Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

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

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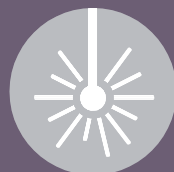

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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 at The Emergency Department at the Grange Hospital, Aneurin Bevan University Health Board on 02 and 04 October 2024. The following hospital wards were reviewed during this inspection:

- Emergency Department (ED)- providing emergency medicine services to adults and paediatrics
- Majors – 16 beds
- Resuscitation – 8 beds
- Paediatric ED – 16 beds
- Medical Assessment Unit – 7 beds for respiratory isolation

Our team, for the inspection comprised of two HIW senior healthcare inspectors, three clinical peer reviewers and one patient experience reviewers.

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 11 questionnaires were completed by patients or their carers and 61 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.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff were working hard under highly challenging conditions. We saw staff treating patients in a polite, professional and dignified manner. However, their efforts were often hindered by the number and high acuity of patients attending the department, and issues with the flow of patients into wards throughout the hospital.

There was overcrowding within the waiting room and reception desk area, resulting in lack of privacy and dignity for patients sharing and discussing confidential information. In addition, staff did not have good oversight of this area and risk assessments had not always been completed. We found that not all patients in the waiting area received timely analgesia where required.

Patients we spoke to, and survey respondents expressed significant dissatisfaction with waiting times. Only half felt they were assessed within 30 minutes of arrival. The department was experiencing high escalation status, and extended waiting times due to volume patients. Capacity was being managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability. This system-wide issue affected the discharge process, with 350 to 400 patients awaiting discharge across the health board.

Whilst the issues highlighted above remain an issue impacting on patient safety, experience and dignity, there has been some improvement since our previous inspection in 2022. This includes initiatives implemented to improve patient triage times. Building work was also underway for an extended waiting area, which is due for completion in spring 2025. This will provide more seating for ambulant patients, and staff are confident this will help improve the patient experience and will enable better visibility of those waiting to be reviewed.

Delivery of Safe and Effective Care

Overall summary:
There were significant challenges with patient flow through the department. On the whole, this was attributed to delays with discharging patients from other areas of the hospital. This meant the department was overcrowded, thus impacting on patient care. This should be regarded in the context of national pressures on emergency departments and is not unique to the Grange University Hospital.

Overall, compliance with risk management was not always adequate. We found several examples to determine this, and some areas were replicated to that found during our inspection in 2022. Consequently, we addressed some of these issues through our immediate assurance process.

Our patient record review found that risk assessments had not always been completed for patients where applicable, particularly for people at risk of falling. In addition, we found prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to some patients, yet there was no mitigation in place to help prevent this. Whilst patients waiting on ambulances appeared to have timely assessments for skin pressure points, within the department, risk assessments were not routinely undertaken or completed in a timely manner.

The process for checking resuscitation equipment was not robust in all areas of the department, and we found that records to indicate whether safety checks of the equipment were undertaken, were incomplete. This finding however is not unique to the Grange University Hospital.

It was positive to find appropriate processes in place to manage infection prevention and control, however we saw staff on several occasions, not removing PPE when they left an area of infection. This posed a risk for cross infection to other areas of the department.

The process in place for safeguarding was supported by the Wales Safeguarding Procedures, and staff demonstrated an appropriate knowledge of safeguarding children and adults, the deprivation of liberty safeguards, and mental capacity.

We found that processes for medicines management were not robust including the timely review of the health board's medicine management policy. In addition, staff had not always completed daily controlled drug stock checks in line with policy.

Since our last inspection, initiatives were implemented to help improve the patient triage process, which included a new patient use eTriage system, with four digital stations based within the waiting area. Additionally, the level of communication between staff within the ED was appropriate and this was an improvement on the findings during the previous inspection.

Overall, staff were generally making the best use of available resources, such as medical equipment, supplies, and staff time, to maximize the benefit to patients, however the demands on the unit and overcrowding in the department, made this difficult to sustain.

Immediate assurances:

- Risk assessments for falls and Visual Infusion Phlebitis (VIP) were not completed in a timely manner
- Medicine management and administration of medicines was not robust to maintain patient safety
- Resuscitation equipment checks were not consistently completed
- We were not assured that all aspects of care were being delivered in a safe and effective manner and found that staff had failed to act on results of investigations
- Expired single use medical equipment was found.

Quality of Management and Leadership

Overall summary:

We found that maintaining nurse staffing levels was less challenging than that found during the previous inspection, and there was significantly less reliance on agency staff to fill vacancies or absences. We were told staff retention had improved and there was a focus on ensuring new staff were supported appropriately. Despite the department being very busy throughout our inspection, staff appeared to be coping well with the pressures and were mostly attentive and responsive to patient needs.

There was a training and development program in place for all staff, and this was supported by a practice development nurse. Processes were in place to identify staff training needs and help identify areas needing improvement. In addition, a staff induction pathway and Journey of Excellence process was in place, which new staff follow to ensure they gain all necessary competencies to work in the ED. Furthermore, compliance with the completion of mandatory training was good, over 85%.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were provided with information about current complaints and actions taken to resolve them.

The service is currently in Level 3 of the NHS Wales escalation and intervention arrangements, and staff explained their focus on improving the 12 hour waiting times in the department, and lost ambulance hours as they are held outside the ED. In addition, staff described the weekly meetings held by the executive team to discuss data on patient waiting times and meeting Welsh Government targets relating to addressing patient flow through the department and wider hospital.

We found good examples of partnership working between various staff disciplines, and professions from other departments, including pharmacy, occupational therapy and physiotherapy.

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

Throughout our inspection we engaged with patients, and also received 11 responses to our patient survey. Responses were mixed and waiting times, and the waiting areas were noted as the most negative responses. Most respondents rated the service as 'very good' or 'good'.

We received some positive comments about the service, and others on how it could be improved. These included:

> *"Amazing service and care by the team."*
>
> *"I was very impressed by service provided since my time spent here as I've heard a few stories, but I cannot fault staff here today."*
>
> *"It was evident that the waiting area was inadequate for the numbers there. At one stage I was sure that the numbers present exceeded the safe capacity from a fire regulation viewpoint plus there was only one exit accessible which also served as an entrance. As a retired clinician I understand the ranking of patients need to be seen in turn has to be governed by the extent and or seriousness of their presenting conditions. There was no clock in the waiting room and there was no system to work out when I might be seen. This was somewhat frustrating for me and for others waiting. Healthcare is and always will be complex and it was clear that many of those there were desirous of some tangible system to know when they might be seen. I know that is asking a lot as the clinical ranking to be seen can change depending on what arrives at A&E during any waiting period but it would have been better to have some idea than none. Apart from that I can only state that the clinical handling, from triage, to diagnosis and treatment and to discharge was first class and all the staff are a credit to NHS Wales. The staff were wonderful despite working under very overwhelming patient numbers."*

Person-centred

Health promotion

Health related information was available in various parts of the department, many of which were bilingual. Information on sepsis was also displayed throughout the department.

