member commented:

"Completely accept that this is a national problem with flow but it is the biggest patient safety concern as there is good evidence that patients come to harm. We don't really need a bigger waiting area as most of those patients need to be on a trolley or the assessment area waiting areas. A nice analogy - If the bath is full and overflowing… don't make a bigger bath… sort out the plug hole please "I do believe all the staff in ED provide the best care they can do to all our patients, however when we're short staffed and at maximum capacity we really struggle."

People's rights

There was level access to the department with further parking now available nearer to the ED so that older relatives did not have to walk as far to accompany their relatives in the ED.

Most people were satisfied with the level to which their friends and family were involved in their care. Most people were not interested in making a complaint because, they either did not want too as they were satisfied with their care even if they had waited a long time, or because they felt if made no difference.

Staff we spoke with confirmed that patients' spiritual needs had been considered and that there was access to pastoral and religious support. They also said that for those religions requiring certain foods and not allowing certain types of treatment that would be document and provided. Staff we spoke with said, regarding equality and diversity in the organisation, that all patients were treated according to their clinical need. They all said that they were aware of the importance of individual needs and rights. Equality and diversity awareness was part of the mandatory training requirements for staff. Staff were also aware of individual requirements of various religious faiths, including after death.

Visitors were now allowed in the ED and there was open visiting. Visitors were able to provide assistance and were involved in patient care at the request of the patient. We noted in resus instances where relatives were encouraged, wherever appropriate, to assist with hydration under the supervision of the nursing staff. Visitors and relatives were discouraged from accompanying patients into the waiting room due to a lack of space and some relatives were noted sitting on chairs outside the waiting room. Relatives of patients in resus were also encouraged to be present, if they wished, when certain treatments were given.

We noted there were specific and suitable places for patients to meet with family and friends in private. Some of the bays in resus had now been converted into confined cubicles with doors, this also allowed space for end-of-life care to be

given appropriately. These cubicles allowed more peace and quiet for the patients. The lights in these resus cubicles could also be dimmed.

All patients who answered said they were assessed by healthcare staff. This ranged from three patients assessed immediately, four within 30 minutes of arrival and four said they waited more than 30 minutes to be assessed.

We asked patients how long they had to wait in total at the ED before receiving treatment or being referred on, five answered that they waited less than two hours, but two waited over 12 hours. Patients commented:

> *"Was not seen until five hours after arriving."*

> *"Reduce waiting times ambulance availability."*

Only one of the eight patients who responded agreed that there was adequate seating in the waiting area and six disagreed. Two of the eight patients who responded to the question agreed that staff checked on them whilst they were waiting but six disagreed.

Listening and learning from feedback

We noted that the department gathered the views of patients and their carers through quick response (QR) codes that were displayed on posters in the department. Additionally, we noted that patients were signposted to relevant routes if they had a complaint to make, this including community health councils. The NHS Putting Things Right poster was also displayed prominently. Staff we spoke to in the department were also aware of the process for feedback and complaints. The audit of patient feedback for the last two days in July also showed that patient feedback on the care provided was generally very positive. One patient commented:

> *"Mixed feelings which included the news that I'd had a {condition} but staff have been superb. Very attentive, efficient, and very focus on getting things right in spite of being up against it resource wise."*

The information on how health boards had learned and improved on feedback received was not displayed within the department.

We spoke with the staff involved in registering and processing complaints and compliments in the hospital. The process was described and included telling the complainant in a timely manner and ensuring staff are made aware of the results of the investigation and any lessons learned. One patient said she they had

complained and only received a response from nursing staff after chasing. She was then told she needed to speak to someone in management about the complaint and someone would ring her, but no one had rung. The original complaint was made six months previously.

A total of 11 ED staff answered questions about patient experience measures.

- All bar one agreed patient experience feedback was collected within their department

- A total of eight of the 11 agreed that they received updates on patient experience feedback in their department but two disagreed

- Only six of the 11 agreed that feedback from patients was used to make informed decisions within their department, again two disagreed.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety

At the previous inspection it was noted that there was limited visibility of the waiting room from the reception area and that the close circuit television (CCTV) in the waiting room was monitored on an ad hoc basis from a monitor in the RAU. Whilst the monitoring of this CCTV was still considered to be ad hoc, it was positive to note that additional cameras had been installed and there was also a monitor in the reception area.

The waiting area was very small, cramped and unfit for purpose. Patients told us that they had previously had to sit on the floor due to the lack of space, although this was not observed during the inspection. Staff acknowledged this and told us they needed a bigger waiting area. A large portacabin style building had been built in the area immediately in front of the children's emergency assessment unit, next to the ED. This was marked as a possible location for another waiting room. However, it was not operational and in its current location would present a significant risk to patient safety if not staffed and monitored sufficiently, as well as the potential of having two separate waiting rooms.

Patients in the waiting room, RAU and majors were observed as being monitored closely. Regular clinical observations were undertaken and any abnormalities in these were identified and escalated as required.

The nurses in the RAU area were responsible for the waiting room and had very good oversight. However, due to the nature of the department there could be in excess of 50 patients in the waiting room and up to ten patients in the RAU. As minor injury patients were redirected to MIUs, the majority of patients in the waiting area were physically or mentally unwell and would be classed as 'majors'. This was a significant risk and placed stress and risk on the staff members. They relayed their concerns during the inspection that the workload was very high due to this and that patients in the waiting area waiting for beds still needed interventions which the nurses would have to undertake.

We were told about the process to ensure risks and incidents were managed effectively. This included reporting incidents on DATIX and escalating issues at departmental or site level. Feedback from incidents was received by various methods including Whatsapp, nursing news and face to face. We were provided

with copies of the risk register and it was evident that this was regularly reviewed and managed. The risks contained in this register included capacity in the waiting room, using the CAZ as a thoroughfare, assessment capacity and holding patients on trolleys and on ambulances.

The environment in the majors and resus areas were considered to be safe. Beds were kept at the lowest levels with call bells to hand. Patients at risk were highlighted in red on the patient safety at a glance board. There was level access to the department with no trip hazards and equipment was stored away from the department when not is use. We also noted that even though there was some maintenance work occurring in the main corridor alongside the ED, there were warning signs and maintenance equipment was kept to one side leaving sufficient room for trolleys to pass. Security were also clearly visible throughout the department. The environment was clean and in a good state of repair with the floor and hard surfaces being cleaned regularly. However, the ED did not have enough room, facilities or staff for the number of patients coming into the ED.

