Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Minor Injury Unit (MIU), Prince Philip Hospital, Hywel Dda University Health Board

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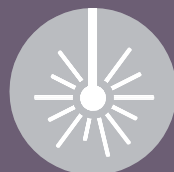

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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.

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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 Minor Injury Unit (MIU) at Prince Philip Hospital, Hywel Dda University Health Board on the evening of the 26 and two full days on the 27 and 28 June 2023.

We did not inspect the Acute Medical Assessment Unit or Same Day Emergency Care (SDEC) Unit. However, we did complete a walkaround of these areas and speak to some staff to establish the 'front door' service arrangements at Prince Philip Hospital.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 8 questionnaires were completed by patients or their carers and 39 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

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 attending the Minor Injury Unit (MIU) for assessment, care and treatment of minor injuries were provided with a timely and overall positive experience. Patients told us that they were happy with the care and advice they received from staff.

Patients accommodated for longer periods however on the MIU in medical / surgical 'surge' beds, due to a lack of bed capacity on site or at another acute hospital, received and reported a less positive experience due to a lack of facilities impacting the dignity and timely care.

This is what we recommend the service can improve:

- There was a lack of toilet and hygiene facilities on the unit for surge patients who are admitted beyond the length of stay associated with an MIU.

This is what the service did well:

- We found that staff treated patients with kindness, dignity and respect at all times throughout the inspection and all patients who completed a HIW questionnaire told us they had been treated by staff with dignity and respect
- We found that patients arriving with minor injuries to the unit were overall seen and treated in a timely manner
- Minor injury patients told us that staff provided explanations about their care and treatment and were well informed about their next steps of care.

Delivery of Safe and Effective Care

Overall summary:
We were assured that patients presenting with minor injuries received a good level of safe and effective care from a skilled workforce. We were however not assured that longer stay patients accommodated on the unit in surge capacity beds received a timely, effective, and consistent level of care.

Overall, we found the issues identified applied inappropriate pressures to the functionality of the MIU as a minor injury service. The staff and unit were not fully supported or equipped in light of these pressures to safely and effectively manage all presentations and patients accommodated on the unit.

HIW acknowledges the significant pressures on front door services and, at the time of the inspection, this service was under immense pressure from multiple sources.

Immediate assurances:

- The environment was not appropriate for mental health, medical or surgical surge patients who are admitted beyond the lengths of stay associated with an MIU
- We were not assured that there were robust care assessment and planning arrangements in place for medical and surgical 'surge' patients
- We could not be assured that medical and surgical 'surge' patients received timely care when awaiting a medical bed within the hospital or when awaiting transfer out to another acute site
- We could not be assured that there was sufficient and robust support for Emergency Nurse Practitioners at times when there is an unexpected lack of medical cover on the Unit

This is what we recommend the service can improve:

- The health board should ensure that all areas of the unit are thoroughly cleaned at appropriate intervals and that this is recorded
- The health board must ensure that confidence amongst staff in the application of deprivation of liberty safeguards (DOLS) processes is strengthened.

This is what the service did well:

- Care assessment and planning in relation to minor injury patient was completed to a good standard
- Minor injury patients, once seen and treated, had appropriate safety netting in place, which included clear advice on how to manage their condition and what to do in the event of further concern
- Staff we spoke with were knowledgeable and were able to describe aspects of infection, prevention and control (IPC) relevant to their roles and responsibilities
- Learning in relation to controlled drugs incidents had been identified and implemented on the unit.

Quality of Management and Leadership

Overall summary:

We identified aspects of good nursing and medical management on the unit and staff spoke positively of the support they provide to each other on the unit.

Staff however expressed significant dissatisfaction in a number of areas. The health board must ensure that robust and sustained action is taken in response this.

This is what we recommend the service can improve:

- The health board must review this staff feedback in the context of these findings. It must continue to provide a platform to listen to staff and must take robust and sustained actions where appropriate
- The health board must identify and implement clinical skills, learning and development needs of its workforce in line with the current operation of the unit
- The health board must consider its approach to community engagement and communication at a corporate level regarding the 'front door' services available at Prince Philip Hospital and accessing the right service according to need.

This is what the service did well:

- Staff spoke positively of the support they provided to each other on the unit
- Falls and pressure damage incidents were reviewed at well documented scrutiny panels, with learning identified and disseminated
- A number of compliments had been received by the service and concerns were managed according to the relevant processes, including duty of candour cases.

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

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 8 were completed. Patient comments included the following:

"All very good"

"Toilet out of order – I had to leave the unit"

Person Centred

Health promotion
Some evidence of health promotion and support information was visible to patients on the Unit. This included information in the waiting area on the various services available and how to access the right service for your illness or injury.

We found that minor injury patients, once seen and treated, had appropriate safety netting in place, which included clear advice on how to manage their condition and what to do in the event of further concern.