We saw good interactions between staff and patients with staff attending to patients' needs in a discreet and professional manner. We saw staff spending time with patients and offering patients advice on how to improve and maintain their health and encouraging and supporting them to do things for themselves to maintain their independence.

Dignified and respectful care

We saw staff treating patients with dignity and respect, and confidentiality was maintained, as much as a crowded environment allowed. Most patients we spoke with reported positive interactions with staff and were generally happy with their care.

Whilst staff were striving to maintain the privacy and dignity of patients who were awaiting further assessment or treatment, this was clearly more difficult to achieve for patients who were waiting on chairs in the corridor area. However, staff were mindful of the need to maintain patient privacy and dignity and endeavoured to move them into more appropriate areas of the department when personal care was required.

There was overcrowding within the waiting room and reception desk area, resulting in lack of privacy and dignity for patients sharing and discussing confidential information. In the majors' section, fit to sit chairs have been introduced, and consequently, patients are sitting closer together, which impacts on their privacy and dignity. This was due to limited space as a result of overcrowding and lack of patient flow. We did not witness any overcrowding in the paediatric department.

Building work was underway for an extended waiting area, and we were told the expected completion date was spring 2025. This will provide more seating for ambulant patients, therefore helping to improve their experience, and will also enable staff to have better visibility of those waiting to be reviewed. We were told that the existing waiting room will be used for a rapid assessment and treatment zone (RATZ), with the aim to increase flow through the department.

We found areas of the department that were well decorated and appropriate for their intended use, for example the artwork within the paediatric area and the décor of the relatives' room.

We were told that staff in the paediatric ED have worked closely with the charity 'make a wish', and charitable funds have been used to build a shared bereavement room with Adult ED, which also has a viewing room, where families can see their loved one following their passing in a more appropriate environment.

The paediatric ED staff have also liaised with the charity '4Louis', which has donated bereavement packs for parents and siblings, for use when a child has passed away. They have also developed miscarriage packs for women and their families, including a specific one for those of Muslim faith. This was implemented following patient feedback and demonstrates learning and improvement from patients.

Individualised care
We reviewed a sample of patient records and found clinician entries were recorded on a multidisciplinary basis. Within the records we found examples where improvements were needed in the planning and delivery of care. This is discussed further later in the report.

Timely

Timely care

During our inspection, patients and survey respondents expressed significant dissatisfaction with waiting times. Only half felt they were assessed within 30 minutes of arrival, while many received treatment within four hours. However, some reported waiting over 12 hours, which negatively impacted their experience and safety.

Several comments highlighted the frustration with waiting times, which includes:

> "My mother spent 12 hours sat on a chair, with no observations during that time and was a suspected heart attack. She had no food or drink offered during that time. She never saw a member of staff. When she was finally seen she was admitted to another chair, where she spent another 12 hours. It was like a zoo in the Grange. I am embarrassed to work for the NHS."

> "Bad points were the amount of time waiting for a bed."

> "There was no sitting or standing room, and ambulances outside all had patients in - so although I had suspected heart attack, I decided after 12 hours to leave and drive to a different hospital. It was my decision as if I was going to keel over, I wasn't doing it there. Wales [is] going backwards."

Upon our evening arrival, the department was experiencing high escalation status, meaning it was experiencing a significant level of crowding and operational pressure. This resulted in overcrowded waiting areas and extended waiting times due to a high number of patients. Capacity was managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability. This system-wide issue affected the discharge process, with 350 to 400 patients awaiting discharge across the health board.

Patients in the majors and ambulatory areas had experienced extensive waiting times. Patients we spoke with had been sat in chairs for approximately 18 hours whilst awaiting admission to a ward bed. It was disappointing to see that some of these were frail elderly patients who required assistance for personal care. When required, they were transferred to a dedicated cubicle to receive personal care.

The waiting area was cluttered, untidy, and unclean, further impacting patient experience. A screen intended to display waiting times was not always operational, leaving patients uncertain about their waiting time to be reviewed. Overcrowding was evident, with patients standing and some waiting outside. One patient reported waiting since eight o'clock that morning.

Significant challenges in patient flow persisted, often beyond the control of ED staff, primarily due to delays in discharging patients from other hospital areas. These delays were caused by patients awaiting further support, such as rehabilitation, care packages, or placements in other facilities. Some patients spent over 48 hours in the department, which is not equipped to accommodate them for such extended periods.

Whilst the issues highlighted above remain an issue impacting on patient safety, experience and dignity, there has been some improvement since our previous inspection in 2022. The health board remains aware of these challenges and continues to explore different initiatives to improve flow within the hospital.

Not all patients in the waiting area received timely analgesia, and those with long waits were not routinely followed up with pain scores and repeat analgesia. We were therefore not assured that all patients receive timely pain assessment and analgesia, and efforts to improve patient flow must continue.

The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.

The health board must develop a process where patients within the waiting room receive a pain assessment and analgesia if required.

An initiative to improve triage target times was implemented. Patients with time critical and high-risk conditions were being escalated promptly and moved to more appropriate areas within the ED for treatment. We were also told that there were good working relationships between the ED and ambulance staff in managing patient care. To manage timely triage of new patients and to address the backlog of patients waiting, more staff resource is deployed to reduce waiting times to meet the 15-minute target. This initiative has at times seen a reduction in triage time from 30 to 17 minutes. Staff endeavour to reducing triage times further to meet the 15-minute target.

Patients waiting in ambulances were well cared for, with ED staff providing care in the ambulance when needed. Patients were also taken off ambulances into the department to start treatment then returned to the ambulance. However, ambulance crew told us that diesel exhaust fumes and keeping patients warm during long waits were an issue.

Ambulance unloading times and the ability of ambulance crews to respond to patients in the community was negatively affecting the ED front door presentations. This meant that many clinically unwell patients were making their own way to the department.

When constructing the Grange Hospital, the ED was not designed for walk in patients, consequently leading to inadequate waiting areas and patient monitoring issues. There was a CCTV camera in place and the monitor screen was in the ambulatory area, however, it was difficult to determine the condition of the patient from a monitor, posing a risk that a deterioration in someone's condition may be unseen by clinical staff.

The health board should develop a robust process where patients in the waiting area are regularly monitored, in addition, that patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.

We were told that patients referred by GPs were directly admitted to a specialty service, such as the Medical Assessment Unit or Surgical Assessment Unit. This reduces the burden on ED staff and assists with the issues of overcrowding and patient flow through the department.

The ED is piloting e-triage, with self-triage screens located in reception, though privacy concerns were noted with the risk others nearby able to see the screen. Staff explained that a privacy screen was in place preventing others from reading the screen.

Equitable

Communication and language

We did not observe staff communicating in Welsh; however, we saw that Welsh speaking staff were identified by the 'Iaith Gwaith' symbol on their uniform. We were told that a language line was also used to provide translation services in other languages when required. Staff in the ED could also provide patient information in easy read format, large text and Welsh language.