There were several areas of the department where substances which could be harmful to health were freely accessible to patients and members of the public. These included storerooms, dirty utility areas, cleaning cupboards and fluid storage areas. This was highlighted to senior nursing staff who assured us that it would be addressed and made safe immediately. In particular we noted the following:

- Medication was left unattended on a countertop in Majors, this included opened packets of Doxycycline Capsules 100mg, Bisoprolol Fumarate 5mg, Sumatriptan 50mg and bags of medication from the pharmacy

- Tablets of bleach were noted in a storeroom that was left open along the main corridor toward the medical assessment unit

- Fluids were contained in unlocked cupboards within the Majors areas, with a sign including the contents of Potassium 40mmol, Glucose 10%, Hartmans and sodium chloride solutions

- A prescription pad was left unattended in Majors.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Preventing pressure and tissue damage

Pressure risk assessments were noted during our inspection, these included waterlow assessments, turn chart and body map being completed on patient records, once the patient was allocated a bed in majors. We did not note any waterlow assessments for patients sitting in the RAU. Pressure relieving mattresses were available and patients could be transferred onto air flow mattress depending on their risk.

The triage nurse completed the paper nursing care record with the waterlow score European Pressure Ulcer Advisory Panel (EPUAP) and body mapping tool on the initial triage assessment. Whilst we noted that skin bundles were completed intermittently, there was good evidence of skin inspection in notes overnight.

All WAST and nursing staff questioned. recognised the risk of developing pressure damage with long wait times to offload. Ambulance trolleys were not designed to relieve pressure and were not suitable for long patient lays. Several elderly patients were observed on ambulances trolleys for several hours. Staff attempted to mitigate the risk, but the long offload waits could contribute to patient harm. We noted an 80-year-old patient had been on an ambulance for over 13 hours during one morning of the inspection and a full comprehensive skin inspection had been carried out only once.

There was also considered to be a high risk of pressure damage when patients were sat in chairs for long periods Some elderly patients were observed to be on chairs for over 18 hours.

Falls prevention

Falls risk assessments were observed as being completed as appropriate and patients were encouraged to wear appropriate footwear when walking around the ED. Patients deemed at a high risk of falls were highlighted as such on the front sheet of the patient notes. We observed staff pass on risk of falls information on handovers and safety briefs.

We were told that all falls were recorded on Datix, the incident management system used in the NHS in Wales. However, agency staff we spoke with were unaware of the process to share lessons learned and action plans as a result of Datix entries.

Multidisciplinary teams (MDT), including physiotherapists and occupational therapists (OT) were observed in the ED on several occasions. Additionally, we saw

that physiotherapist and OTs carried out the relevant assessments prior to patients being deemed safe for discharge.

We checked a sample of patient records and noted that ED documentation included falls screening questions for all patients attending the ED. If the patient was deemed to be at risk of a fall, staff would complete an ED falls assessment tool. Documentation on this in majors was of a good standard. However, patients in the RAU, who were deemed as fit to sit did not have any assessments completed.

Infection prevention and control (IPC)

The way the department ensured that IPC was managed carefully and appropriately was examined. Overall, we noted good IPC practice throughout the department. Staff were in most cases seen to be wearing their masks properly and gowns and gloves were available with handwashing undertaken at appropriate points. There was also good access to sinks and hand gel. There were isolated instances noted of staff wearing watches and therefore not bare below the elbow. Staff were observed wearing appropriate personal protective equipment (PPE) when delivering personal care to patients.

We noted that social distancing for patients and staff was difficult if not impossible to maintain in the RAU. Additionally, whilst seats in the waiting room had red crosses on them to facilitate social distancing, patients were seen sitting on them and all seats in the waiting room were occupied for the majority of the inspection.

We were told that neutropenic patients would be placed in the cubicles with separate doors and bathrooms. Additionally, one of the cubicles in majors was a negative pressure room. None of these rooms were being used as isolation rooms at the time of the inspection.

Staff we spoke with also told us, that there had been an increase in the number of staff contracting COVID-19 recently. This was believed to be at the point when masks were not being used in the department due to the change in the legal requirements. We were told that as a result, all staff and patients now wore masks in all clinical areas.

We also spoke to senior staff involved in IPC. They spoke about the support and cover available to the ED on IPC. This included trying to introduce new initiatives and giving staff the tools to use in this area. IPC staff were also involved in a full regular annual rolling audit and surveillance using an electronic audit tool. The audit would be completed in various sections throughout the year. Any improvements needed would be discussed with the ward manager at the time and

the relevant action would be taken to rectify the issue. If this was then identified to be part of a trend, the IPC staff would ensure that daily monitoring would take place together with the relevant education and additional resources to support the area.

We saw that the 'one patient one day' themes for June 2022 included, out of 13 checks, cannula bundle not updated - six instances; waterlow not updated for over eight hours – five instances; and falls assessment not completed/updated – four instances. The same documents for July 2022 showed that an improvement had been made in these areas.

The IPC dashboard provided for July 2022, related to items such as healthcare acquired infections, hand hygiene, patient screening and infection prevention procedures and staff awareness. The majority of items were 'Green', such as new clostridium difficile (C.diff) infections in the last month and completing urethral catheter insertion and maintenance bundles. Some items were in 'Red' such as staff were not aware of their current compliance with screening, bundles, infection rates and audits. Information on the results of the audits and lessons learned were shared via email and 'nursing news'.

All patients, in the questionnaires indicated that, in their opinion, the setting was at least 'fairly clean'. However, only three of the patients agreed that, in their opinion, COVID-19 infection control measures were being followed where appropriate and five disagreed.

Staff responses showed that all bar one agreed that their organisation had implemented the necessary environmental changes. They all agreed that their organisation had implemented the necessary practice changes, that there has been a sufficient supply of PPE and that there were decontamination arrangements for equipment and relevant areas. All staff agreed there are appropriate infection prevention and control procedures in place.

We spoke with the domestic staff and they were aware of the requirements of deep cleaning. If specialist ultraviolet of hydrogen peroxide vapour cleaning was required, the supervisor would be contacted. However, we noted that the documentation in patient cubicles were not regularly completed to show that they had been cleaned in several cubicles. There was one cubicle, where the last check listed was 21 July 2022. During our visit we noted that the department was clean, with cleaners clearly visible throughout the day.

Patients were triaged for COVID-19 symptoms before entering the ED. Patients with symptoms of COVID-19 would be streamed down a corridor known as the COVID corridor. Approximately five metres down this corridor there was an area

with equipment for a patient to be briefly triaged and tested for COVID-19. The patients would then sit in soft chairs, with screens between each patient, along this corridor. At the end of the corridor, approximately 80 metres long, was the COVID-19 ward known as A1. There would normally be two members of staff on duty, one qualified nurse and one healthcare support worker. Staff would wear the appropriate PPE with patients (apron, mask and gloves).

We noted that staff from other areas, such as resus, the main ED or the paediatric area would pass through this area from time to time creating additional footfall and risk of cross infection. There was also an office next to where the patients would sit whilst being monitored before moving onto the COVID-19 ward A1, creating further footfall. We were also told that there would be occasions when accompanied patients from the CEAU, which was adjacent to the triage and testing area, would need to pass through this area to go to radiology.