Dignified and respectful care
We found that staff treated patients with kindness, dignity and respect at all times throughout the inspection. All patients who completed a HIW questionnaire told us that they felt staff had treated them with dignity and respect.

The environment however, was not appropriate for medical and surgical patients who were accommodated in surge beds on the unit beyond the lengths of stay associated with a minor injury unit.

Staff made efforts to improve the comfort of surge bed patients who were on trollies for extended periods, for example by using repose mattresses. However, we observed lengths of stay for up to five days. By the nature of these patients being generally older and acutely unwell, this equipment did not provide the necessary comfort for extended stays and increases patient susceptibility to pressure damage and falls.

There was only one toilet and no hygiene facilities available for patients on the unit. Patients told us that they were directed away from the unit to use the toilet, which on the second day of the inspection, was broken. We also noted one patient discharged themselves against medical advice in order to return home to have a shower.

Due to the seriousness of the issues, this matter was raised through our immediate assurance process. Further details can be found in appendix B.

Individualised care

We found that staff provided individualised care to minor injury patients. This promoted independence through the provision of appropriate clinical advice for the patient to return home with.

Regarding longer stay patients on the unit, staff worked to the best of their abilities to provide individualised care through multidisciplinary team processes. This included input from TOCAL team, which included a multidisciplinary team of therapy, nursing, social work, and discharge liaison staff, which staff spoke positively about. There were however limitations to the overall level of individualised care able to be provided to this patient group due to the unit environment and available facilities.

We noted that patients with cognitive needs, such as dementia, were identified on a patient board and within their patient record. Staff were aware of and conscious of meeting the needs of these patients as far as possible. The environment, however, was again not appropriate for this patient group for extended periods due to the noise, lack of windows, and which impaired the ability of patients to orientate to the time of day and their surroundings.

Timely

Timely care

We found that patients arriving with minor injuries to the unit were overall seen and treated in a timely manner. However, we could not be assured that medical and surgical patients in surge capacity beds received timely care when awaiting a bed within the hospital or when awaiting transfer out to another acute hospital site.

Whilst HIW acknowledges the national pressures associated with patient flow, we were concerned with the lengths of stay and associated negative patient experience patients received on the unit.

Further details are included in the 'Efficient' section on page 15.

Equitable

Communication and language

We observed respectful and sensitive conversations between staff and patients at all times. This promoted patient confidentiality and patients overall told us that they felt listened to by staff.

Minor injury patients told us that staff provided explanations about their care and treatment and were well informed about their next steps of care. However, some longer stay patients, told us that they would have valued greater communication to better understand their own situation.

We observed some opportunities of the Welsh language Active Offer in use. Some patients told us that they had been offered the opportunity to communicate through Welsh if preferred. Some bilingual posters and other information materials were displayed on the unit.

Rights and Equality

The service provides non-discriminative care and treatment to all patients who attended the unit. There was an organisational equality and diversity policy in place and there was a good level of completion amongst staff of the mandatory NHS equality and diversity training.

Delivery of Safe and Effective Care

Safe

Risk management
The environment was generally accessible to all patients and visitors. There were however limitations for longer stay patients, for example a lack of accessible toilets or showering facilities. Staff were aware of how to report issues to the health board estates team and reported that these were reviewed in a generally timely manner.

Staff we spoke with were aware of the escalation procedures in place, for example patient deterioration or capacity concerns. However, we were informed that the unit is a 24 hour service and does not close or routinely redirect patients. Therefore, patients continued to be seen and admitted, despite the pressures caused by surge beds on the unit. We were not assured that aspects of the current escalation arrangements were effective in robustly managing risk.

In relation to ligature risk, we identified ligature points within the unit which required risk assessing and remedial actions as necessary.

Furthermore, we were not assured that there were adequate arrangements in place for the observation of patients who presented with mental health concerns. The physical environment of the unit limits visibility of patients unless there is constant 1-1 supervision. Staff also reported to us that there is often a lengthy waits before mental health teams attend the unit to assess patients.

Due to the seriousness of the issues, this matter was raised through our immediate assurance process. Further details can be found in Appendix B.

Infection, prevention, control and decontamination
We found satisfactory compliance with infection prevention and control (IPC) procedures. Staff we spoke with were knowledgeable and were able to describe aspects of IPC relevant to their roles and responsibilities.

Staff were well presented in clean uniforms, were bare below the elbow and were observed adhering to good hand hygiene principles in between tasks.

We reviewed examples of audit activity, such as hand hygiene audits, which were positively scored. However, we noted that there were gaps on cleaning schedules and we observed the need for improved cleanliness in toilets and some storage rooms during our tour of the unit.

The health board should ensure that all areas of the unit are thoroughly cleaned at appropriate intervals and that this is recorded.

