Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

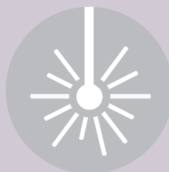
Inspection Summary Report

Emergency Department (and Assessment Areas), Morriston Hospital, Swansea Bay University Health Board

Inspection date: 5, 6 and 7 September 2022

Publication date: 8 December 2022

This summary document provides an overview of the outcome of the inspection



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Overall, we found that all staff were working hard to provide patients with a positive experience and good levels of care despite extreme system pressures.

However, patients were not always receiving the experience that they should expect. This was because of a lack of timely care and treatment, despite constant efforts demonstrated by the health board to increase patient flow within the department and wider hospital.

We found that the environment was not conducive of maintaining patient privacy and dignity due to the number of patients accessing the service. We observed staff making efforts to maintain this, despite the limited space available.

A number of areas for improvement were also identified in relation to aspects of infection prevention and control, nutrition and staffing. Overall however we found that patients received a generally safe service.

Staff responses to the HIW questionnaire were mixed and the health board is strongly encouraged to ensure that staff have appropriate channels of communication in which to provide feedback. Despite this, staff expressed positive views in regarding local leadership and immediate line manager support.

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 Morriston Hospital, Swansea Bay University Health Board on the 5, 6 and 7 September 2022. We also inspected a number of the assessment areas during the course of this inspection. The following areas were reviewed:

- Emergency Department (ED)
- Children's Emergency Unit (CEU)
- Surgical Decision Making Unit (SDMU)
- Rapid Assessment Unit (RAU)

We also spoke with staff in the Older Persons Assessment Service (OPAS), but did not visit Ward D (Medical Assessment Unit) during this inspection.

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

This summary version of the report is designed for members of the public.

A full report which 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 can be found on our website.

Quality of Patient Experience

Overall Summary

- Patients were not always receiving the experience that they should expect. This is because of a lack of timely care and treatment, despite constant efforts demonstrated by the health board to increase patient flow. However, patients were generally happy with the care provided by staff once they were seen.

  We found that the environment was not conducive to the maintenance of patient privacy and dignity due to the number of patients accessing the service. We observed staff making efforts to maintain this, despite the limited space available.

What we found this service did well

- We observed staff speaking with patients in a polite, professional and dignified manner
- Patients expressed the view that they were generally happy with the way staff interacted with them.

Where the service could improve

- Review the use and availability of suitable seating
- Patient privacy and dignity.

Patients told us:

"Very good service in RAU and staff were marvellous. However ED service was very poor. On admission, first few days in A&E were very stressful, in pain, lacking sleep and sitting in a chair…"

"No food offered in ED"

"Keep the patient informed. I had been assessed as needing IV antibiotics at 9am and at 14.40 I was still waiting"

"If we hadn't phoned the surgeons secretary, my daughter would probably still be waiting. The whole system needs a shake-up"

Delivery of Safe and Effective Care

Overall Summary

- Patients were generally receiving a safe service, but this was negatively impacted upon by the lack of timely care and treatment at times due to poor patient flow within the department and wider hospital.

  Aspects of infection prevention and control (IPC) need to be reviewed to ensure that risks to staff, patients and visitors are eliminated or minimised.

  We had a number of concerns in relation to nutrition within the ED which must be reviewed due to the periods of time patients remain in the department and wider hospital.

What we found this service did well

- Link Nurse initiatives, for example bereavement and safeguarding specialists
- Certain patient pathways, e.g. Older Persons Assessment Service (OPAS).

Where the service could improve

- We found that patients were not always triaged, reviewed, or treated in a timely manner.

  This was dealt with through out immediate assurance process. Full details are contained in Appendix B of the full report.

- Paediatric nurse staffing levels
- Aspects of infection prevention and control
- Patient nutrition
- Aspects of record keeping.

Quality of Management and Leadership

Overall Summary

- Overall we found that staff in all roles were committed to providing a good level of care despite the pressures. Clinical and non-clinical management teams made efforts to provide appropriate support and to maintain effective running of the ED and assessment areas.

  Staff responses to the HIW questionnaire were mixed and the health board is strongly encouraged to ensure that staff have appropriate channels of communication in which to provide feedback.

What we found this service did well

- ED staff expressed positive views regarding Band 7 leadership and immediate line manager support.

Where the service could improve

- Staffing shortfalls and skill mix
- Aspects of staff training and development

Staff told us:

"As the ED is constantly overcrowded then managing the assessment and treatment of new patients, even acutely unwell patients is quite challenging."

"… the morale of the ED department has lifted since [names] have stepped in, the support they give the staff is outstanding and we all know they are there for us through thick and thin…"

"The environment is often not safe due to high volume of patients attending ED and shortage of beds in the hospital."

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.