There was a large sign on the entrance to this area to say that it was a COVID-19 area. There was no signage further down the corridor for staff coming from the other directions or at the bottom of the stairs again adjacent to the triage and testing area to inform staff not to enter.

This was also reported as an area requiring immediate assurance during the previous inspection, alongside the need for hand washing and printing facilities and the number of patients that needed to be monitored and tested. During this inspection we noted that a hand washing facility and printing facilities were in place and that the number of patients in this area had significantly reduced, with only one patient noted as being monitored at any one time during the inspection.

These issues were dealt with under HIW's immediate assurance process and are referred to in Appendix B of this report.

Nutrition and hydration

Patients we spoke with praised those involved, including staff and the Red Cross volunteers for the care and nutrition provided. All patients in majors were noted as having jugs of water and there was a water dispenser in the waiting room. Patients within the majors area were offered tea and coffee, patients in the RAU also had water provided. Staff we spoke with said that they were able to meet the nutrition and hydration needs of the patients. Meals were provided three times a day and sandwiches were available out of hours. However, meals were not provided to patients in the waiting room.

Staff we spoke with said that fluid balance charts were not regularly started for patients in the RAU. However, bed area fluid balance charts were completed when

patients were in cubicles. Additionally, we were told that the All Wales Nutrition Charts were not always used due to patients not being in the ED for a sufficient period of time. We also noted that not all intravenous (IV) fluids and oral fluid intake was recorded on the fluid balance charts. From the five records checked, nutrition charts were not completed for patients who had been in the department for over 16 hours. At the last inspection we recommended that nutrition and fluids were recorded appropriately on the relevant documentation. The health board replied that the "ED would ensure IV fluids were recorded on the All Wales Medication Charts. Fluid balance was recorded within the ED patient care record which is a mirror image of the All Wales Fluid Balance Chart. The All Wales Nutrition Chart has been introduced into ED."

We saw that the triage nurse and ambulance crews liaised with each other regarding feeding patients if not nil by mouth. Red Cross personnel were available to provide hot drinks and meals during the day. All staff and patients were complimentary about the Red Cross service and that it was a valuable service to maintain patient and staff welfare.

All patients who were eating seemed happy with their meals. Patients in ambulances were provided with sandwiches distributed by the Red Cross volunteers during the day. Overnight the feeding and hydration of patients was the responsibility of ambulance staff with sandwiches being available stored in fridges inside the ED. We also noticed drinks had been provided to ambulance staff to ensure they were kept hydrated.

The meals served appeared to be hot and looked appetising. Patients were seen to be helped to eat their meals and with hydration needs where required. In response to the question four of the eight patients agreed that they had adequate access to food and drink, three disagreed.

Medicines management

The systems in place to ensure that medicines were managed safely, administered correctly and used safely were reviewed. We viewed five medication charts in majors and all were completed correctly and medicines administered within time limits. All patients had oxygen prescribed appropriately when required. We were told that the pharmacists visited the department daily. The arrangements relating to administering medicines out of hours was described and this included completing a prescription form for patients to obtain medication from community pharmacists. The lack of ready access to medication out of hours could delay the discharge for certain patients.

All medication was observed to be administered and recorded contemporaneously and all patients were observed wearing patient identity bands. The good practice was noted that reception staff printed out name bands on booking in and placing them on patient notes prior to triage. However, we noted that pain scores were not completed for all patients. Paramedics we spoke with also stated that pain relief on ambulances could be significantly delayed. This would be when the triage nurse was under pressure and was waiting for a prescription or did not have sufficient time to come on board the ambulance to administer pain relief.

Due to pressures on staff and the acuity of patients, staff were often called away to deal with other patients when administering medicines to patients. Medication was observed as being left at the patients' bedside, but we did note that the nurse returned later to ensure that the patient had taken the medication. There continued to be difficulties in maintaining patient confidentiality when administering medication to patients in the RAU.

Staff were commended on ensuring that the medication administration record in the drug charts were recorded to a high standard. Staff were attentive and ensured patients received analgesia and other interventions as needed.

We considered the arrangements for the checking of the contents of resuscitation trollies in majors. There was a requirement to check the contents of the trollies daily to ensure the seal was intact and that the defibrillator, portable suction and portable oxygen cylinders were serviceable. The records in this area showed that during July 2022 checks had not taken place on 11 days for one trolley and 20 days for another trolley. This demonstrated that the resuscitation equipment had not always been checked daily.

We noted that the latest emergency drugs list and expiration dates relating to the medication in the trolley showed that all the contents were in date. We reviewed the contents of the resuscitation trolley and we found that two ampoules of Hydrocortisone Efcortesol 100mg in 1ml ampoules had passed their expiry date (June 2022). These were immediately replaced.

We checked the temperature checks of the fridges in majors containing medication, to ensure that they were within an acceptable temperature range for the storage of the medication. We noted that the temperatures had not been checked on 11 occasions during July 2022. There was also an error code flashing on one fridge.

Further, we checked the controlled drugs register in Majors to ensure that daily checks of the stocks of controlled drugs were being carried out. We noted that on five days during July 2022, checks had not been carried out.

HIW considers that the lack of regular checks meant that there was a risk to patient safety, as the resuscitation trollies in both units may not be sufficiently stocked, or equipment / medication may not be in-date and ready for use, in the event of a patient emergency. Additionally, the medication in the fridge may be not as effective as if they had been stored correctly and the controlled drugs may not be available or may have been misappropriated and the fact they were missing not identified in a timely manner.

The lack of these daily checks on the resuscitation trolley on every occasion had also been identified as an improvement needed on the previous inspection in November 2021. We were told by the Director of Nursing that as a result of this and a previous failing in another inspection within the health board, the health board issued an organisational-wide alert. This was to ensure that these checks were carried out daily and evidenced. The health board at the time stated they would be carrying out a health board wide audit to ensure compliance with these checks. However, despite any actions that were carried out, staff were still not checking the resuscitation trollies daily as evidenced by this inspection.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Safeguarding children and safeguarding adults at risk

The department used a safeguarding proforma at triage should the nurse have suspicions or safeguarding concerns at this stage. There were also safeguarding questions included in the patient notes that would be completed for patients in cubicles in majors. Although we did not inspection the paediatric area of the emergency department, patients aged 16 and over would normally be seen in the main ED.

We were told that patients assessed as at risk of self-harm would be allocated a member of staff to care for them on a one-to-one basis. There was a dedicated room for relevant patients that had been adapted with anti-ligature handles.

Staff we spoke with were aware of the systems and processes in place to ensure patients were safeguarded and kept safe from abuse. All staff were aware of the procedures that needed to be followed and who to seek advice from. We also spoke to senior staff involved in safeguarding, they described the high impact service for patients who attended the ED on a frequent basis to provide additional support to the patient.