There was a dedicated housekeeper based on the unit, whose role extended to providing meals to patients. Staff spoke positively of their contribution to the unit.

We found that the unit had no designated isolation rooms to accommodate infectious patients. Staff informed us that they would attempt to accommodate the patient in a side room, but there were no en-suite facilities available to manage infections robustly.

When asked if their organisation implements effective IPC procedures, the majority of staff agreed. However, a third of staff disagreed that the environment allows for effective infection control.

Safeguarding of children and adults

There were clear health board policies and procedures in place for staff to follow in the event of a safeguarding concern. Staff we spoke to were aware of the process for reporting safeguarding concerns and feel comfortable doing so.

Some staff however told us that they did not feel confident in aspects of Deprivation of Liberty Safeguards (DOLS) as DOLS is not routinely required for MIU patients.

The health board must ensure that confidence amongst staff in the application of DOLS processes is strengthened.

We confirmed that relevant checklists are completed by nursing staff for patients at risk of abuse and for paediatric patients. We noted that there are daily calls with the health visiting team to discuss any safeguarding concerns.

There was a small, separate children's waiting / play area, but this was empty and appeared out of use. The health board is advised to review this space.

We found good compliance with safeguarding and associated mandatory training amongst clinical staff.

Management of medical devices and equipment

We found general medical devices and equipment to be in date and in working order. Devices we observed had a label to indicate when they had last been serviced and staff were clear on how to report faulty or missing equipment. Corridors and storage areas however appeared cluttered with equipment and other items which prevented easy access to these areas and did not enable effective cleaning.

The health board must review the storage of equipment and other items on the unit to ensure ease of access and to enable effective cleaning in all areas.

In relation to emergency equipment, we found that resuscitation trolley checks had not been completed in line with health board procedure and Resus UK guidance. There were also a small amount of significantly expired items present. This posed a patient safety risk due to the potential for equipment to be missing and not immediately available when required in an emergency.

Due to the seriousness of the issues, this matter was raised through our immediate assurance process. Further details can be found in Appendix B

Medicines Management

We found that aspects of medicines management relating to the assessment, prescribing, administration, and its review was overall appropriate.

There were some inconsistencies in relation to pain management for longer stay patients. This included a lack of consistent pain assessment, on-going scoring and administration of adequate pain relief at the necessary intervals. However, we found the pain management of minor injury patients was assessed and managed to a good standard.

We reviewed aspects of controlled drugs security and found that controlled drugs were securely stored, administered and logged appropriately, and staff confirmed that there was good input on the Unit from pharmacy colleagues. It was also positive to note that learning in relation to controlled drugs had been identified and implemented following a controlled drugs related incident.

We found that fridge temperatures were generally checked and logged daily to ensure the integrity of the medicines held inside. However, there were inconsistencies in the frequency of these checks.

The health board must ensure that fridge temperature checks are completed and logged on the required basis.

Effective

Effective Care

Staff demonstrated a good awareness of the management and escalation of sepsis. This included completion of a sepsis screening tool and appropriate escalation of clinical concerns. Whilst this was completed in most cases, we noted some incidences of inconsistent sepsis scoring, despite triggered signs of infection.

We identified good input from unit medical staff. However, multiple staff informed us that there are occasions whereby the wider on-site medical teams, at times, do not feel equipped or feel that they are acting outside of their scope of practice when asked to provide emergency resus for paediatric patients.

Whilst we were overall assured these patients received timely and effective care from staff on the Unit, we were concerned that patients at the point in which it was identified required transfer to another acute site, were not always conveyed in a timely manner.

We identified that handover (SBAR) sheets for longer stay patients were available on the unit but were not routinely used in the records we reviewed. We recommended their use at all times due to high levels of agency use for the care of longer stay patients and the transfer of patients out to other sites.

In relation to care assessment and planning, we found suitable risk assessments in use for minor injury patients. However, these shortened risk assessments (e.g. falls and nutrition) were not suitable for longer stay patients due to the potential increased risks associated with this patient group.

We also identified some inconsistencies in the completion of, and timely commencement of falls risk assessments for patients at risk of falls. The environment was also not conducive to supporting patients at risk of falls due to the physical layout and lack of suitable beds and equipment.

It was positive to note however that the need to strengthen falls risk assessment and mitigation processes had been identified by the Unit Manager prior to the inspection and that updates were in progress.

Whilst the assessment of the pressure damage was generally satisfactory. There were limitations on staff to mitigate pressure damage due to the environmental, equipment constraints already mentioned, and the lengths of stay experienced by patients on the unit.

Due to the seriousness of the issues, this matter was raised through our immediate assurance process. Further details can be found in Appendix B

Nutrition and hydration

We found that there were provisions for minor injury patients to purchase food and drink from shops located within the hospital. However, water was readily available for patients to access in the waiting areas.