Within our staff survey, most felt they always explain to patients what they were doing and listened to patients and answered their questions.

To support patient navigation through the department, a flow diagram was in place in the waiting area.

Rights and Equality

We saw that staff were striving to provide care in a way that promoted and protected people's rights regardless of their gender or background. This is aligned to Welsh Governments approach to deliver good quality patient-focused care in EDs.

Welsh Government's quality statement for EDs emphasises providing the right care, in the right place, at the right time, and staff endeavoured to do this to the best of their ability, in a high-pressure environment.

Delivery of Safe and Effective Care

Safe

Risk management

Overall, compliance with risk management was inadequate. We found several examples to determine this, which are highlighted throughout this section of the report.

Prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to frail or elderly patients, yet there was no mitigation in place to help prevent this.

Our patient record review found that risk assessments had not always been completed for patients at risk of falling, and for those with an intravenous cannula. This was dealt with through our immediate assurance process.

In addition, risk assessments had not been completed in the rooms used to assess mental health patients, to identify potential risks to both patient and staff safety.

The health board must ensure staff are adequately supported to identify potential risks to patient and staff safety and complete a risk assessment where applicable.

As highlighted earlier, the layout of the department resulted in inadequate oversight of the waiting area. Staff relied on reception personnel to alert them to any issues or unwell patients, with clinical staff's visibility limited to a CCTV screen in the ambulatory area.

Throughout our inspection there was insufficient oversight for patients in the waiting room and discussed this with clinical staff, recommending the presence of staff to maintain patient safety. We were informed that staff had not been assigned to the waiting room to assess patients to maintain staff wellbeing. Whilst we acknowledge the importance of staff wellbeing, we suggested that staff work in pairs, if necessary, to help minimise their anxieties. It is important to ensure that patient monitoring and safety is maintained.

The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.

We identified safety risks within the paediatric department. Notably, we found that staff had left a flask of hot water in the patient kitchen, within reach of patients, posing a risk to young children. This issue was escalated to the

management team, and the flask was subsequently relocated to a safer area during our inspection. We also found baby formula in unlocked cupboards, which were at risk of cross contamination or being tampered with by the public.

We accessed a dirty utility room (sluice room), which was unlocked and was therefore accessible to the public. Within this room there was an unknown substance in an unlabelled bottle, possibly a cleaning product, and tubs of bleach tablets. This was escalated to senior management and both items were removed and locked away.

The health board must ensure that all COSHH equipment is stored safely in a locked cabinet as stated in the COSHH regulations.

We noted there was no ligature free assessment space, toilet or wash facility within the paediatric ED and no risk assessment had been completed for this.

The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.

We reviewed the process for checking resuscitation equipment within the resuscitation area, paediatric department and major's department. We found that the records to indicate whether the emergency equipment and defibrillator had been checked, had not been completed on multiple occasions. This was dealt with through our immediate assurance process.

The department operated a 'red release' protocol, which means a space is maintained to offload a patient from an ambulance in the event of a community emergency, negating a need to release an ambulance immediately. Due to overcrowding within the department, we found that this was not always available.

Infection, prevention and control and decontamination
The hospital had a dedicated infection prevention and control (IPC) team, and the ED had an IPC link nurse.

We saw evidence that regular hand washing audits were completed and the high scores indicated good compliance with hand hygiene. Staff are provided with updates relating to IPC by leaders and feedback from audits are provided during handovers.

We saw staff adhering to unform policy, and clinical areas were visibly clean and generally free from clutter. The department had its own domestic cleaning team, who were present during our visit.

Individual cubicles were available for isolating infected patients where required, including a negative pressure room. There are also seven beds staffed by ED nurses within the Respiratory Assessment Zone (RAZ) within the Medical Assessment Unit for those requiring respiratory isolation. This is to minimise the risk of airborne transmission of infection, such as for those with COVID 19, Flu or other respiratory infections.

Personal Protective Equipment (PPE) was available in all areas however, we saw staff on several occasions, not removing PPE when they left an area of infection. This posed a risk for cross infection to other areas of the department.

The health board must ensure staff use and remove PPE appropriately to prevent the spread of infection.

Safeguarding of children and adults

The staff we spoke with demonstrated a satisfactory knowledge of safeguarding children and adults, and for the deprivation of liberty safeguards and mental capacity.

We found robust safeguarding procedures in place for referral, escalation and follow up of safeguarding concerns. This was supported by the Wales Safeguarding Procedures. We were shown staff training compliance records for safeguarding and found these to be appropriate.

Blood management

Staff described the process of safe blood product transfusion, which in the health board is a two registered nurse process, and a clear protocol was in place to support this. We were told that staff complete blood transfusion competency training before they are permitted to administer blood products, and the department held a register of competent staff.

Management of medical devices and equipment

Staff had access to a range of medical devices and equipment, to manage the needs of patients. The equipment appeared clean and was in good condition.

There were robust systems in place to ensure that medical devices and equipment were being regularly serviced and maintained to ensure they were safe to use.

Medicines management

We reviewed the health board medicines management policy and found its review date had expired.

The health board must ensure the medicines management policy is reviewed and approved in a timely manner.

We reviewed records for Controlled Drugs and saw that records were not routinely completed in all areas of the ED. This related to drug stock balance checks in line with the health board's policy. These checks had been missed in the majors and RAZ areas.

The health board must ensure that controlled drug stock checks are completed in all areas of the emergency department.

We found expired medication in the paediatric and majors departments. We escalated this to the nurse in charge and the medications were disposed of immediately. We were also not assured that regular stock checks are undertaken to identify medicines with near expiry dates. This may pose a risk to safety if administered to patients. This was dealt with through our Immediate Assurance process.

There were four designated pharmacists that covered the department, and support was available out of hours if required. This included suitable arrangements for accessing medicines that were not in stock.

We witnessed two occasions when medication was administered and not signed for on the prescription chart. This highlighted the risk that medication could be administered twice and potentially overdose the patient.

The health board must ensure staff sign the medication record promptly after administering medication, to avoid overdose or drug errors.

We found the process for medication fridge temperature checks was not robust to ensure messages regarding out-of-range temperatures was acted on promptly. We were told an email was sent to the nurse in charge if the temperature is out of range. However, staff said that messages are not always checked due to the nurse in charge providing clinical support. Therefore, we were not assured that the system was robust and efficient to ensure temperature-controlled medication was being stored appropriately.

The health board must ensure a robust process is in place to report issues with medication fridge temperatures to ensure these can be addressed promptly.

For those we checked, we found all patients had an identification band in place. However, allergy bands were not always worn by patients with known allergies, neither were falls risk bands worn where applicable.

The health board must ensure that allergy bands and falls risk bands are placed on patients where applicable.

Preventing pressure and tissue damage

We found that skin pressure area risk assessments were not undertaken routinely or in a timely manner. On review of patient records, we found that initial completion of a risk assessment was not always done and rechecks were not recorded. When rechecks were recorded, this was usually longer than advised by the risk identifiers. We also found that where a patient's risk assessment score was high, pressure relieving mattresses or cushions were not used in a timely manner. This exposed patients to risk of skin pressure damage.