The nurse in charge said that staff had also received additional bespoke training relating to patients who may need to be subject to a Deprivation of Liberty Safeguard (DOLS). There were also plans in place to provide training on adult slavery, child sexual exploitation and non-accidental injuries in the future to staff.

Blood management

All staff we spoke with were aware of the importance of blood transfusion safety and the potential risks of incorrect blood product transfusions. There were appropriate systems in place to monitor the safe and appropriate use of blood components and their products. Staff were also able to describe the patient identification and blood component checks at all stages of the transfusion process. There were no patients in the department with blood transfusions at the time of inspection.

Staff were fully aware of the importance of maintaining the cold chain for blood products and the time critical element of using blood within certain time limits when outside the cold chain. There had not been issues noted with the supply of blood and there was always a sufficient supply of O rhesus positive blood.

Whilst staff we spoke with were aware of the use of Datix to report adverse events, they were not aware of the Serious Hazards of Transfusion (SHOT) reporting system. This was also reported at the last inspection. The health board action plan stated that SHOT awareness formed part of the IV training package and that SHOT awareness was re-enforced via the nursing newsletter, a copy of which was seen at the inspection.

Medical devices, equipment and diagnostic systems

The equipment at the ED appeared to be new and in a good state of repair. The areas had all the equipment needed to meet the needs of the patients. Faults were reported and equipment that was taken out of circulation was removed from the patient facing areas to await removal to electrical and biomedical engineering (EBME). All commodes seen had been decontaminated and cleaned and were labelled after use.

Staff we spoke with including nurses, healthcare support workers and the ward assistants were all aware of the correct processes to ensure that the appropriate equipment within the department was accessible, stocked, used and maintained appropriately. However, we were told that at times of peak demand there may be a lack of blood pressure machines, monitoring equipment and tympanic thermometers.

Effective care

Safe and clinically effective care

Patients and their carers that we spoke with were mainly complimentary of the care overall with positive comments on staff.

We spoke to a number of staff in various areas of the ED. Staff confirmed they were aware of how to access the relevant clinical policies and procedures through the health board intranet. All staff questioned were also aware of patient safety notices and had read them in the last month, this included medical staff that we spoke with who stated that these were also highlighted at the medical handover.

There was clear evidence from information supplied that a number of different audits were undertaken in the department. These included one patient one day, uniform, wristband and hand hygiene audits. We also noted that risk assessments were being completed for all admissions. The results of these audits were not displayed in the department. However, we were told that the results of the audit would be discussed with the members of staff concerned and as a headline on the nursing newsletter.

Well established patient pathways were noted particularly for stroke and segment elevation myocardial infarction (STEMI). All staff we spoke with were aware of these and said they were used daily. This included medical staff that we spoke with, one of whom stated that the guidelines on the intranet were very good.

We spoke with three staff about access to the Nursing and Midwifery Council guidance for nurses and midwives and all were able to access these through the NMC website.

The ED was busy but calm, staff were busy but in control. Staff in the RAU were very knowledgeable around who was in the waiting room and department. Staff were clearly working hard to mitigate risks associated with holding people on hard chairs in the RAU and waiting room. However, the patient experience in these areas was poor. When speaking to staff who were manning the RAU, they said they felt deeply uncomfortable about the area known as the RAU and the risk in there and the waiting room. They advised that patients were accommodated there daily with very serious conditions and needed a bed to lie down.

Whilst patients in the RAU were deemed fit to sit according to the health board criteria, we question whether this was the case as we noted two instances where patients in our opinion had conditions that required a bed not a chair.

We asked the 12 staff who stated in the questionnaire that they were permanently based in the ED questions about various aspects of patient care, including how this was facilitated. Ten staff disagreed with the statement that the facilities within the ED were appropriate for them to carry out their specific tasks. Staff commented:

> *"Assessment not suitable environment. Waiting room too small. Poor flow means patients spend too long in the department."*

> *"There are a lot of good things but the main underlying issue of the whole dept is a lack of assessment space for the waiting room. This has a massive ripple effect through the dept and means even if we are fully staffed we can't work at full capacity."*

> *"The facilities are excellent and are adequate if we had flow of patients, but as we have no flow the department runs out of the waiting area and ambulance bay. You could keep building a bigger waiting area but most of those patients should be on a trolley or in an assessment area."*

Additionally, ten staff disagreed with the statement that the ED environment was appropriate in ensuring patients received the care they required at their 'point of attendance'. Staff commented:

> *"Flow through hospital means over crowding in the department. Assessment area not suitable. Not able to monitor patients in waiting room. Department disjointed with sub waiting area at the top of majors. Waiting room is too small."*

> *"The wait time is too long."*

> *"I feel like if you are really poorly you are in safe hands. But as I've said before it's a real issue not having enough space to do obs, ECGs and clinical assessments. The patients do get the care they require but not in good time."*

That being said, eight of the twelve staff agreed there was an adequate skill mix within the ED team with four disagreeing. The following comments were made about staff skill mix:

> *"Lots of junior staff due to experienced staff leaving."*

> *"We struggle to retain experienced nurses because the working conditions are so hard."*

"The ED team is very clicky, you are likely to get a promotion if you are friends with someone in management, regardless of your clinical experience. People new to the department are made to feel inadequate by other members of staff."

Staff answers in the questionnaire indicated that patients were not generally assessed within the 4-hour target, but they knew how to escalate when the department was close to capacity. The majority agreed that they were not able to meet the conflicting demands on their time at work and that there were not enough staff to enable them to do their job properly. Staff told us:

"When working in 'red' triage which is basically in a corridor. Often you are the only nurse in the area. You are expected to triage patients both walk ins and ambulances, transfer patients, do swabs for MAU if they have red patients, take patients for ECG within 10 mins of cardiac symptoms however machine is at the other end in a1. If you have other patients there and are on your own it's impossible to get everything done, even if you're lucky enough to have a HCA often the workload is too heavy. It is unsafe…"
"It is very rare for us to see and assess patients in the otherwise excellent clinical areas, because there is no flow. The majority of patients are seen in ambulances or in non-clinical spaces such as relatives rooms. Though we have some assessment rooms, this area is cramped, woefully inadequate and dangerous as access and egress is poor and the notes are liable to get mixed up. The nursing staff are hugely overburdened and highly stressed when working in this area. The root cause of this is poor flow."

Staff mainly agreed that they had adequate materials, supplies and equipment to do their work and they were able to access ICT systems they needed to provide good care and support for patients. Eight staff said they were able to make suggestions to improve the work of their team, but three disagreed.

We asked staff permanently based in the ED how the department could improve the service it provides. Staff suggested:

"Improvements in environment, bigger waiting room and subwaiting areas. Improvements on flow through hospital. Improved staffing. Visible senior management team to support staff."

"Shorten wait times. Make more room in assessment room."

"It's the whole system than need to be rethink, the hospital backdoor need to be looking after to allow patient flowing in the right direction in a manner time."