For longer stay medical patients who were accommodated on the Unit, there was access to hot meals, drinks and sandwiches at regular intervals throughout the day. There was however a lack of choice for patients, which could prevent nutritional needs being fully met.

Nutrition assessments were completed, however, there is a need to strengthen these risks assessments for longer stay patients as outlined in the Effective Care section.

Patient records

We reviewed 10 patient records. Overall, we found that nursing and medical records were completed to a good standard. This was notable for minor injury patients, where we found care and treatment was responsive, appropriately assessed, monitored and recorded.

In relation to longer stay medical patients, and as identified throughout this report, there is a need for the unit to use more robust ward based care plans and risk assessments in order to reduce risk and improve the quality of care for these patients. The level of risk assessments and associated documentation was not appropriate for this patient group, particularly for those at risk of falls and pressure damage and was not always completed in consistent and timely manner.

Records were stored appropriately on a lockable trolley.

Efficient

Efficient

We found that patients arriving with minor injuries to the unit were overall seen and treated in a timely manner. However, staff and patients told us that longer stay patients on the unit could often pull staff away from their minor injury duties due to the acuity of patients in these beds.

We could not be assured that medical and surgical patients in surge capacity beds received timely care when awaiting a bed within the hospital or when awaiting transfer out to another acute hospital site.

Whilst HIW acknowledges the national pressures associated with patient flow, we were concerned with the lengths of stay these patients experienced on the unit due to the overall issues identified. In some instances, this included lengths of stay of up to five days. We recognise that the health board had a significant number of patients who were medically fit for discharge across its sites at the time of the inspection.

We were not assured that patients requiring transfer by the Welsh Ambulance Service Trust (WAST) to another acute site received timely transfers. There was a strong consensus amongst staff who told us that this has occurred when an emergency transfer is required due to the acuity or deteriorating nature of a patient. This was evidenced in recent patients records we reviewed. Staff added that they are told by WAST that the service is considered a place of safety and, therefore, does not always receive a priority call category.

Due to the seriousness of the issues, this matter was raised through our immediate assurance process. Further details can be found in appendix B.

Quality of Management and Leadership

Staff feedback

During the inspection we spoke with and used online questionnaires to obtain views and feedback from staff. A total of 38 were completed.

Responses to this questionnaire were generally negative. Only around half of staff are satisfied with the quality of care and support they provide to patients (20/38) and around only half agreed that they would be happy with the standard of care provided for themselves or for friends and family (19/37).

In relation to patient care, only a third of respondents felt they are able to meet conflicting demands of their work (13/39) and very few thought there are enough staff to do their job properly (6/39).

Other themes identified within the staff feedback include:

- The operation of the Minor Injury Unit akin to an Emergency Department rather than an MIU due to its 'no turn away' or redirection protocols
- Caring for high acuity of patients and the risk this presents due to either inappropriate attendance or a lack of timely transfer out to another acute site
- A lack of public awareness and engagement within the local community of the services provided at Prince Philip and the MIU
- A lack of privacy, dignity and timely care for patients in medical / surgical surge beds
- Poor staffing skill mix when expected to care for non minor injury patients and being expected to work outside of scope of practice
- Poor engagement and support from senior management and leadership in acting upon concerns.

Staff comments included the following:

> *"…There is clearly a lack of unity in the department due to role boundaries and conflicts. Staff are working within multiple roles per shift and a reduced amount of time is given to their designated role. This compromises patient care and safety…"*

"We are classed as a Minor Injuries Unit but operate as something that is somewhere between being an MIU/AMAU/A&E. Therefore we can lack in confidence in some instances due to intermittent exposure. We need to be one thing."

"This is in all but name an A&E department. Staffed by nurses and GPs. We deal with A&E patients and seriously unwell Mental Health patients in an unsuitable and unsafe department."

"I suggest the unit becomes multi-professional with a skilled workforce of Paramedics/paediatric nurses/Physiotherapists/Podiatrists/mental health practitioners to name a few. This will engage staff and promote a positive learning environment to deliver quality, safe and effective care."

"The positive about our unit is that we have a very good team of staff that work very hard to cover shift deficits, and to support each other."

The health board must review this staff feedback in the context of these findings. It must continue to provide a platform to listen to staff and must take robust and sustained actions where appropriate to do so.

Leadership

Governance and Leadership

We confirmed that there was an appropriate nursing and medical management structure within the unit. Staff were clear on who their immediate managers were and how to escalate issues.