Patients arriving by ambulance received a skin inspection on triage and the triage nurse had the responsibility to reassess the patient as indicated by the Waterlow. Regular skin inspections were performed, and Datix incident reports were made if a patient had an existing pressure area, or developed one during their care in ED. However, for older adult patients sitting on hard chairs in the waiting room, we were not assured they were receiving regular pressure relief or skin inspections. We were told that often, triage nurses are too busy managing triage wait times, to enable them to regularly check patients in the waiting room. We identified at least one elderly patient who had been in the waiting room overnight and had not received a skin inspection.

The health board must ensure that patients in the waiting room are assessed for their risk of pressure damage and re-evaluated as indicated by the risk assessment.

Falls prevention

Falls risks assessments were not routinely undertaken for patients where appropriate to do so. We found an example where a patient had been admitted following a fall at home, but staff had not completed a falls risk assessment. This patient subsequently suffered a fall in the department. This was addressed through our immediate assurance process.

Staff we spoke to lacked understanding and knowledge regarding the correct way to complete falls documentation. We found that risks assessments that had been completed were not always acted upon. We were later told that the documentation was new and training on these had not been carried out by all staff at the time of our inspection.

We were told the frailty team, physiotherapists and occupational therapists supported ED staff in caring for patients identified as being at risk of falls.

Effective

Effective care

Senior staff described the department's initiatives to develop and improve the service provided to patients. This included a new eTriage system in place, as highlighted earlier, where patients can self-triage using one of four digital stations based within the waiting area.

We found clinical pathways in place for stroke, ST Elevation Myocardial Infarction (STEMI) and neck of femur fracture, additionally, the hospital had ring fenced beds to support patients with these emergencies. Paramedics also had pre-hospital pathways in use, for vascular, trauma and cardiac issues, and can divert patients to regional centres if required.

Nutrition and hydration

Patients could access food and drink when needed, and in general, the nutrition and hydration needs of patients were being met within the department, however, our inspection found this was not consistent in the waiting area. This included meeting the needs of patients who were waiting on board ambulances. Patients who required assistance with eating and drinking were seen to be supported by staff and the Red Cross volunteers.

Patient records

We reviewed a sample of nine patient care records and generally found these to be organised and easy to navigate. Handwritten records were found to be legible. However, as highlighted earlier in the report, risk assessments were not routinely completed or reviewed.

Efficient

Efficient

Hospital meetings were held throughout the day to discuss patient flow, where an overview of the department was discussed, including ambulance delays, patients awaiting ward beds and concerns regarding acuity. Whole site meetings were held every two hours during the day. These were usually attended by the nurse in charge of the ED, however, staff felt that it was difficult at times to implement the patient flow actions set at the meetings, due to the frequency of meetings.

We found an appropriate level of communication between staff within the ED, which included the sharing of patient information during shift handover, and details of the actions to help achieve patient flow. This was an improvement on the previous inspection. However, as highlighted earlier, staff were not always ensuring that patients were receiving timely care or treatment based on test

results or presenting condition, which was impacted by the volume of patients throughout the department.

Staff were generally making the best use of available resources, such as medical equipment, supplies, and staff time, to maximize the benefit to patients, however the demands on the unit and overcrowding in the department, made this difficult to maintain.

Quality of Management and Leadership

Staff feedback

HIW issued a staff questionnaire to obtain their views and their experiences of working in the ED. In total, we received 61 responses; all but one respondent said they are permanently based in the department.

Staff responses were generally negative, with most comments relating to staffing issues throughout the department, and patient flow impacting on the ability to care for patients in a timely manner. Less than half the respondents felt satisfied with the quality of care and support they give to patients, and even less felt they would be happy with the standard of care provided by the hospital for themselves, or their friends and family. Just over half said they would recommend their organisation as a place to work (32/58).

Staff comments highlighted several key issues within the emergency department. This included overcrowding, long wait times, and the lack of appropriate clinical spaces, collaboratively compromising patient safety and care quality. Staff also sited poor communication and support from senior management, which was leading to low staff morale and burnout.

Despite the issues highlighted by staff, they generally described themselves as hardworking and dedicated, and were striving to provide the best care possible under difficult circumstances.

Staff suggestions for improvement included better management of patient flow, increased staffing, and more support from senior leadership staff.

Some comments we received were concerning, and include the following:

> *"Whilst I believe that teams on the ground are working very hard and keep patient safety paramount, the overall department is frequently unsafe due to capacity issues. The department itself is well equipped and fit for purpose but every trolley is filled with patients waiting for beds which means the ED area is not used correctly and we cannot assess our emergency patients in a suitable environment. This means that we cannot move patients out of Resus and so critically unwell patients are managed in inappropriate clinical areas eg triage and ambulances. Patients who should be being assessed on the trolleys are having to sit in the waiting room. This means that they are uncomfortable, their care is delayed as they are having to move in and out of spaces for assessments, investigations and treatments. And so whilst I am confident in the skills of staff and the*

overall level of care being provided, the environment in which we are having to deliver this care is not acceptable. If the emergency department could operate as an emergency department and every trolley was available for emergency assessment and care the facility would be incredible...”

“The Department itself is very new, spacious and generally well designed. The ongoing issue is that we are always massively over-capacity and forced to treat patients in inappropriate and unsafe areas (e.g. decontamination room, back of an ambulance, corridors). We often have elderly patients sitting >12 hours in the waiting room or on chairs within the Dept...”

“It is too small to cope with the amount of people that attend. This encumbers effective patient flow through the department. Minor injury departments should be on-site which will help with timely referrals of patients requiring alternative treatments, instead of them then having to travel miles to be treated more appropriately and /or quickly than in the ED setting, and vice versa when they attend a minor injury unit only to be told they have to travel further to attend ED. This would also rotate clinical staff more effectively, keeping skills maintained instead of them being lost because of insular treatment areas.”

The health board must consider the staff comments and seek feedback more widely form ED staff and consider how improvements can be made in the interest of both patients and staff.

Leadership

Governance and leadership

Despite the staff feedback relating to senior leaders and managers highlighted above, in general, we found the leadership and oversight within the ED was appropriate. It was evident that the ED leadership team was striving to improve the service, but the key issue relating to overcrowding was beyond their control, given the wider patient flow issues across the hospital.

Dring the inspection, staff responded positively when presented with areas requiring immediate action. However, several issues require ongoing work and time to implement improvements to fully reduce the risk to patients’ safety and wellbeing.

As highlighted earlier, we issued an immediate assurance letter to the health board regarding several areas where immediate improvement was required. It is concerning that some of these issues were replicated from our previous inspection

in 2022, therefore highlighting a weakness in the health board's governance processes and the ability of the department to sustain improvement.

