Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Department, Princess of Wales Hospital, Cwm Taf Morgannwg University Health Board

Inspection date: 17, 18 and 19 October 2022

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

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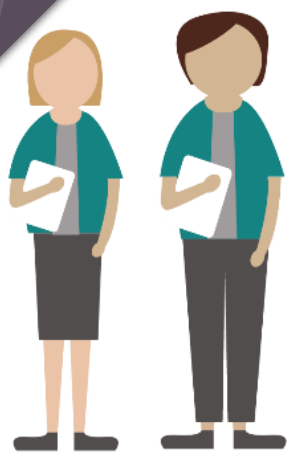
We found that all staff were working hard to provide patients with a positive experience and good levels of care despite extreme system pressures. Patients were generally positive of the care they received from staff.

However, patients were not always receiving the experience that they should expect due to the length of time spent in the department. Patients, once clinically reviewed, referred and a decision to admit made were in the department for longer than they should expect due to poor flow which affected the department and wider hospital.

At the time of the inspection, there were 87 medically fit for discharge patients in the wider hospital site who were awaiting an appropriate package of care.

The environment did not fully promote patient privacy and dignity due to the number of patients accessing the service. Despite this, there was appropriate clinical oversight of patient waiting areas and an overall timely medical review of patients to provide a generally safe level of care.

There was cohesive teamworking amongst Emergency Department staff and staff expressed positive views regarding local leadership and managerial support. 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 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 (ED) at Princess of Wales Hospital, Cwm Taf Morgannwg University Health Board on the 17, 18 and 19 October 2022.

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

- We found that staff worked hard to provide patients with a positive experience despite the pressures on the department. Staff were observed providing respectful care, and patients were generally positive of the care they received from staff.

  The patient experience however was affected by the lengths of stay patients encountered. Patients, once clinically reviewed, were in the department for longer than they should expect due to poor flow which affected the department and wider hospital. At the time of the inspection, there were 87 medically fit for discharge patients who were awaiting an appropriate package of care.

  We found areas of the department to be overcrowded and lacking privacy, particularly in the lounge and corridor area in the majors area. which negatively impacted upon patient dignity.

What we found this service did well

- The department provided a calm and welcoming paediatric area
- We observed staff providing respectful care at all times.

Where the service could improve

- The health board must ensure that patients are accommodated in suitable areas of the department for appropriate lengths of time
- The health board must ensure that the environment promotes patient privacy and dignity.

Patients told us:

"Doctor was excellent explained everything clearly. Nursing care was excellent too"

"No privacy in the corridor. Give [patients] a bed"

"Patients should be checked more often"

Delivery of Safe and Effective Care

Overall Summary

- We found that patients were provided with a generally safe level of care. However, this was negatively impacted by poor patient flow out of the ED and wider hospital site. Specifically, the inability to transfer patients from the ED to wards within the hospital in a timely manner once patients no longer require emergency care.

What we found this service did well

- There was appropriate clinical oversight of patient waiting areas
- We found a responsive rapid assessment and treatment model in lieu of the traditional triage process, which provided an overall timely medical review of newly presenting patients
- Regular review of clinical pathways to help promote clinically safe and optimal care.

Where the service could improve

- Generally, medicines were managed appropriately, however we noted some issues relating to sharps waste and medicines storage
- Provision of better facilities for patients presenting with mental health issues
- Generally, infection prevention and control was managed appropriately, however we noted some issues in relation to housekeeping, disposal of PPE and isolation facilities
- Evidence of good record keeping was identified, but areas requiring improvement in relation to medical and nursing entries were identified

Quality of Management and Leadership

Overall Summary

- We found cohesive teamworking in the ED. Staff were complementary about the way in which they supported each other and provided positive feedback about local managerial support.

  Staff responses to the HIW questionnaire were mixed, with positive comments relating to local ED and site management, good professional development and visible leaders. However, staff also raised issues regarding feedback not being acted upon by senior managers, poor staffing skill mix and aspects of wellbeing.

What we found this service did well

- Staff described a cohesive and supportive team
- Staff provided positive comments relating to local and immediate managerial support
- Staff told us that professional learning and development helped them to do their job effectively.

Where the service could improve

- Staff told us that senior managers could improve how effectively they act upon on staff feedback
- Staff felt that aspects of the staffing skill mix needs to be strengthened and that staff wellbeing could be improved.

Staff told us:

"POWH ED is a very good ED with strong internal team leadership and a desire to provide good quality of care to patients."

"Our immediate managers, who's offices are in the department, go above and beyond to ensure we operate as safe as we can."

"… the lack of social care provisions means that 'medically fit patients' are in hospital for sometimes in excess of a year creating a front door block where there are no beds for sick patients..."

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.