When asked if their immediate manager can be counted on to help with a difficult task at work, almost two thirds of staff agreed (21/34). Just over half agreed that they are given clear feedback on their work (19/34), but only one third of staff agreed that they are asked for their opinion before decisions are made which affect their work (!2/34)

Staff expressed generally negative reviews in response to senior managers. Only one quarter agreed that senior managers are visible (9/34), that communication is effective (8/34), and only a third agreed that senior managers are committed to patient care (12/34)

Workforce

Skilled and Enabled Workforce

We found a committed workforce amongst all disciplines in the MIU. Staff we spoke with were knowledgeable of their roles and responsibilities and how this relates to providing quality patient care for minor injury patients.

However, we found that staff felt under pressure and professionally conflicted in their roles and responsibilities when expected to care for longer stay, non minor injury patients. Staff comments included:

> *"It's the staffing levels and the patients that come through that require emergency treatment when it is a minor injuries department. Also not having the facilities in the department for medical patients. When bank members of staff cover when the unit needs help, they are not suitably qualified to do bloods or ECGs, and difficult to get training for bank staff."*
>
> *"We are not A&E doctors but are expected to deal with A&E patients. Most of the Dr's are GPs but there is a surgeon a radiologist and at least 3 Dr's with no speciality training at all. On the occasions when there is no Dr cover there has been an ANP. This is dangerous it would not be acceptable in any A&E Department why is it allowed to continue in PPH."*

We could not be assured that there was sufficient and robust support for Emergency Nurse Practitioners at times when there is an unexpected lack of medical cover on the unit, e.g. overnight. This applies inappropriate pressures to the unit and creates a heightened risk situation for staff due to the issues identified during this inspection.

Due to the seriousness of this issue, this matter was raised through our immediate assurance process. Further details can be found in appendix B.

We found that staff training in relation to mandatory requirements was overall up to date. There were five new triage nurses joining the Unit and we confirmed that there were suitable induction arrangements and triage training in place for this cohort.

It was positive to note that appraisals were up to date. When asked if they had received full training on all areas within the Unit, around half of staff agreed (20/38). Comments from staff included:

"We are classed as a Minor Injuries Unit but operate as something that is somewhere between being an MIU/AMAU/A&E. Therefore, we can lack in confidence in some instances due to intermittent exposure. We need to be one thing."

"Given the amount of paediatric and trauma cases some specific training related to this would be helpful."

“Major patients presenting to MIU requiring ED skills which GPs are not officially trained in eg: nerve block for fractured neck of femur / resuscitation of unwell child etc.”

The health board must identify and implement clinical skills, learning and development needs of its workforce in line with the current operation of the unit.

Culture

People engagement, feedback and learning

There were opportunities displayed for patients to provide feedback through the Putting Things Right process. Posters providing details of how to do this were displayed in the waiting area and main unit.

We noted a number of complements had been received by the service. These included comments of gratitude for staff for the care and treatment provided.

Where complaints were made, we identified no clear themes. However, we were assured that concerns were discussed with the wider team through staff meetings and with individuals where required. There were appropriate governance mechanisms in place to review these at a site and corporate level to ensure learning is captured.

During the inspection, it was evident from discussions with staff and patients that there is a clear need for the health board to engage more widely with the local community on the services available Prince Philip Hospital and where to access the most clinically appropriate services, at the right time. Despite it being several years since the re-organisation of front door services at Prince Philip, several patients still perceived this service to be a full, traditional Emergency Department service, which results in inappropriate attendances.

The health board must consider its approach to community engagement and communication at a corporate level regarding the ‘front door’ services available at Prince Philip Hospital and accessing the right service according to need.

Learning, improvement and research

Quality improvement activities

Audits related to quality, safety and spot checks were completed on the unit. These captured a good level of detail and learning. The results of audits and incident learning was shared through an appropriate local governance mechanism.

However, due to the findings in this report, some of which are longstanding, there is a greater level of oversight required at a main committee / board level.

Incidents, including pressure damage and falls, were reviewed at regular scrutiny panels. The minutes of these meetings contained a good level of detail, with learning actions for implementation in the respective service areas.

Whole system approach

Partnership working and development
HIW acknowledges the significant pressures on front door services and, at the time of the inspection, this service was under immense pressure from multiple sources.

Some of the improvements identified in this report extend beyond control of the unit and of the health board. This requires high level discussions with partners to ensure patients receive timely care, in the right clinical environment for their needs. As a result, some of the actions provided within the immediate improvement plan have a longer time scale for completion than usually expected.

The health board must continue to ensure its service provision ensures patients are cared for in the right environment and at the right time. HIW will monitor progress against the actions provided in the improvement plan.

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

Appendix B - Immediate improvement plan

Service: Prince Philip Hospital

Date of inspection: 26-28 June 2023

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	Service action	Responsible officer	Timescale
PART A - Standards: Safe, Timely, Effective, Whole Systems Approach. HIW was not assured that all aspects of care were being delivered in a timely and effective manner within the Minor Injury Unit (MIU) to medical and surgical patients in 'surge' beds. At the time of the inspection, the service was under immense pressure from multiple sources. These findings do not apply to short stay 'see and treat' minor injury patients.			