More work is required from the health board to assure itself that staff understand what is required of them when implementing improvements. In addition, strengthening the governance processes in place is required to monitor action progress and to ensure improvements are sustained. Furthermore, robust executive oversight is needed regarding progress on improvement actions, and for the accountability of sustaining the implemented improvements. This was addressed through our immediate assurance process.

Workforce

Skilled and enabled workforce

We found that maintaining nurse staffing levels was less challenging than that found during the previous inspection, and there was significantly less reliance on agency staff to fill vacancies or absences. We were told staff retention had improved and there was a focus on ensuring new staff were supported appropriately. We were provided with the staff induction pathway and Journey of Excellence (JOE), which new staff follow to ensure they gain all necessary competencies to work in the ED.

Despite the department being very busy throughout our inspection, staff appeared to be coping well with the pressures and were mostly attentive and responsive to patient needs.

We saw regular meetings taking place and were provided with minutes from previous meetings. Processes were in place to share this information with ED staff and wider staff teams throughout the hospital. We were provided with copies of staff newsletters and Educating and Recommendations After Significant Events (ERASE) bulletins and saw these displayed in staff areas.

There was a training and development program in place for all staff, and this was supported by a practice development nurse, who was based in the ED. The practice development nurse was proactive and worked effectively to identify staff training needs and help identify areas needing improvement.

Compliance with the completion of mandatory training was good, over 85%.

We were provided with records of staff appraisals and saw that 67% of staff had received an up-to-date appraisal, processes need strengthening to improve this figure.

The health board must continue with its efforts to ensure all staff receive an annual appraisal in a timely manner.

Culture

People engagement, feedback and learning

Patients and their representatives had opportunities to provide feedback on their experience of the services provided. We saw QR codes displayed in staff and patient areas to encourage feedback.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were provided with information about current complaints and actions taken to resolve them.

Information

Information governance and digital technology

An electronic patient management and records system was in use within the ED to access patients GP records, order investigations such as blood tests and radiology and access investigation results. Staff, in general, commented positively on the system.

Learning, improvement and research

Quality improvement activities

The service is currently in Level 3 of the NHS Wales escalation and intervention arrangements, and staff explained their focus on improving the 12 hour waiting times in the department, and lost ambulance hours as they are held outside the ED. In addition, staff described the weekly meetings held by the executive team to discuss data on patient waiting times and meeting Welsh Government targets relating to addressing patient flow through the department and wider hospital.

We found formal processes in place for audit, and the reporting and escalation of issues within the ED, which were collectively driving forward quality improvement.

We were told that funding had been agreed for six ED consultant posts and a new model of rapid assessment and treatment is being planned. This aims to increase patient flow through the department, with more senior doctors reviewing patients and discharging patients as appropriate.

We were told the renovation work will be completed in the spring of 2025 with waiting room and triage room and existing waiting room becoming clinical treatment and assessment areas, bays and sitting area.

We saw evidence of staff wellbeing initiatives and leaders explained that since the service had received the status of Level 3 monitoring as highlighted above, there has been a focus on improving provisions for staff wellbeing.

Whole-systems approach

Partnership working and development

There were examples of good partnership working between various staff disciplines and professions from other departments, including pharmacy, occupational therapy and physiotherapy.

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
Hot water flask in paediatric area within reach of children.	Risk of scalds or burns.	Escalated to the nurse in charge.	Flask removed to a safe place not accessible to children.

Appendix B - Immediate improvement plan

Service: The Grange University Hospital Emergency Department (ED)

Date of inspection: 02 to 04 October 2024

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.

Findings 1.
We looked at a sample of patient records and found that the risk assessments for patient falls and Visible Infusion Phlebitis (VIP) had not been undertaken in a timely manner.

- We found that some patients had been in the department for over 24 hours and were at risk of falling however a falls risk assessment had not been completed.
- We found examples where VIP risk assessment had not been completed.

Incomplete risk assessments pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action		Responsible officer	Timescale
1.	The health board must ensure that measures are in place to ensure risk assessments for both Falls and Visible Infusion Phlebitis (VIP) are completed promptly, to maintain patient safety.	Safe Care and Timely Care	1.	All staff have been reminded of their responsibility and the importance of timely completion of risk assessments via ED and paediatrics What's app groups	Senior Nurse	Actioned Immediately & Ongoing
			2.	HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed

		3.	ED Staff induction and educational days reinforce the importance of accurate nursing documentation. Also covered in corporate induction	Practice Educators & Senior Nurse	Actioned Immediately & Ongoing Next corporate induction November 2024
		4.	1-patient 1-day audits ensuring all risk assessments and cannula bundles are completed daily by person on ED management. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Actioned Immediately & Ongoing
		5.	Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Actioned Immediately & Ongoing
		6.	All learning to be shared with nursing staff at the time. Any concerns regarding individual	ED Management Team Daily / Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing

		nursing practice to be managed in line with Health Board policies and escalated to senior nursing team		
		7. Monitor MFRA compliance via 1-patient 1-day audits and DECIs. Improvements and learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Senior Nurse / ED Management Team / QPS Leads	Actioned Immediately & Ongoing
		8. Senior Nurse and Head of Nursing to undertake weekly spot checks of patients records and also undertake monthly DECI's	Senior Nurse / Head of Nursing	Weekly / Monthly
		9. ED falls poster shared across Division and is displayed within ED, to raise awareness of risk assessment interventions	QPS Lead / ED Sister Responsible for Falls Improvement work	Actioned Immediately & Ongoing
		10. ERASE bulletin on Cannula bundles developed and shared via email with ED team	Senior Nurse / QPS Team / ED Admin support	Actioned Immediately
		11. All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed

			12. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			13. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			14. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			15. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
			16. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			17. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 2.
HIW is not assured that the management and administration of medicines is robust to maintain patient safety.

- We found examples of expired medication within the paediatric emergency department and in the resuscitation department
- We checked the medication fridges in all areas of the department and found that daily temperature checks were not recorded on multiple occasions
- We found examples on the controlled drugs register where the stock and medication checks had not been completed on a daily basis, in line with the health boards policy.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The health board must ensure that medication stock is checked, and any items where 'use by' dates have expired are disposed of appropriately. The health board ensure medication fridge temperature checks are completed regularly. The health board ensure controlled drugs stocks are checked and recorded daily.	Safe and Effective Care	18. All Staff have been reminded of their responsibility and importance of undertaking daily checks and that these checks include reviewing expiry dates of all products via ED and paediatrics What's app groups	Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing
			19. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
			20. Daily Omnicell fridge temperature report already in place for Majors and Resuscitation - emailed daily to ED Senior Nurse and Band 7 team. This is now in place in paediatrics and monitored	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing

		21. Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		22. The paediatric department has implemented a new allocation checklist to monitor completion of resuscitation trolley checklist and checking all drugs are in date	ED Band 7 Paediatric Lead	October 2024
		23. ERASE bulletin to raise awareness of CD checks, storage and disposal in development with wider Divisional and Pharmacy colleagues	QPS Lead	December 2024
		24. Senior Nurse and Head of Nursing will undertake monthly audits of all checklists to ensure compliance	Senior Nurse / Head of Nursing	Monthly
		25. All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed
		26. Improvement plan along with updates on actions will be presented to the ED Senior	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly

			Management Team (SMT) meeting and Divisional Management Team (DMT)		
			27. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			28. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			29. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
			30. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			31. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 3.
HIW was not assured that all risks to health and safety were managed appropriately.

