Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Unit, Glangwili General Hospital, Hywel Dda University Health Board

Inspection date: 05, 06 and 07 December 2022

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

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Patients and carers were generally satisfied with the service they had received when using the Emergency Unit at Glangwili General Hospital.

However, they expressed frustration with waiting times and the lack of updates on their care and treatment.

We found good arrangements were in place to assess and monitor patients arriving by ambulance. However, we were not always assured that patients self-presenting to the unit were being triaged in a timely manner or being regularly re-assessed or observed while waiting to be seen by doctors.

A suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated.

Staff were generally positive about their immediate line managers and told us the health board takes positive action on health and wellbeing. However, less favourable responses were received regarding addressing issues escalated by staff and staffing levels in the unit.

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

What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Unit at Glangwili General Hospital, Hywel Dda University Health Board on 05. 06 and 07 December 2022.

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

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

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

The feedback we received from patients and carers indicated they were generally satisfied with the service they had received at the Emergency Unit.

Their experiences, however, were negatively affected by the length of time some patients were required to wait to be seen or admitted to a ward, the lack of updates on their care and treatment and the environment of the unit.

Significant challenges with maintaining patient flow through the hospital meant patients were required to wait in the unit for longer periods than they should expect. Overcrowding and a lack of facilities in the unit impacted negatively on staff being able to maintain patients' privacy and dignity.

While there was a Paediatric Care and Assessment Unit (PACU), there were still delays in children being seen. This meant children were sometimes required to wait in the main waiting area, which was unsuitable for them.

Where the service could improve

- The health board must take suitable action to promote the comfort of patients, especially where patients are required to wait for extended periods
- The health board must take suitable action to protect patient confidentiality
- The health board must take suitable action to ensure staff provide patients with regular updates about their care and treatment.

What we found this service did well

- We saw staff treating patients with respect, courtesy and politeness at all times
- We saw efforts were made to deliver the 'Active Offer'.

Patients told us:

"Top notch service carried out under extremely difficult circumstances. Needs more beds made available."
"Staff were excellent, but they were rushed off their feet and disgruntled …"
"I went in as an emergency not with any optimism. However the hospital established what treatment I needed after tests. I am very satisfied."
"The receptionist was lovely and helpful."
"Staff are amazing and dedicated. They take such care with patients."

When asked what could be done to improve the service, patients told us:

"By not cramming … patients into a small room and making them sleep on chairs or the floor."
"More comfortable seating. After 24 hours your bottom is sore. Vomit cleaned up in less than 3.5 hours would be better."
"Excessive wait times for bed and very little communication in the mean time."
"More staff, more beds."

Delivery of Safe and Effective Care

Overall Summary

We found staff worked extremely hard to provide patients with safe and effective care at a time when the service was under considerable pressure.

We did identify a number of improvements were needed, some of which required immediate action by the health board to promote patient safety.

Where the service could improve

Immediate assurances:

- We found storerooms were not secured to prevent unauthorised access. This may have presented a risk to patients or other persons gaining access to these rooms and those in the vicinity of these rooms
- We found overcrowding in the unit due to significant pressure on the service. This impacted negatively on patients' privacy, dignity and comfort. It also posed a potential infection control risk
- We found checks of resuscitation equipment trolleys were not always being recorded. Therefore, we were not assured checks were being conducted to confirm the necessary equipment was available in the event of an emergency
- Within the sample of records were reviewed, there was not always evidence of patients in the waiting room being reviewed after being seen by the Triage Nurse. Therefore, we were not assured patients in the main waiting were being regularly reassessed
- Within the sample of records we reviewed, sepsis screening was not always completed. Therefore, we were not assured sepsis screening was being consistently performed
- We found when PACU did not have capacity to see children presenting to the unit, they were required to wait in the main waiting room of the unit, which was not a suitable environment for children. Therefore, we were not assured suitable arrangements are in place to promote the safety and wellbeing of children.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board must take suitable action to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed

- The health board must take suitable action to promote effective handwashing by staff working in/visiting the unit.
- The health board must take suitable action to ensure staff record when oxygen therapy is administered
- The health board must take suitable action to respond to staff concerns about the provision of monitoring equipment
- The health board must take suitable action to ensure audit activity is fully completed.

What we found this service did well

- We found staff had assessed patients for their risk of developing pressure damage and saw evidence of ongoing monitoring of patients' skin state and pressure relieving equipment being effectively used
- We saw effective arrangements were in place to assess and monitor patients waiting in ambulances to maintain patient safety
- Generally, we saw medicines were safely managed in the unit
- We saw arrangements were in place for the safe administration of blood products
- We saw good examples of 'safety netting' advice given to patients or their carers
- We saw patient records were easy to navigate, handwritten entries were legible and logically set out.

Quality of Management and Leadership

Overall Summary

A suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated.

Staff responses made within the HIW questionnaire were mixed. Generally, staff responses were positive regarding their immediate line managers, that the hospital encourages teamwork, that patient care is the health board's top priority and the health board takes positive action on health and wellbeing.

However, less favourable responses were received regarding senior managers acting on feedback, addressing issues escalated by staff and staffing levels in the unit.

The health board had a comprehensive mandatory training programme, however we identified staff training compliance needed to be improved.

Where the service could improve

- The health board must take suitable action to ensure staff are aware of the escalation on call arrangements and to provide regular updates on the action taken during periods of escalation
- The health board must take suitable action to improve staff compliance with mandatory training
- The health board must take suitable action to respond to the less favourable comments made by staff during the course of our inspection.

What we found this service did well

- Staff told us the health board takes positive action on health and wellbeing
- Staff felt their training or development had helped them do their jobs more effectively and safely.

Staff told us:

"Nobody listens,.you don't need a degree or surveys galore to realise that the problem in ED is the fact that it is the doorway to the hospital,. unfortunately the exit doors within the hospital are locked tight and no one moves. Paediatrics need to use PACU to see patients rather than pick and choose."
"We need more staff and rooms department too small for the amount of patients attending."
"I am confident in everybody that I work with and feel management are doing an amazing job with the resources available versus volume of patients. A problem that we have is that we have been overcapacity for so long we have accepted this to be the norm."
"We are expected to maintain emergency front line services and then also act as a ward with all the documentation/ risk assessments etc they come with long stays."
"All specialities and other hospital departments need to work with ED as currently we are carrying massive risks. It currently feels we have to fight for support and the correct treatment and care for all our patients."
"The Emergency department is lucky to have a caring, kind senior nurse whose main priority is the well being of her staff and quality of patient care. She is always approachable no matter what the problem is."

When asked what could be done to improve the service, staff told us:

"The ED department could thrive if it was allowed to be one rather than a holding area for patients from all specialities."
"Allowing staff to work in a safe environment. Allowing patients to have the dignity and respect they deserve. And for senior management to realise that the department is unsafe, and staff are very unhappy."
"Give us flow of patients out of the ED: make wards responsible for their part in ED overcrowding."
"Better communication. Safer staffing levels. Safer skill mix. Adequate equipment fit for purpose. Senior staff on floor more.

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

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

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