• **The environment was not an appropriate environment for medical or surgical 'surge' patients who are admitted beyond the lengths of stay associated with an MIU:** • Whilst efforts were made to improve the comfort of patient on trollies for extended periods. Surge patients are kept, for the most part, on trollies with limited pressure relieving equipment available. By the nature of these patients being generally older and acutely unwell, they are more susceptible to pressure damage, as well as falls, when on this equipment for longer stays • A patient with infective eczema self-discharged against medical advice, returning the following morning for antibiotics, in order to have a shower due a lack of facilities on the Unit • There was only one toilet, and no shower facilities available to patients on the Unit. If medical patients continue to be accommodated, access to this provision must be reviewed. • We identified ligature risks on the unit, which required risk assessing and remedial actions as necessary. We were also not assured of the	1. To discuss the findings of the monthly audits, which includes evidence from the health and care monitoring system relating to pressure damage, infection control and nutritional scores, at the monthly scrutiny meeting, and ensure where necessary appropriate action is taken. (The SNM undertakes monthly audits reviewing all aspects of care.)	Senior Sister / SNM	31/07/2023
	2. To remind staff that the two rooms that can accommodate a bed within MIU is to be considered on a clinical needs and risk basis and discussed during the safety huddles.	Senior Sister / SNM	Complete
	3. To remind all staff that pressure relieving equipment is available through the TVN service and should be utilised based on the risk assessment for individual patients.	Senior Sister / SNM	Complete
	4. All nursing staff including HCSW to receive update training on pressure damage management. Training to be provided by the TVN service and records of attendance to be kept by the Senior Sister.	Senior Sister / SNM	30/09/2023
	5. Staff to be reminded that the shower facility based in AMAU can be offered and	Senior Sister / SNM	Complete

adequacy of the observation arrangements of patients who presented in a crisis situation.	where required patients should be supported to use the shower.		
• **We were not assured that there were robust care assessment and planning arrangements in place for medical and surgical 'surge patients:**	6. Staff to be reminded that wash bowls and toiletries are available for all patients (this is in place)	Senior Sister / SNM	Complete
• Whilst the risk assessments for MIU patients were suitable, shortened risk assessments, e.g. falls, nutrition etc, for longer stay surge patients were not clinically appropriate	7. Reminder to be issued to all staff regarding patients not being left unattended	Senior Sister / SNM	Complete
• We saw instances of inconsistent pain relief and pressure area checks for patients at high risk	8. Standard operating procedure for the management of patients experience mental health crisis to be reviewed and circulated to all. This review will require input from the MH &LD Directorate	Senior Sister / SNM	31/08/2023
• We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	9. Advice to be sought from Head of Health and Safety	Senior Sister / SNM	Complete
• Handover (SBAR) sheets were available on the unit, but were not routinely used. Due to the high level of agency use and transfers out, there use must be increased.	10. Ligature risk assessment to be revisited	Senior Sister / SNM	10/07/2023
	11. Site assessment to be undertaken by H&S Team and work plan developed with estates	Head of H&S	14/07/2023
Due to the risk for patent safety, there is an immediate need for the Health Board to provide additional assurance and any actions taken related to how surge patients on the MIU are cared for and	12. Report to be presented to the H&S Assurance Committee	Head of H&S	30/09/2023

managed, as well as the flow out of the MIU to other areas. • **We could not be assured that medical and surgical 'surge' patients received timely care when awaiting a medical bed within the hospital or when awaiting transfer out to another acute site:** • Whilst HIW acknowledges the national flow pressures, we were concerned with the lengths of stay these patients experienced on the Unit. We noted stays of up to 5 days • We were equally concerned with the wait times involved for the transfer of some acutely unwell or deteriorating patients due to a lack of timely transfer from the Welsh Ambulance Service Trust (WAST) following urgent requests by Unit staff • Overall, we identified a strong theme from staff that there is decreasing capacity from WAST in supporting emergency transfers in a timely manner. • Whilst we were informed that WAST consider the hospital to be a place of safety, due to the issues	13. To undertake a spot check audit of the use of risk assessments (paper ward bundle) which were recently introduced. 14. To identify a pain Link nurse to act as a point of resource for staff and to liaise with the pain team. 15. To undertake an initial baseline audit to identify key areas of improvement relating to assessment, prescribing, action, monitoring and escalation of pain. 16. To develop a programme of further audits to monitor practice (pain management) 17. To develop a training with the pain team for MIU staff, which includes information on how staff can ensure patients' pain is adequately assessed and managed. 18. To engage with clinical colleagues and medical teams to ensure timely patient assessment and prescribing of medication. 19. To update the teaching board and provide information on how to fully complete NEWS chart and sepsis screen.	Senior Sister / SNM Senior Sister / SNM Senior Sister / Link Nurse Senior Sister / Link Nurse Senior Sister / Link Nurse MIU GP Lead Senior Sister / SNM	31/07/2023 Complete 31/07/2023 31/07/2023 31/08/2023 14/07/2023 14/07/2023