- We reviewed the resuscitation equipment checking process and records for the resuscitation department, paediatric emergency department and major's department and found that the emergency equipment trolley and defibrillator checks had not been recorded on multiple occasions.

- This meant that we could not be assured that the resuscitation equipment was being regularly checked to ensure that all required items were available and that they were safe to use in an emergency.

  These pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The health board must ensure that checks of resuscitation equipment are undertaken and recorded on a regular basis in line with health board policy.	Safe and Effective care	32. All staff have been reminded of their responsibility and the importance of daily checks of the resuscitation trolleys. The person on ED management will check each morning that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	Senior Nurse / Head of Nursing / ED Band 7 Team	Actioned Immediately & Ongoing
			33. Monthly resuscitation trolley checks, as per ABUHB protocol, to be undertaken to include breaking of seal, and drug expiry check. The person on ED management will check the first day of each month that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing

		34. Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing
		35. Internal Alert regarding the importance of resuscitation trolley checks to be added to the Health Board's intranet carousel	Senior Nurse for Resuscitation Services	Completed
		36. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
		37. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		38. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		39. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		40. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025

		41. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

Findings 4.

HIW was not assured that all aspects of care were being delivered in a safe and effective manner.

- We looked at one patient's care notes and found that results of investigations were not acted on in a timely manner.
- We found an example of deterioration in a patient's condition due to the delay in commencing appropriate treatment.
- We were not assured that staff were appropriately monitoring the patient in a timely manner.

These can increase risk to patient safety.

Improvement needed		Standard/ Regulation	Service action		Responsible officer	Timescale
4.	The health board must ensure results of blood tests and investigations are reviewed and action is taken promptly to avoid delays in necessary treatment.	Safe and Effective care	42.	There is continued work across the Health Board to improve the flow of patients through the ED to ensure patients are cared for in the appropriate environments	Head of Operations	Actioned Immediately & Ongoing
			43.	Any delays to treatment due to system flow to be escalated to the Emergency Physician in Charge (EPIC) and Operations team to support flow	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Actioned Immediately & Ongoing
			44.	Any concerns regarding patient care and treatment to be escalated at the time to the speciality and the most senior clinician responsible and if required a Datix to be completed and appropriate actions undertaken	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Actioned Immediately & Ongoing
			45.	All referred patients in ED to be reviewed daily with a clear medical plan and appropriate reviews undertaken	Clinical Director's for Specialties	Actioned Immediately & Ongoing
			46.	If at handover medical plans or nursing care/assessments have not been implemented then reasons for this need to be identified and if required a Datix completed with appropriate investigation and outcomes	Senior Nurse / Clinical Director	Actioned Immediately & Ongoing
			47.	Staff induction and educational days reinforce the importance of ensuring	Senior Nurse / Practice Educators	Actioned Immediately & Ongoing

		clinical concerns are escalated timely as part of various clinical sessions and scenarios		
		48. ERASE bulletin on the importance of checking bloods tests developed and will be shared across ED and wider Divisional teams	QPS Lead	December 2024 for ED
		49. All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed
		50. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
		51. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		52. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		53. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		54. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Head of Nursing / Divisional Nurse	January 2025
		55. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

			56. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 5.

HIW was not assured that the stock of single use medical equipment was being checked. This posed a risk to patient safety.

- We found examples of expired single use medical equipment within the paediatric emergency department and in the resuscitation department, such as male external urinary sheaths and some equipment from a 'Can't Intubate Can't Oxygenate (CICO)' pack which included a Cuffed Oral Endotracheal Tube (COETT), 5ml syringe and Rapi-fit Connector.

  These issues pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The health board must ensure that the stock of single use medical equipment is monitored and any items where 'use by' dates have expired, are disposed of appropriately.	Safe and Effective care	57. The grab bag was immediately removed from use during the HIW inspection	Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing
			58. All staff will check expiry dates of equipment prior to use. This will be included in November's Nursing News	Senior Nurse	November 2024
			59. Several reviews of the department have been undertaken to ensure all products are in date / any excess equipment removed from use immediately	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing

		60. All staff have been reminded of their responsibility and the importance of daily checks of the resuscitation trolleys. The person on ED management will check each morning that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		61. Monthly resuscitation trolley checks, as per ABUHB protocol, to be undertaken to include breaking of seal, and drug expiry check. The person on ED management will check the first day of each month that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		62. Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		63. Senior Nurse and Head of Nursing will undertake monthly audits of all checklists to ensure compliance	Senior Nurse / Head of Nursing	Monthly
		64. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed

		65. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		66. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		67. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		68. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
		69. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
		70. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

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): **Chris Morgan**

Job role: **Divisional Nurse - Urgent Care**

Date: **20 November 2024**

Appendix C - Improvement plan

Service: The Grange University Hospital Emergency Department (ED)