"… Flow. We do need adequate staff to meet demand which is higher than expected. We need no expected patients to come to the department and for referred patients to leave within an hour. We need a faster response from inpatient teams when referred and not made to feel we are inconvenience."
"1) Improved flow from ED into wards to allow newly arriving patients to be accommodated.
2) more senior management presence to encourage inpatient specialties to be more responsive to ED referrals
3) frailty team embedded within ED
4) re-design of assessment rooms and area surrounding to improve patient safety
5) co-location of MIU and urgent primary care on the GUH site. This could then be the sole 24/7 Minor injuries within ABUHB with all other MIU'S closed overnight. Would allow for better streaming of patients and reduce the ED queue.
6) improved communication with other sites/ teams. The vocera system is not functioning well and often delays patient care by taking multiple attempts to connect with other teams.."

Sepsis

We noted the process used to ensure that cases of sepsis were identified and managed in a safe and effective way. Patients would be assessed at triage and bloods would be sent from there. We were also told that WAST pre-alerted the ED if severe sepsis was identified and a space would be created in the resus area.

The sepsis six tool was used and the ED nursing documentation had the sepsis risk identified highlighted. There was a good awareness of sepsis amongst staff at all levels and all staff were aware of, and used, the sepsis six pathway. Some staff reported that the lack of capacity and space could sometimes delay commencement of treatment, but staff mitigated this delay by starting IV infusions whilst patients were sitting on chairs in the RAU.

We were also told that patients at risk of sepsis were given relevant information to take away with them.

Quality improvement, research and innovation

In addition to the nutrition and hydration services provided by the Red Cross we were also told that the Red Cross also maintain patient care needs and assisted nursing staff to attend to welfare needs of patients. They did this by ensuring safe discharge with transport and access to patients' homes. We were told this included providing a welcome pack to ensure patients had basic necessities such as milk, bread and other items when they returned home and that the heating was on if needed.

We were also told about initiatives in place by staff to instigate improvements to care such as the changes to the electro cardio graphs (ECG) process to also improve safety.

Record keeping

We viewed a total of ten patients records in detail and also a number of records as discussed elsewhere in this report.

In general, pain scores were routinely taken and appropriate analgesia in response to this was prescribed and administered. The records reviewed all showed that appropriate risk assessments were completed and actioned. In all, the nursing and medical documentation was comprehensive and easy to locate and understand.

Quality of Management and Leadership

Governance, Leadership and Accountability

The department was considered as being well led with clear lines of responsibility and systems in place to monitor and respond to service needs. Staff we spoke with were complimentary about the management of the department. The senior nurse and assistant divisional nurse were noted in the department in uniform and were seen supporting areas.

We were told that all incidents were reported on Datix and would be reviewed by the nurse in charge and then reviewed by the serious incident team if necessary. Depending on the severity of the incident the review could be carried out at corporate level. A senior clinician from ED would attend the serious incident meetings. Any action plans would be fed-back to staff, through various methods including the nursing newsletter, email, Whatsapp or to individual staff. Staff would report incidents and were aware of the list of incidents that should be reported.

A management structure was in place and senior staff described clear lines of reporting to the wider health board management team. Roles, responsibilities and lines of accountability were also described and clear. Senior staff we spoke with described the on-call system, with a senior nurse at work throughout the week providing onsite cover. There was an on-call consultant during the silent hours. Additionally, senior staff were able to describe the gold, silver and bronze on call out of hours arrangements, with managers available during the core hours. The inspection team saw evidence of good management throughout the areas inspected.

We noted that triage staff were resilient and worked hard in a difficult working environment and that they balanced the risk to patients in the waiting room and the risk in the ambulance well.

The flexible staffing business case was described and we were told that there were normally enough staff to flexibly move staff around the department. There was also a pool of nurses available for bank work.

There were a number of meetings noted with cross departmental working trying to address the flow. There were also safety huddles in the ED to discuss staffing and other issues. Whilst the inspection team questioned the number of meetings, the health board considered that these meetings were important. The department

were building diverse teams, building people together and there was a lot of negotiation around patient flow and patient perspective. There was challenge about the need for a meeting and trying to generate a whole system response.

One member of staff spoke about their part time course and the support they had been given by the charge nurse and that they thoroughly enjoyed the experience of working in the resus area. They were clearly motivated and wanted to learn.

There were a number of student nurses working in the ED and the department hoped that these students would want to work in the department once they qualified.

We noted good communication during the medical round and particular noted the way that one consultant was speaking to the patient at a level the patient could understand. Also, in general all staff were working well to a good standard.

The nurse in charge was clearly identifiable and visible in all areas. Staff told us that the senior staff in ED were supportive and visible. Good working practice were observed between doctors and nurses who worked collaboratively for the best interests of the patient.

Staff we spoke with were open and honest and knew what was happening, particularly in the RAU. They understood the risks with sitting patients and delays. They knew how to find the relevant information, they had access to information and who to go too.

A total of eleven staff answered questions about reporting incidents and concerns. Only five said they had seen errors, near misses or incidents that could have hurt staff. All relevant staff said that the last time they saw an error, near miss or incident that could have hurt staff or patients, they or a colleague reported it. They all agreed their organisation encouraged them to report errors, near misses or incidents and that their organisation treated staff who are involved in such incidents fairly. Also, they all agreed their organisation treated reports of errors, near misses or incidents confidentially. All bar one agreed that, when errors, near misses or incidents were reported, their organisation took action to ensure that this did not happen again. Again ten of the eleven who expressed an opinion agreed that they were given feedback about changes made in response to reported errors, near misses and incidents.

The majority of staff agreed that if they were concerned about unsafe practice, they would know how to report it and they would feel secure raising concerns about unsafe clinical practice, one said no. Additionally, eight out of twelve staff

said they were confident that their concerns would be addressed but two said they were not.

Workforce

Staffing

We reviewed how the department ensured that there were sufficient numbers of appropriately trained staff for the provision of safe and effective patient care. Whilst the Nurse Staffing Levels (Wales) Act 2016 did not apply to the ED there was a ratio and skill mix required within the ED establishment. We were told that the additional staff referred to in the previous inspection had now been recruited (just over 19 staff including two practice educators).

The off-duty rotas were checked and staffing levels were generally in order. However, it was noted that on some shifts up to 50% of agency staff were used. The department tried to use the same agency staff to ensure some continuity of care and that these staff were aware of how the department operated. However, on the day of our inspection, there were five nurses short on shift. This included one triage nurse short, leading to an increase in triage waiting times. The risks were mitigated with senior nurses relocating staff to higher demand area.

Staff felt pressured on most shifts and believed there were insufficient staff on most shifts for the volume of patients together with extended stays in the department. The ED was regularly full with little movement including elderly and vulnerable patients requiring an increased level of nursing care. However, staff remained flexible and were redeployed to other areas within the department when staffing and acuity was a problem in a specific area. Staff reported that the department had been in escalation on multiple occasions for several months and that this was now the normal state.