identified above, the environment cannot be considered appropriate in all patient scenarios • Additionally, multiple staff informed us that there are occasions whereby the on-site CRASH response team, at times, do not feel equipped or that they are acting outside of their scope of practice when asked to provide emergency resuscitation for paediatric patients. ***Due to the risk for patient safety, there is an immediate need for the Health Board to provide additional assurance regarding the timely conveyance of patients****. This will likely require discussions with WAST and, at the minimum, the implementation of a local standard operating procedure (SOP) for the escalation and transfer of patients.* • **We could not be assured that there was sufficient and robust support for Emergency Nurse Practitioners at times when there is an unexpected lack of medical cover on the Unit, e.g. overnight.** • This creates a high-risk situation for nursing staff and patients due to the issues raised above. ***There is an immediate need for the Health Board, at the minimum, to implement a local SOP for MIU staff***	20. To identify a sepsis link nurses as point of resource for staff and to liaise with the resuscitation team.	Senior Sister / SNM	Complete
	21. To undertake an initial baseline audit to identify key areas of improvement.	Senior Sister / Link Nurse	31/07/2023
	22. To develop a programme of further audits to monitor practice (sepsis management)	Senior Sister / Link Nurse	31/08/2023
	23. To send an email to all staff received e-mail to emphasise importance of sepsis screening and action.	Senior Sister / Link Nurse	Complete
	24. To source additional sepsis book and ensure they are visible to doctors and nurses in all MIU areas	Senior Sister / Link Nurse	Complete
	25. To consider and action the findings of the monthly sepsis compliance spot check audits carried out by the resuscitation team	Senior Sister / Link Nurse	31/07/2023
	26. To continue the work ensuring that all agency nurses are aware of the resource booklet which incorporates specific knowledge and skills on sepsis screen documentation, recognition and compliance. (Positive verbal feedback has been received from Agency Nurses to PDN regarding the resource file.)	Senior Sister / SNM	31/07/2023

to follow in the event of patient presentations outside of their scope of practice. Overall, these issues apply inappropriate pressures to the functionality of the Minor Injury Unit as an MIU, as the staff and the Unit are not fully equipped in the present situation and pressures to manage all the patients admitted to the Unit.	27. To ensure that all MIU staff are familiar with the SBAR documentation that is embedded in the MIU documentation. 28. Nurse in charge to ensure that the SBAR documentation is used on a daily basis and monitor compliance through the spot check audits (see action 1) 29. When the MIU is in surge capacity to continue to book and allocate a Registered Nurse and HCSW to manage the surge patients 24 hours a day. In the event of an unfulfilled shift, to identify resource from other area of hospital and deploy accordingly.	Senior Sister / SNM Senior Sister / SNM Clinical Site Manager	Complete 31/07/2023 Complete

	30. To continue to attend the Patient Flow meetings twice daily at 8:30am and 3pm (this includes RTDC to promote discharge before 2pm) and escalate issues to Manager of the Day, which are communicated on the twice daily Health Board calls. 31. To ensure that the Safety Huddles which take place in the AMAU (incorporating MIU) at 12, 5 and 10pm are attended by appropriate MIU staff. 32. Working alongside DELTA and TOCALS, ensure any unforeseen issues regarding discharge are dealt with promptly to avoid unnecessary admissions. 33. To implement draft of an escalation flow chart which will assist the escalation of patients that need immediate transfer to other services. 34. To develop an MIU escalation SOP which will include the escalation and transfer of patients. *Hospital wide 'Deep Dive' of patients takes place weekly with all Ward Sisters to ensure forward planning of any requirements to enable a safe and prompt discharge.* *Twice weekly Carmarthenshire System Escalation Panel facilitate resolution of delays.*	 DLN assigned to MIU/AMAU, Senior Sister / SNM Senior Sister / SNM	Complete Complete Complete 31/07/2023 30/09/2023