Date of inspection: 2 to 4 October 2024

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	Standard / Regulation	Service action	Responsible officer	Timescale
1	There remains to be significant challenges in the flow of patients through the department.	The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.	Timely care	1) Ongoing - 24/4 to reduce congestion in ED and minimise crew delays (0 Patients >24hrs in ED & 0 Crews > 4hrs)	General Manager Urgent Care / Director of Operations	Completed /Ongoing
				2) Continued monitoring of ED performance as part of Welsh Government Enhanced Monitoring	General Manager Urgent Care / Director of Operations	Completed/ Ongoing
				3) Weekly meetings in place with members of the executive board to review patient flow across the Health Board & Implement improvement plans	Director of Operations	Completed/ Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			4) 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	Clinical Director for Emergency Medicine	Completed / Ongoing
			5) X6 Consultants appointed to improve Wait to be Seen Time and look to implement early Rapid Assessment / Stream to Alternative pathways	Clinical Director for Emergency Medicine	Completed / Ongoing
			6) Review of Flow Centre Pathways to ensure patients go to the right place first time	Divisional Director Urgent Care / Medical Director	March 2025
			7) Development of further pathways for Same Day Emergency Care (SDEC)	Divisional Directors for Urgent Care / Medicine & Surgery	Completed / Ongoing
			8) Continued work with WAST to reduce conveyance rates and	Associate Director for Patient	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
					utilise alternative pathways to ED	Transportation Services	
				9)	Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
2	We found that patients in the waiting area had not had a pain score assessment and had not been given analgesia.	The health board must develop a process where patients within the waiting room receive a pain score assessment and analgesia if required.	Timely care	10)	All staff have been reminded of their responsibility and importance of timely pain assessments and provision of analgesia (via PGD or prescription)	Senior Nurse / Clinical Director	Completed / Ongoing
				11)	All patients are assessed at triage and where required analgesia provided	Band 7 Team / Senior Nurse	Completed / Ongoing
				12)	Rapid Assessment Nursing team to ensure all patients receive ongoing pain assessments and analgesia. Escalate to medical staff where required	Band 7 Team / Senior Nurse	Completed / Ongoing
				13)	1-patient 1-day audits ensuring all risk assessments are completed daily by person on	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			ED management/ Majors Lead. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			14) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			15) CIVICA data shared with wider teams	Senior Nurse / Head of Nursing	Completed and Monthly
			16) All referred patients to be moved to the respective assessment areas at the point of referral	Operations Team	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				17) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
				18) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing
				19) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				20) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
3	There was poor oversight of the waiting area and unwell patients	The health board should develop a process where patients in the	Timely care	21) All staff have been reminded of their responsibility and importance of timely risk assessments	Senior Nurse	Immediately & Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
were not regularly monitored or risk assessed.	waiting area are regularly monitored, and patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.		22) All patients will be assessed at triage for falls risk and developing pressure areas and will be escalated to the NIC to try and find an appropriate clinical area within the main ED	Band 7 Team / Senior Nurse	Ongoing
			23) Rapid Assessment Nursing team to ensure all patients receive ongoing falls monitoring / Pressure Area Management	Band 7 Team / Senior Nurse	Completed / Ongoing
			24) Patients identified at triage to be a falls risk or potential deterioration in pressure areas to be prioritised for a space in the ED whilst balancing other clinical risks	Nurse in Charge / EPIC / Operations team	Completed / Ongoing
			25) Nurse in Charge (NIC) to escalate all clinical concerns to the operations team and the Emergency Physician in Charge (EPIC) of ED	Nurse in Charge / EPIC	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			26) All referred patients to be moved to the respective assessment areas at the point of referral	Operations Team	Completed / Ongoing
			27) ED Staff induction and educational days will reinforce the importance of accurate nursing documentation including risk assessments. Also covered in corporate induction	Practice Educators & Senior Nurse	Immediately & Ongoing
			28) 1-patient 1-day audits ensuring all risk assessments are completed daily by person on ED management or major's lead. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			29) Dignity and Essential Care Inspections (DECI) in place. All	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			30) All learning to be shared with nursing staff at the time. Any concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse / Head of Nursing	Immediately & Ongoing
			31) Monitor MFRA compliance via 1-patient 1-day audits and DECIs. Improvements and learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Senior Nurse / ED Management Team / QPS Leads	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			32) Senior Nurse and Head of Nursing to undertake weekly spot checks of patients records and undertake monthly DECI's	Senior Nurse / Head of Nursing	Completed Weekly / Monthly
			33) Continue to monitor Datix for potential learning opportunities	Senior Nurse / Head of Nursing	Completed / Ongoing
			34) New waiting room currently being built will provide improved patient visibility and availability of clinical space	Urgent Care Triumvirate	May 2025
			35) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			36) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				37) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				38) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
4	Risk assessments had not been completed in the rooms used to assess mental health patients, to identify potential risks to both patient and staff safety.	The health board must ensure staff are adequately supported to identify potential risks to patient and staff safety and complete a risk assessment where applicable.	Risk Management	39) Management of CAMHS and adult Mental Health patients is on departmental risk register	Divisional Management Team	Completed / Ongoing
				40) Patients will be assessed at the point of triage for any potential mental health concerns and then supported in an assessment room with direct vision of nursing staff and all risks removed	Band 7 Team / Senior Nurse	Completed / Ongoing
				41) If required enhanced staffing put in place based on clinical need and risk	Band 7 Team / NIC / Senior Nurse for ED or Paediatrics	Completed / Ongoing
				42) Crisis liaison service available 24/7 with CAMHS support	Crisis Liaison service	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				43) Mental Health & Deliberate Self harm Triage Assessment tool in development	Divisional Director / Senior Nurse	Feb 2025
5	We found that staff did not have an appropriate view of patients in the waiting area which meant patient safety was at risk.	The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.	Risk management	44) Waiting room is currently monitored via a series of video cameras with a team of nurses overseeing this area	Nurse in Charge / EPIC	Completed / Ongoing
				45) X3 RN's & 2 HCSW's are assigned to oversee the waiting room along with an ECG technician. 46) X4 RN's & 1 HCSW also work in triage and these staff also support the waiting room	Nurse in Charge / Senior Nurse	Completed / Ongoing
				47) Catering staff provide a trolley service x3 times a day - tea/coffee/toast/ lunch / dinner and sandwiches also available on request	Facilities	Completed / Ongoing
				48) Red Cross provide support to the waiting room along with hospital volunteers	Nurse in Charge / Senior Nurse	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			49) Wellbeing assistant role to support waiting room	Executive Director of Nursing	March 2025
			50) All patients at clinical risk to be highlighted to the NIC or EPIC and moved to another area of the ED	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Completed / Ongoing
			51) New waiting room currently under construction will provide improved patient visibility	Urgent Care Triumvirate	May 2025
			52) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			53) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			54) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action		Responsible officer	Timescale
6	We found COSHH equipment in areas that were accessible to patients and visitors which posed a threat to their safety.	The health board must ensure that all COSHH equipment is stored safely in a locked cabinet as stated in the COSHH regulations.	Risk management	55)	All COSHH equipment to be stored in cabinets within appropriate clinical areas	Senior Nurse / ED Band 7 Team	Completed / Ongoing
				56)	Sluices to be reviewed by Infection Prevention and Control (IP&C) & Works & Estates (W&E) to see if Locks or swipe card access is appropriate	IP&C & W&E	Dec 2024
7	We noted there was no ligature free assessment space, toilet or wash facility within the paediatric ED and no risk assessment had been completed for this.	The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Risk management	57)	Management of CAMHS and adult Mental Health patients is on departmental risk register	Divisional Management Team	Completed / Ongoing
				58)	Patients will be assessed at the point of triage for any potential mental health concerns and then supported in an assessment room with direct vision of the nurse's station and all risks removed	Paeds team / Band 7 Team / Senior Nurse	Completed / Ongoing
				59)	If required enhanced staffing put in place based on clinical need and risk	Band 7 Team / NIC / Senior Nurse for ED or Paediatrics	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				60) Crisis liaison service available 24/7 with CAMHS support	Crisis Liaison service	Completed / Ongoing
				61) Mental Health & Deliberate Self harm Triage Assessment tool in development	Divisional Director / Senior Nurse	Feb 2025
				62) Review of area to assess ability to make an assessment area ligature free	Estates Manager / Senior Nurse	Dec 2024
				63) This action will be reported through the Patient Quality Safety and Oversight Committee	Executive Director of Nursing	Quarterly
8	We witnessed staff failing to remove PPE when they left an area of infection which can cause infection to spread.	The health board must ensure staff use and remove PPE appropriately to prevent the spread of infection.	Infection, prevention and control and decontamination	63) All staff have been reminded of the correct process for using PPE	ED Band 7 Team / Senior Nurse	Completed / Ongoing
				64) IP&C spot check of Respiratory Assessment Area	IP&C Nurses	Completed / Ongoing
				65) Senior Nurse and Head of Nursing to undertake daily spot checks	Senior Nurse / Head of Nursing	Completed / Ongoing
9	We reviewed the health boards medicines management policy	The health board must ensure the medicines management policy is	Medicines management	66) Medicines management policy is being reviewed	Lead Pharmacist	Review date extended to Feb 2025 while under