Regarding whether staff felt they had enough time to provide care safely, a number of band five nurses we spoke with said that the workload could be excessive and unrelenting, with the demands on the system being unsustainable. This included two members of staff saying they were close to burn out and considering other jobs and career options. Staff consider the staffing to be inadequate to deal with the increasing demand and acuity of patients.

We were told that there were a number of vacancies in the department, including 22 at band five level. There were also a number of healthcare support worker vacancies but very little interest had been generated for these posts. Additionally, we were told of three band five resignations recently. This has had a significant impact on the department and increased the need for bank and agency staff.

Training

Staff training was mainly online, but face to face training had started recently. There were a number of training rooms available at the hospital that could be booked for training. Staff we spoke with said that their training was up to date and that they had received additional training such as triage training. Mandatory training records provided showed that compliance was generally good with over 90% compliance for safeguarding and violence and aggression for example. The lowest being 73% for fire safety.

A total of 12 staff who completed the questionnaire said that were based permanently in the ED and answered questions about professional development. The majority agreed they have had full training on all areas within the department. Staff commented:

> *"Although I have been in the department a year in August, I do not think I have had adequate training for the role. This is my first hospital setting in my career and I do not feel I have received the right amount of training."*

> *"Bank staff don't get training."*

> *"I'm yet to receive paediatric."*

> *"I love my job and just want more training provided."*

A total of seven staff agreed that their competency-based learning objectives were signed off before they started practicing in all treatments and three said they had not. We asked if there was any other training staff would find useful. Staff told us:

> *"All training to be able to do my job."*

> *"European Trauma Course."*

All bar one member of staff agreed that their training, learning and development helped them do their job more effectively and helped them to stay up to date with professional requirements. Nine respondents agreed that their training, learning and development helped them to deliver a better patient experience, three disagreed.

Information supplied showed that only 65% of staff at band five had appraisals within the last 12 months. Management stated that they were always available for

a one to one. In the survey, eleven of the 12 respondents indicated that they had an annual review or appraisal within the last 12 months.

Support and Management arrangements

Staff we spoke with felt supported by management. Senior staff we spoke with also described the arrangements in place to support student nurses, including being allocated a placement supervisor and mentor. Newly qualified staff would work as supernumerary staff for their first three weeks in post and followed a structured induction from the practice educators. We were also told that each student was given a primary and associate practice assessor or supervisor on commencing their placement. Mentors of students also ensured that they received an adequate level of supervision as appropriate to their level and competency.

Senior staff believed that there was a positive culture in the department and staff were passionate about their job. They were frustrated because no matter how hard they worked, they were unable to solve the issues regarding patient flow and numbers of patients attending the unit.

Team meetings were arranged but there was no regularity to these meetings. The last all staff meeting being the end of May. Staff were kept informed through Whatsapp groups as well as the local nursing newsletter.

A total of 11 ED staff answered questions about the hospital / organisation in the questionnaire. All bar one agreed that their organisation encouraged teamwork and eight agreed they would recommend their organisation as a place to work and three disagreed. The replies to the other questions in this area were mainly not as positive:

- Partnership working with other departments was effective -eight disagreed
- Partnership working with outside organisations was effective - five disagreed
- Staff were supported to identify and solve problems - six disagreed
- The organisation took swift action to improve when necessary - seven disagreed
- Care of patients was their organisation's top priority -five disagreed
- If a friend or relative needed support, they would be happy with the standard of care provided by this hospital.

Again, 11 ED staff answered questions about their immediate manager / line manager. The responses in this area were generally more positive. Nine agreed that their immediate manager could be counted on to help with a difficult task at work and gave them clear feedback on their work. Seven agreed that their immediate manager asked for their opinion before making decisions that affect their work. Ten agreed that their immediate manager was supportive in a personal crisis.

Regarding senior management, 11 ED staff answered questions, again the responses were generally positive. Ten agreed they knew who the senior managers were, seven agreed that senior managers were visible, eight agreed that senior managers were committed to patient care. Nine agreed that communication between senior management and staff was effective and seven agreed that senior managers tried to involve staff in important decisions and acted on staff feedback. A member of staff commented:

> *"Overall, the team and physical environment is excellent at GUH, but the system is made inefficient by crowding- meaning patients are rarely in a clinical space when we go to see them. Crowding is also leading to an unsafe department where patients with serious pathologies are often kept in inappropriate areas- we have had several serious incidents as a direct result of this. The ED team have worked hard to make the dept as safe and efficient as possible. Further improvement now need board level Senior managers to step up, be more visible and more supportive in their approach. To improve things further requires significant change to be made outside of the ED, and a more system-wide approach."*

Wellbeing

Staff told us of the monthly wellbeing sessions that were in place that had received good feedback.

We asked a series of questions about health and wellbeing of staff in the questionnaire, 11 ED staff answered questions.

- Nine agreed that their job was not detrimental to their health
- Five agreed their organisation took positive action on health and wellbeing
- Eight agreed that they are offered full support in the event of challenging situations

- Eight agreed that their current working pattern / off duty allowed for a good work life balance

- Nine agreed that they were aware of the occupational health support available

Equality

From our conversations with staff, we considered that equality and diversity was promoted within the organisation. We were also told that consideration was given to allow staff to observe any prayer times and to take leave during any religious festivals as required. Staff we spoke with believed that all staff were treated equally and that patients were also treated equally. Staff gave examples of how equality rights of all patients were considered regardless.

All nine members of staff who answered indicated that they had not faced discrimination at work within the last 12 months. Nine members of staff agreed that their workplace was supportive of equality and diversity. Staff commented:

> "ED team are diverse and welcoming."

> *"I really like the staff in A&E. I find everyone very helpful and supportive…"*

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the 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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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 on this inspection.			

Appendix B – Immediate improvement plan

Service: Emergency Department (ED), The Grange University Hospital

Date of inspection: 1 – 3 August 2022

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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to reduce the risk of cross contamination in the area known as the COVID corridor.	Standard 2.4 Infection prevention and Control (IPC) and De-contamination	1) Point of care testing has been implemented to support rapid testing to ensure that Covid status of patients is identified.	Senior Nurse	Completed
		2) Staff have been reminded of the importance of appropriate usage of PPE.	Senior Nurse/IPAC	Completed
		3) Ensure a good supply of PPE is available at all times for patients and visitors.	Senior Nurse	Completed
		4) Daily checks of PPE trolleys in place to ensure adequate supplies of PPE.	Nurse in Charge	Completed
		5) Signage prominently displayed to ensure corridor is not utilised as a thoroughfare.	General Manager/IPAC	Completed

