Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Inspection Summary Report

## Emergency Department, Ysbyty Glan Clwyd
## Follow-up Inspection
## Inspection date: 28, 29 and 30 November 2022
## Publication date: 29 March 2023

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

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We saw improvements in many areas of the Emergency Department (ED), but there remained some areas of significant challenge, which were not progressing at the pace required.

Staff continued to work incredibly hard under challenging conditions. Many staff members went above and beyond to ensure patients were well cared for. However, their efforts were often hindered by the number and acuity of patients attending the department.

The majority of patients we spoke with were happy with the way that staff interacted with them, and the care provided. However, patients were critical of waiting times. Although an improvement on what we saw during the previous inspection, we found that some patients had been waiting to see a doctor for over three hours.

We found that the dignity of patients was affected by either lengthy waits within the department, or as a result of being accommodated in corridor areas.

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, follow-up inspection at the emergency department at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board on 28, 29 and 30 November 2022.

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

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

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

# Quality of Patient Experience

## Overall Summary

We saw improvements in many areas of the Emergency Department (ED), but there remained some areas of significant challenge, which were not progressing at the pace required.

Staff continued to work incredibly hard under highly challenging conditions. Many staff members went above and beyond to ensure patients were well cared for. However, their efforts were often hindered by the number and acuity of patients attending the department.

The majority of patients we spoke with were generally happy with the way that staff interacted with them, and the care provided. However, patients were critical of waiting times. Although an improvement on what we saw on the previous inspection, we found that some patients had been waiting to be seen by a doctor for over three hours.

We saw the vast majority of staff speaking with patients and their relatives in a polite, professional and dignified manner.

We found that the dignity of some patients was affected by either lengthy waits within the department, or as a result of being accommodated in corridor areas.

We also found that the overall culture in the department did not always promote accountability and dignified and respectful patient care.

## What we found this service did well

- Comfortable and well decorated relatives' room
- Provision of food and drink to patients
- Involvement of family and friends in the provision of care
- Availability of leaflets and posters inviting feedback from patients about the service provided
- Notices informing patients and visitors about the action taken by the health board as a result of the concerns or suggestions made.

## Where the service could improve

Immediate assurances:
HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff.

The culture in the department did not always promote dignified and respectful patient care. For example, we found that:

- Some patients felt unsupported, forgotten and uninformed. Others told us that some staff were not always kind and courteous to them
- Some staff were rude and hostile during interactions with the inspection team and patients with a small number of staff overheard using derogatory language to describe patients.

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

- Ensure that patients are kept informed of their journey through the ED and what is happening to them in relation to care and treatment.

**Patients told us:**

Patients provided us with the following comments:

***"Impressed that matron went around waiting room to issue masks to patients…"***

***"Very happy with treatment."***

***"Less waiting, more staff."***

***"Better liaison between shifts."***

# Delivery of Safe and Effective Care

## Overall Summary

There were significant challenges with patient flow through the department. This was due, in the main, to delays in discharging patients from other areas of the hospital which meant there were insufficient numbers of spaces to move patients into. This meant that some patients were spending in excess of 48 hours in the department.

We found improved oversight of the waiting area including a registered nurse allocated to the front door. When there was no nurse available, a health care assistant (HCA) was assigned to this role. There was a lack of oversight from more senior staff of the waiting area, particularly when the nurse role was not filled.

Patients in the waiting room were offered regular drinks and food.

We observed a patient emergency in the waiting room, and this was managed in a highly effective manner, with immediate attendance and resuscitation by the team.

We found the main areas within the ED to be generally clean and tidy and that high throughput areas and touchpoints, including toilets and door handles, were being cleaned regularly and to a good standard. However, we found some evidence that general infection prevention and control measures were not sufficiently robust in all areas, to include clinic and treatment rooms.

We found that health and safety risks were not appropriately managed within the department and there was an inconsistent approach to the completion of risk assessments.

Medication management processes were not sufficiently robust and safe.
Staffing remained problematic. There continued to be over reliance on agency staff with the management team within the ED struggling to ensure that there were sufficient staff on duty in order to provide safe and effective care.

## What we found this service did well

- Daily medical in-reach to assess patients
- Staff working in the discharge lounge assess and prompt the movement of patients from ED

- Doctors part of staff communication group
- Patient feedback shared with staff
- Learning from incidents and national reviews discussed and implemented
- ED medical staff input
- Slight improvement in documentation
- Improvement in oversight of waiting room
- Separate paediatric area and availability of specialist paediatric consultant nurse and doctor
- Designated pharmacy services within the ED
- Designated occupational therapists and physiotherapists within the ED.

## Where the service could improve

Immediate assurances:
HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff.