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
	and found this had not been recently reviewed.	reviewed and approved in a timely manner.					review, as agreed with Chair of CSPG Medicines Management Policy Code of Practice
10	We inspected records for Controlled Drugs and saw that records were not routinely completed in all areas of the ED. We saw controlled drug checks had been missed in the majors and Respiratory Assessment Zone (RAZ) areas.	The health board must ensure that controlled drug checks are completed in all areas of the emergency department.	Medicines management	67)	All Staff have been reminded of their responsibility and importance of undertaking daily checks	ED Band 7 Team / Senior Nurse / Head of Nursing	Immediately & Ongoing
				68)	Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge or ED area leads. This includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Immediately & Ongoing
				69)	Improvement plan along with updates on actions will be presented to the ED Senior	Senior Nurse / Head of Nursing /	SMT Monthly / DMT Quarterly

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			Management Team (SMT) meeting and Divisional Management Team (DMT)	Divisional Nurse	
			70) Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			71) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			72) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			73) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
			74) Regular monitoring of improvement plan via Patient,	Head of Nursing /	Quarterly

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
					Quality, Safety, Learning & Improvement Forum (PQSLI)	Divisional Nurse	
11	We witnessed two occasions when medication was administered and not signed for on the prescription chart. This means there was a risk that medication could be administered twice and potentially overdose the patient.	The health board must ensure staff sign the medication record promptly after administering medication, to avoid overdose or drug errors.	Medicines management	75)	All staff will administer medication in line with Health Board policy. Any staff who do not will be managed in accordance with the Health Board's Policy for Managing and Supporting Staff Following a Medication Error	Senior Nurse / Practice Educators / Head of Nursing	Completed & Ongoing
				76)	Staff induction and educational days reinforce the importance of medication management	Senior Nurse / Practice Educators	Immediately & Ongoing
				77)	Datix to be completed for all medication errors	ED team	Completed / Ongoing
				78)	Datix is reviewed daily and appropriate actions taken	Senior Nurse / Head of Nursing / Divisional Nurse	Completed / Ongoing
				79)	1-patient 1-day audits which will check medication charts. All learning to be shared with	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			80) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			81) QPS slides presented monthly at Divisional Assurance to the COO	Head of Nursing / Divisional Nurse	Completed / Ongoing
			82) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
12	We found the process for medication fridge temperature checks was not robust to ensure messages regarding out-of-range temperatures was acted on promptly. We were told an email was sent to the nurse in charge if the temperature is out of range. However, we were told that messages are not always checked due to the nurse in charge providing clinical support. Therefore, we	The health board must ensure a robust process is in place to report issues with medication fridge temperatures to ensure these can be addressed promptly.	Medicines management	83)	Daily Omnicell fridge temperature report in place for Majors and Resuscitation - emailed daily to ED Senior Nurse and Band 7 team. This is now in place in paediatrics and monitored	ED Band 7 Team / Senior Nurse	Completed / Ongoing
				84)	All temperature faults reported to pharmacy/works & estates immediately so appropriate action can be taken	NIC / Senior Nurse / Divisional Pharmacist	Completed / Ongoing
				85)	Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
				86)	Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	were not assured that the system was robust and efficient to ensure temperature-controlled medication was being stored appropriately.			87) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				88) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
13	For those we checked, we found all patients had an identification band in place. However, allergy bands were not always worn by patients with known allergies, neither were falls risk bands worn where applicable.	The health board must ensure that allergy bands and falls risk bands are placed on patients where applicable.	Medicines management	89) Allergy bands are to be placed on all patients with a known allergy and documented on their medication chart	ED Band 7 Team / Senior Nurse / Head of Nursing	Completed / Ongoing
				90) All patients identified with an allergy or a falls risk to have the required identification band	ED Band 7 Team / Senior Nurse / Head of Nursing	Completed / Ongoing
				91) 1-patient 1-day audits which will check medication charts and falls risk assessments. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be	ED Management Team Daily / Senior Nurse	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			managed in line with Health Board policies and escalated to senior nursing team		
			92) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			93) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			94) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				95) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				96) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
14	There was no assurance that elderly patients sitting in the waiting room had regular skin inspections.	The health board must ensure that patients in the waiting room are assessed for their risk of pressure damage and re-evaluated as indicated by the risk assessment.	Preventing pressure and tissue damage	97) Please refer to actions in Point 3	Please refer to Point 3	Please refer to Point 3
15	Staff responses to the online survey were mixed with some staff critical of staffing levels and patient flow.	The health board must consider the staff comments and seek feedback more widely from ED staff and consider how improvements can be	Staff feedback	98) Bi-annual review of ED staffing in place	Senior Nurse / Head of Nursing / Divisional Nurse	Completed / Ongoing
				99) Regular staff wellbeing sessions provided	Clinical Director /	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	made in the interest of both patients and staff.			Senior Nursing / Divisional Management Team	
			100) Senior nursing, medical and Divisional management staff are visible daily in department so staff can raise concerns	Divisional Triumvirate Senior Nurse / Clinical Director / Head of Nursing / Divisional Management team	Completed / Ongoing
			101) Staff QR code in place for staff to raise concerns or ideas (this can be done anonymously). Weekly meeting in place to review submissions and provide staff with a response	Divisional Triumvirate Senior Nurse / Clinical Director / Head of Nursing / Divisional Management team	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			102) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			103) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Ongoing
			104) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			105) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
			106) Formal Nurse Staffing Levels Assessment to be completed annually in line with the NSWLA	Executive Director of Nursing	Annually

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				107) EDoN and Deputy EDoN visits with the Divisional Nurse	Executive Director of Nursing (EDoN)	Quarterly
16	Appraisal compliance rates were 67% meaning a significant number of staff had not received an appraisal within the last year.	The health board must continue with efforts to ensure all staff receive an appraisal.	Workforce	108) Monthly reports provided by workforce and reviewed at Senior Management Team (SMT) and Divisional Management Team (DMT) - 109) Improvement plan developed and in place	Band 7 team / Senior Nurse / Head of Nursing / Divisional Nurse / SMT / DMT	Completed / Ongoing
				110) PADR data presented monthly at Divisional Assurance with COO	Triumvirate team	Completed / Ongoing
				111) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Divisional Nurse/ Triumvirate Team	Completed / Ongoing

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): Chris Morgan

Job role: Divisional Nurse

Date: 12 December 2024