		6) Hand hygiene audits to be completed weekly to monitor compliance with effective hand hygiene and actions taken on compliance rates. These will be uploaded onto the Health and Care monitoring system.	Senior Nurse	Completed and will be ongoing
		7) Cleaning schedules to be monitored and reviewed weekly to ensure effective cleaning. Actions to be take in regards compliance rates.	Senior Nurse	Completed and will be ongoing
		8) All staff have been reminded of the importance of closing doors along the A1 corridor, to minimise the potential for cross contamination This will be further reinforced via site meetings.	Senior Nurse	Completed
		9) Standing agenda item on the weekly GUH Hospital Management Team meetings, to ensure this message is reinforced.	General Manager	Completed
		10) Communication to be sent out via the health board intranet to reinforce use of A1 corridor.	General Manager	Completed

		11) Current risk assessment reviewed and amended to reflect risk mitigations that are in place.	Senior Nurse	Completed
		The A1 (Covid) corridor is in use as an interim area for the assessment of Covid positive patients. The longer term plan is to utilise the portacabin that is located outside the emergency department - the risks of using the A1 corridor is recognised and as far as reasonable they are mitigated. This includes consideration of alternative areas within the emergency department which were not considered to be appropriate.		
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure that resuscitation equipment and medication is always available and safe to use in the event of a patient emergency within the emergency department and within all other wards and	Standard 2.6 Medicines Management and Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	12) Staff have been reminded of the necessity to ensure daily checks of resus trolleys are undertaken.	Senior Nurse	Completed
		13) Monthly resus trolley checks, as per ABUHB protocol, to be undertaken to include: breaking of seal, and drug expiry check.	Senior Nurse	Completed – review by 31 August 2022
		14) Internal Alert regarding resus trolley checks re-distributed to all areas within the Health Board.	Risk Manager	Completed

departments across the health board.		15) Further assurance being sought from Divisions in regards Health Board compliance.	Interim Director of Nursing	30 August 2022
		16) Daily Omnicell fridge temperature report for Majors and Resus emailed daily to ED Senior Nurse and Band 7 team.	Senior Nurse	Completed
		17) New 'ED safety checklist' commenced allocating checks based on role will be reviewed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy.	Senior Nurse	Completed
		18) Monthly safety checklists to be uploaded onto share point.	Senior Nurse	31 August 2022
The health board is required to provide HIW with details of the action taken to ensure medicines are managed safely and that substances that could cause a hazard to	Standard 2.6 Medicines Management and Standard 3.1 Safe and Clinically Effective Care	19) Nursing News has been displayed in the staff room reminding all staff of their responsibility to store medication and prescription pads in the Omnicell. It has been reinforced that no medication or prescription pads are to be left unattended at any time. To be discussed at team meetings.	Senior Nurse	Completed

health are appropriately secured.		20) Clinical director has been requested to remind all medical staff of the safe storge of prescription pads within the Omnicell.	Clinical Director	Completed
		21) Operation service manager has alerted all supervisors within GUH to the importance of ensuring all doors that lead into storage space areas are kept locked at all times to ensure the safe storage of substances.	General Manager / Operation Service Manager	Completed
		22) Flammable cupboard ordered to store substances in majors.	Senior Nurse	Completed
		23) High strength potassium solution removed from majors cupboard and now locked in storage cupboard.	Senior Nurse	Completed
		24) Locks to be fitted to intravenous storage cupboard in majors department. Request has been submitted.	Senior Nurse	31 August 2022
		25) Lead pharmacist has attended the emergency department to consider potential solutions and improvements.	Pharmacy	Completed

		26) Clinical areas to re-check compliance with patient safety notice.	Divisional Pharmacist / Senior Nurse	12 September 2022