- Not all risks to health and safety within the ED were managed appropriately. For example, we found that:
  - There was a lack of oversight of the waiting area by more senior staff, particularly when there was no qualified nurse covering this role
  - Self-harm and suicide risk assessments were not always completed for patients presenting with these issues
  - Risk assessments such as pressure damage and falls risks were not being undertaken routinely for patients who had been in the department for over 24 hours. This exposed patients to risk of harm and meant mitigations were not always put in place
  - Storage cupboards were unlocked and unsecured throughout the inspection. One cupboard contained scalpels
  - Dirty and clean utility rooms, which contained bleach and other substances hazardous to health, were unlocked and accessible to members of the public
  - Automatic doors leading to the ambulance bay and resuscitation area were not working. This presented a risk of unauthorised access
  - Consultation rooms and connecting doors were unlocked, presenting a risk of unauthorised access from the waiting room into the main department.

- Not all aspects of care were being delivered in a safe and effective manner. For example, we found that:
  - There were significant delays in patients being triaged and this placed patients at significant risk of harm

- These delays exceeded two hours at times and included patients with time critical conditions such as stroke and chest pain. This meant that, in some cases, patients could not be offered time critical interventions due to the delays taking them outside of the recognised critical intervention timescales. This included one patient who had suffered a stroke
- The acuity of patients walking into the department was high. Patients with chest pain, heart problems and stroke were all routinely attending the department. Patients told us that this was due to lack of available ambulances in the community and their lack of confidence that an ambulance would get to them. Some patients told us that they had been asked to make their own way to the department as there were no ambulances available. This resulted in acutely ill patients arriving at ED reception which then resulted in the triage nurses having to provide more interventions and detail gathering which led to delays
- There was a system in place for reception staff to alert triage staff. However, this did not always work well, and time critical conditions were missed
- The reception team had not received any training on non-medical triage.
- Time critical conditions were not always managed in a safe and effective way. This presented a significant risk of harm to patients
- There was a lack of cohesion and team working between speciality doctors and ED. This was most evident in urology and medical services, where ED doctors experience significant issues in obtaining specialist reviews for patients who required them. In some cases, patients were uninformed, in pain and at risk of harm. This also meant that nursing staff struggled to escalate patients who required specialist review when they deteriorated. This also significantly impacted flow. In some cases, when patients were eventually seen by speciality doctors, they were discharged immediately following review. This meant that they would not have required a bed space had they been seen earlier. There were documented incidents where speciality doctors had refused to see patients and were unwilling to support ED staff. This led to backlog in ED which then resulted in patients being accommodated in inappropriate areas
- Observations were not undertaken at a frequency that would detect deterioration in a patient's condition at an early stage. The National Early Warning System (NEWS) was in place, which is good practice. However, staff were following this to an extreme degree and not using their clinical judgement and deviating when a patient's condition indicated. NEWS scoring is a helpful tool for recognising deterioration in relatively stable patients. However, due to the unstable and urgent nature of patients presenting to ED clinical judgement needs to be applied alongside this. This includes the use of specific standards and guidelines from professional bodies such as the Royal College of Emergency Medicine (RCEM) and the National Institute for Health and Care Excellence (NICE). The RCEM standards for vital signs state all

patients should receive a full set of observations within 20 minutes of arrival. They further state that any abnormal parameters must result in a repeat set of observations within 60 minutes. This was not met in any of the cases we reviewed
    - Patients at risk of sepsis were not always identified and managed effectively and in a timely way. There was an absence of sepsis screening despite patients being in the ED for over 24 hours. This meant that key interventions recommended by NICE, which are required to minimise risk of harm and death, were not implemented in a timely way. In some cases, patients waited 12 hours for their first dose of antibiotics despite being diagnosed with sepsis. In other cases, required blood tests were not taken and oxygen was not administered as needed
    - There were significant challenges with patient flow through the department. This was due, in the main, to delays in discharging patients from other areas of the hospital which meant there were insufficient numbers of spaces to move patients into. This meant that some patients were spending in excess of 48 hours in the department. The staff in the department are not trained or used to managing patients who are past the initial urgent stage of their treatment. In addition, the department is not set up to accommodate patients for this length of time. These issues significantly impacted on patient safety, experience and dignity
    - During out of hours periods, staff were consistently under pressure from site managers and senior managers to make space for patients. This included pressure to place adult patients in the paediatric area. This presents a significant child safety and safeguarding risk
    - Multiple patients with time critical and high-risk conditions were having to sit on chairs in the waiting room for long periods, when they should have been cared for on a trolley, or bed, in a more appropriate location.
    - There was a lack of space for doctors to examine patients which resulted in significant delays
    - There were significant delays in offloading patients from ambulances. These delays meant that ambulances were not available for other emergencies within the community.