	The above wider hospital actions support the reduction of in-hospital delays to facilitate and improve flow through the hospital. 35. To continue the work being undertaken as part of TUEC policy goal 5 with regards to the effective functioning of the Hospital 'front door' services. 36. To include in the escalation flow chart the management of patients who need immediate transfer (there will need to be a discussion between the clinician in charge of the patients' care and WAST clinical desk) 37. To share the concerns of HIW with WAST Executive colleagues 38. To undertake an assessment of PILS and ILS training requirements for nursing staff in MIU and develop a schedule for training. 39. To undertake an assessment of PILS and ILS training requirements for MIU GP	Directorate Triumvirate Team Directorate Triumvirate Team Director of Nursing Senior Sister / SNM GP Clinical Lead	31/12/2023 30/09/2023 31/07/2023 31/07/2023 31/07/2023

	enhanced medical staff and develop a schedule for training		
	40. In this situation, to continue with current process of: • Exploring all available avenues to source medical cover for unexpected absences and the Medical Registrar on-call is advised of the deficit and the added support that is need in MIU • Informing the Health board communications team and information being circulated to WAST, 111 and Police to ensure that they are aware of the reduced service.	Hospital Service Manager	Complete
	41. To prepare a schedule for the development a suite of Redirection Protocols to assist with the effectiveness of triage and for streaming to take place within MIU to ensure patients are re-	SNM/ GP Clinical Lead/Clinical Director	31/07/2023

PART 2 - Standards: Safe			
• Resuscitation trolley checks had not been completed in line with Health Board procedure and Resus UK guidance. We found evidence of gaps, with last checks having taken place on the 21 June in the resus bay on the MIU. There was also a small amount of expired equipment on the paediatric resus trolley. The Health Board must ensure that checks include expiry dates and that these are completed and logged at all times. This must include mechanisms to identify when checks are not completed or logged.	directed to the correct services. (This will take time to develop and will need input from other directorates, clinical colleagues including Primary Care.)		
	42. To order 2 suitable resuscitation trolleys that can be sealed in line with the which is resuscitation council standard.	Senior Sister / SNM	Complete
	43. To remind staff of the requirement to undertake: • daily checks on all trolleys (adult and paediatric) which includes ensuring the seal is secure on a daily basis evidenced by a signature in the handover book • that if the tag has been removed, a full check of the trolley • if the tag is intact, a full check of the trolley every Sunday morning and the checklist must be signed.	Senior Sister / SNM	Complete
	44. To remind staff that where equipment is due to expire within 3 months an email must be sent to the Senior sister so that replacements can be sourced in a timely manner.	Senior Sister / SNM	Complete
	To include a check of resuscitation trolleys in the daily spot checks and take immediate	Senior Sister / SNM	14/07/2023

	action to address any issues during the spot check.		

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

Service representative:

Name (print):

Job role:

Appendix C - Improvement plan

Service: **Minor Injury Unit, Prince Philip Hospital**

Date of inspection: **June 2023**

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Risk to infection, prevention and control	The health board should ensure that all areas of the unit are thoroughly cleaned at appropriate intervals and that this is recorded.	1. Monthly synbiotix audits that are completed by hotel services supervisor, SNM and estates representative 2. Monthly QIA monthly audits. Scores below 90% trigger monitored improvement plans. 3. Fundamentals of Care (FOC) monthly audits to include cleaning schedules. MIU staff reminded daily to complete the	Senior Sister	completed

		checklists. Compliance monitored by Unit Senior Sister.		
Risk of not upholding patient rights	The health board must ensure that confidence amongst staff in the application of DOLS processes is strengthened.	1. DoLs training to be completed by all staff. Timescale influenced by frequency of the face-to-face training sessions.	Senior Sister	6 months (1st Feb 24)
Right to infection prevention and control	The health board must review the storage of equipment and other items on the unit to ensure ease of access and to enable effective cleaning in all areas.	1. Undertake a comprehensive review and analysis of equipment requirements, ordering and storage of equipment and supplies. 2. Seek alternative area in MIU to store larger pieces of equipment to rationalise the amount stored in the unit 3. Scope the re-purposing of existing rooms to	Senior Sister/SNM	3 months (1st December 2023)

		find a solution for the storage issue.		
Risk to integrity of medicines and medicines management processes	The health board must ensure that fridge temperature checks are completed and logged on the required basis.	1. The nurse in charge of the shift is responsible for checking that fridge temperature checks are undertaken daily and documented.	Senior Sister	Completed
Risk to workforce	The health board must review this staff feedback in the context of these findings. It must continue to provide a platform to listen to staff and must take robust and sustained actions where appropriate to do so.	1. Additional RN & HCSW requested for additional non MIU patients. 2. Liaising with Mental Health colleagues to review management of MH patients presenting to MIU 3. Regular meetings with Senior Management colleagues established.	SNM and Triumvirate. SNM SNM and Triumvirate.	Complete 2 months (1st November 23) Completed

Risk to patients – effective and timely care	The health board must consider its approach to community engagement and communication at a corporate level regarding the ‘front door’ services available at Prince Philip Hospital and accessing the right service according to need.	1. Review of current MIU scope and criteria documents and development of redirection protocols underway.	SNM, GP Lead, HoN and Triumvirate.	3 months (1st December 23)

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): A Morris

Job role: Senior Nurse Manager

Date: 23/08/2023