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): **Sue Pearce**

Job role: **Divisional Nurse**

Date: **12 August 2022**

Appendix C - Improvement plan

Service: Emergency Department (ED), The Grange University Hospital

Date of inspection: 1 - 3 August 2022

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/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that the 'No Smoking' legislation is enforced.	Standard 1.1 Health Promotion, Protection and Improvement	x2 WTE Smoking Officers employed and currently undertaking their training. All staff are encouraged to advise patients and relatives regarding No Smoking Policy on site. As appropriate all patients admitted are offered Nicotine replacement and provided with the relevant Health Promotion advice.	Facilities Manager	October 2022
The health board must ensure that action is taken to promote the use of the Welsh language within the ED.	Standard 3.2 Communicating Effectively	Welsh & English signage in place across GUH site. Signage in ED reception promoting the 'active Offer' for patients wishing to receive information in Welsh. Welsh language training available to all staff. Translator available for any service user requesting to converse in Welsh if ED staff unavailable.	Head of Welsh Language Unit	Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Posters advertising translation service in place across department.		
The health board must ensure that waiting times are displayed in a prominent position within the waiting area.	Standard 3.2 Communicating Effectively	The ED is working towards a safe system to provide live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	Service Lead / Clinical Director / Senior Nurse	November 2022
The health board must ensure that the microphone in the reception desk is working correctly at all times.	Standard 3.2 Communicating Effectively	Reception staff have been reminded to escalate any concerns regarding the microphone to Works & Estates.	Service Lead	Completed
		Works & Estates aware to expedite any calls regarding microphone faults from the Emergency Department.		Completed
		The department is currently scoping alternative solutions to the current microphone system to improve communication between patients and staff.		December 2022
The health board must review the use of the area known as the RAU to ensure that patient dignity and privacy is promoted and maintained. This	Standard 4.1 Dignified Care	Fit to sit criteria in place and all patients in chairs are assessed with appropriate escalation to the site ops team in the event of concerns.	Service Lead / Clinical Director / Senior Nurse	Completed
		ED escalation process is in place.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
includes maintaining patient confidentiality when administering medication to patients in the RAU.		Staff have been reminded of the importance of maintaining patient privacy throughout the department. Private rooms are available if required.		Completed
		All staff have been reminded of the importance of maintaining patient dignity and privacy in all areas of the department.		Completed
		All staff have been reminded of the importance of confidentiality when undertaking medication administration checks.		Completed
The health board is to provide details to HIW with the continuing actions taking place to manage the overcrowding in the waiting room and the RAU that are not conducive to providing safe and dignified care.	Standard 4.1 Dignified Care	The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times.	General Manager for Urgent Care / Director of Operations	Completed
		The ED and assessment units have invested in alternative roles to support medical staff and reduce the wait to be seen time (Nurse Practitioner's / Physician Assistants / Acute Care Practitioners).		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		Ongoing
		ED escalation process is in place.		Completed
		Same Day Emergency Care Unit (SDEC) to pull appropriate patients direct from triage.		Completed /Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.		December 2022
		If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.		December 2022
The health board must ensure that there is an area available to facilitate red release calls at all times.	Standard 5.1 Timely Access	There is an agreed red release trolley space within the ED along with an agreed process for managing red release requests and escalation process to the hospital flow team.	General Manager for Urgent Care / Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing
		A dual-pin handover between Paramedic and Nurse has been established to maintain a focus on reducing lost hours and to expedite patient handovers.		Completed /Ongoing
		3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.		November 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		ED Nurse in Charge (NIC) to alert Clinical Site Manager if a crew is held without a plan. The Clinical Site Manager to agree plans with ED NIC and reinforce plans at Site Meeting so that there is a wider specialty / system response to de-escalate the demand / pressures within the ED.		Completed
		If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.		Completed
		If there is a crew delay of >1hr the Clinical Site Manager will authorise pre-empting of defined patients in ED to their specialty wards against the 'definite' discharge profile. This will then escalate to the 'potential' discharge profile when a crew is held for two hours and where there has been no plan confirmed.		Completed / Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Patients who have been identified for discharge will not be held on ambulances for tests / investigations. Patients will be brought into the hospital to undergo their tests and then moved to the Transfer Lounge whilst they await their results and transport home. The Health Board will use the WAST Launchpad demand data at every cross-site meeting to identify what is on the WAST Stack (WAST Community Demand and Acuity) to plan ahead, potentially pre-empting moves to make capacity for the demand expected. The aim is to clear 6 trolley spaces by 16:00hrs every day to support the late afternoon surge profile.		December 2022
The health board must ensure that patients are not required to wait on chairs overnight in the RAU.	Standard 5.1 Timely Access	There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. Please refer to actions above.	General Manager for Urgent Care / Director of Operations	Completed / Ongoing
The health board is to provide HIW with an update on the actions taken to continue to put processes in place to ensure a system wide solution to poor flow and overcrowding at the ED.	Standard 5.1 Timely Access	There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. An overarching Programme plan is under development including highlighting where other improvement and transformation work will impact on the 6 Goals measures.	General Manager for Urgent Care / Director of Operations	Completed / Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that regular reviews of patients in ambulances, waiting room and RAU are carried out to ensure that patients receive appropriate and timely pain relief and treatment.	Standard 5.1 Timely Access	There are agreed policies with the ED and WAST with roles and responsibilities outlined for patients held on ambulances. Staff have been reminded of the importance of ensuring patients receive the appropriate timely care, observations and medication in accordance with their presentation.	Clinical Director / Senior Nurse	Completed Completed
The health board must ensure that the information on how they have learned and improved on feedback received is prominently displayed within the department on a 'You said, We did' board or similar.	Standard 6.3 Listening and Learning from Feedback	'You said, we did' implemented as part of the commissioning of the Screening & Testing Unit. You said, we did system to be introduced wider across the ED.	Service Lead / Senior Nurse	Completed September 2022 December 2022
The health board must ensure that there is a robust process in place to ensure that staff are regularly reviewed to ensure that their stresses	Standard 2.1 Managing Risk and Promoting Health and Safety	Regular staff wellbeing sessions are available. There are x2 wellbeing Consultants and a Band 7 nurse in place.	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
as a result of the workload are managed.	Standard 7.1 Workforce	Open door availability to meet with Senior Nurse which has been reinforced through nursing news.		Completed
		Senior management team visible daily to allow staff the opportunity to raise concerns.		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		Ongoing
		Staff are reviewed annually via their PADR process during which wellbeing at work is discussed and any actions noted.		Completed
		Wellbeing services and resources are available to all staff.		Completed
		Debriefing sessions are in place for staff involved in critical incidents which may impact on wellbeing.		Completed
The health board is required to update HIW with the actions taken to further reduce the risk of pressure damage to	Standard 2.2 Preventing pressure and tissue damage	There are agreed policies with the ED and WAST with roles and responsibilities outlined.	Senior Nurse / Divisional Nurse	Completed
		Patients identified at risk will receive the appropriate pressure relieving devices.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
patients required to wait on ambulances.		The importance of pressure area care has been shared via the nursing news in ED.		Completed
		All pressure ulcer Datix's are reviewed by the ED Band 7's and appropriate actions implemented. Any involving WAST will be shared with WAST colleagues.		Completed
		Equipment is available for use based on patient risk assessment.		Completed
The health board must ensure that all areas are cleaned as required and that evidence of this cleaning is recorded and displayed in a prominent position.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The ED has dedicated domestic staff undertaking cleaning with formal records of cleaning completed.	Senior Nurse / Facilities Manager	Completed
		Monthly Synbiotix cleaning assessments undertaken by facility staff and shared with senior management (Last assessment was 96% undertaken on the 25 August 2022).		Completed
		Nursing cleaning schedules are in place for all areas across the ED and will be displayed in a prominent position ensuring completion.		Completed / Ongoing
The health board must continue to ensure that the relevant nutrition charts are completed for patients in the ED.	Standard 2,5 Nutrition and Hydration	Patients are assessed on their clinical presentation which includes eating and drinking.	Clinical Director / Senior Nurse	Completed / Ongoing
		The ED will ensure intravenous fluids are recorded on the All Wales medication charts.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Fluid balance is recorded within the ED Patient Care Record which is a mirror image of the All Wales Fluid Balance Chart.		Completed
		Nutrition & Hydration Training is included within induction for new staff.		Completed
The Health Board must ensure that all staff are made aware of Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances.	Standard 2.8 Blood management	SHOT awareness forms part of the IV training package. SHOT awareness re-enforced via Nursing Newsletter. Any infusion incidents are reported on Datix. The blood transfusion service then report these incidents to SHOT.	Clinical Director / Senior Nurse	Completed / Ongoing
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the availability of equipment.	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	All staff have been reminded of the process for escalating concerns to the Nurse in Charge or Emergency Physician in Charge (EPIC).	Clinical Director / Senior Nurse / Band 7's / Assistant Divisional Nurse	Completed
		Staff are encouraged to raise concerns verbally to the NIC.		Completed
		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken.		Completed
		Any equipment deficits as a result of delays in repair to be escalated to the EBME manager.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		A review of the medical equipment across ED has been undertaken and there is sufficient equipment to provide a safe service if all equipment operational.		Completed
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the manning and risk associated with patients in the waiting room and the RAU.	Standard 3.1 Safe and clinically effective care	Staff are encouraged to raise concerns verbally to a senior member of staff with confidence.	Clinical Director / Senior Nurse	Completed
		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken.		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. Please see actions above.		Completed
The health board must continue with its efforts to recruit permanent staff.	Standard 7.1 Workforce	The ED will continue to actively retain permanent staff and recruit new staff to the unit.	Clinical Director / Senior Nurse	Completed
		Streamlining events are in place to actively recruit newly qualified staff.		Completed
		Nursing and Health Care Support Worker posts to be advertised continuously.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Experienced Health Care Support Workers in the ED are supported to undertake their nurse training via the Flexible nursing route.		Completed
The health board must ensure that action is taken to improve compliance with staff appraisals.	Standard 7.1 Workforce	Improvement plan in place for annual appraisals.	Clinical Director / Senior Nurse	December 2022

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): **Sue Pearce**

Job role: **Divisional Nurse**

Date: **26 September 202**