- Medication management processes were not sufficiently robust and safe. For example, we found that:
    - Medication left unattended on work surfaces. These included fluids containing potassium and tranexamic acid
    - Several items of medication were found to be out of date within the fridge in the clean utility area. This fridge also contained several insulin pens and vials of medication prescribed to patients no longer accommodated in the department
    - Used eye drops container found in an unattended consulting room
    - Gaps in medication storage fridge temperatures records.

- There was not always sufficient staff on duty in order to provide safe and effective care. For example, we found that:

- Nurse staffing remained a significant challenge. There were frequent gaps in rotas from long and short-term absence. This was significantly impacting on staff ability to deliver safe and effective care
- Last minute absences were a frequent occurrence, as were last minute agency and bank staff cancellations. This caused significant challenges for the department and negatively impacted on staff wellbeing and patient safety
- On day two of the inspection the department only had half the establishment of health care assistants and were two nurses short of their complement. We saw evidence that this significantly impacted on staff wellbeing, patient safety and patient experience. On one occasion there were significant delays in triage of over one hour. A nurse was moved to support with triage and as a result the corridor area where unwell patients were accommodated was left unsupervised. The inspection team were present in this area for over 15 minutes and could not locate staff. Consequently, members of the inspection team had to support a patient who was actively vomiting
- The workload for nursing staff in some areas of the department was excessive and led to them being overburdened. These areas included triage and the waiting/corridor area. This led to them feeling burned out and stressed. It also meant that they were unable to take breaks in a timely way
- The increased workload in these areas meant that staff could not always deliver the care and treatment required. This meant that medication administration and other interventions were delayed or not undertaken.

In addition to the Immediate Assurance issues above, this is what the service must improve:

- Ensure that patients are kept informed and updated during their journey through the ED
- Improve communication between shifts
- Some aspects of record keeping
- Take steps to ensure that the acuity at front door, due to self-presenting patients, is effectively managed
- Review the requirement for written referrals for cardiac patients in order to speed up the process and avoid unnecessary delays in treatment or discharge
- Take measures to ensure that appropriate treatments are commenced whilst patients are waiting specialist medical/surgical review
- Take steps to ensure the timely administration of medication, in particular antibiotics and pain relief
- Ensure that staff adhere to the health boards medication administration policy and procedures at all times

- Ensure that appropriate risk assessments are undertaken on patients who have been waiting within the ED for long periods e.g pressure area, falls, wounds, bed rails etc
- Move ahead with the review of the standard operating procedure for the Senior Triage, Assessment & Rapid Treatment (START) area
- Ensure that all areas of the department are kept clean and tidy at all times and that used crockery, vomit bowls, urine bottles etc are removed in a timely way and not left on patients' bed trays or on the floor
- Clean blood splatters on walls in a timely way
- Ensure that opened sterile equipment is not placed back in cupboards
- Ensure that computers screens are locked when staff not in attendance to ensure information security
- Review the responsibilities of the nurses working within the waiting room to ensure clarity and ownership of roles
- Continue to encourage staff to attend team meetings.

**Patients told us:**

Patients provided us with the following comments:

***"Sleeping in bed on corridor."***

***"No blankets or pillows offered overnight."***

***"It has not been made clear what pathway is. Received tablet for [condition] - unaware had [condition]…"***

# Quality of Management and Leadership

## Overall Summary

We were not assured that there was a supportive culture in place which promoted accountability and safe patient care and that the management and leadership was sufficiently focused and robust.

We spoke with a cross-section of staff working in the ED with many telling us that they were unhappy and struggling to cope with their workload. Staff also told us that they did not feel supported by the senior managers outside of ED.

## What we found this service did well

- Visibility and leadership of the ED matron
- Weekly governance meetings.

## Where the service could improve

Immediate assurances:
HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff.

- The culture within the department did not promote accountability and dignified and respectful patient care. For example, we found that:
  - There was inconsistency in the approach of senior doctors in terms of their support and willingness to assist out of hours and at times of pressure
  - Some staff were rude and hostile during interactions with the inspection team and patients
  - A small number of staff were overheard using derogatory language to describe patients
  - A small number of staff were resistant to change and negative in their outlook on improvements required. This included nursing staff at band 7 level.

In addition to the Immediate Assurance issues above, this is what the service must improve:

- Review and clarify the roles and responsibilities of Band 7 nurses working in the ED
- Ensure that staff are appropriately supported by senior managers outside of ED.

**Staff told us:**

Staff provided us with the following comments:

> *"We have lots of new band 5 starters and at times end up with not a great skill mix on shift. Having said this our training is now really good and those new starters have had the training opportunities to give them the best knowledge they can."*
>
> *"Long waits on corridor + ambulances make it impossible to provide adequate care for patients where very regular patients are left on chairs for 24-36 hours at a time without toileting facilities, adequate staffing, adequate meals, privacy, dignity."*
>
> *"I feel that this ED provides excellent care to patients in very difficult times."*

# 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.