Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Hospital Inspection (Unannounced)

Aneurin Bevan University Health Board;

Royal Gwent Hospital, Emergency Department

Inspection Date: 7–9 March 2017

Publication Date: 12 June 2017

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.
Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978-1-4734-9716-0

Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an unannounced inspection of the Emergency Department (ED) of the Royal Gwent Hospital, Cardiff Road, Newport, NP20 2UB within Aneurin Bevan University Health Board on the 7 March (evening visit) – 9 March 2017.

Our team for the inspection comprised of two HIW Inspection Managers (one lead), two Clinical Peer Reviewers, one Lay Reviewer and one Clinical Fellow.

Further information about how HIW inspect NHS hospitals services can be found in Section 6.

2. Context

Aneurin Bevan University Health Board was established on the 1 October 2009 and covers Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. The health board serves an estimated population of over 639,000, approximately 21% of the total Welsh population.

The health board has two large district general hospitals; the Royal Gwent (in Newport) and Nevill Hall Hospital (in Abergavenny) and a further two local general hospitals; Ysbyty Aneurin Bevan (in Ebbw Vale) and Ysbyty Ystrad Fawr (in Ystrad Mynach). These are supported by a network of community and mental health hospitals and day care premises located throughout the health board.

The Royal Gwent Hospital has more than 3,400 staff and approximately 774 beds. The hospital provides a comprehensive range of hospital services for inpatients, day cases and outpatients.

At the time of our inspection the Emergency Department (ED) was separated into five main areas:

- Majors area (ten beds) – where patients received urgent treatment for severe illness and injury.
- Minor injuries unit (MIU - six beds, two examination rooms, one ENT room, interview rooms and one plaster room) – where staff treated patients with minor injuries. The MIU had recently been refurbished and had re-opened at the beginning of this year. The unit was primarily run by emergency nurse practitioners (ENPs).
- Clinical observation area (two beds, one ECG room, one seating area) – where staff assessed and treated patients, making decisions about their ongoing care and treatment.
- Resuscitation bay (four cubicles) – where patients were admitted for life-saving treatment and resuscitation.
- Paediatric assessment unit – where children were assessed and treated.

In addition there were two other distinct patient areas within the department:

- Main reception and waiting room – where patients presented to the department and waited for triage[1] and treatment.
- Corridor – this area was used as a holding area for patients waiting for capacity in the department (mainly for patients who were admitted to the department from ambulances). Patients waited on trolleys.

[1] **Triage** is the process of determining the priority of patients' treatments based on the severity of their condition.

3. Summary

Overall, we found evidence that care was safe and effective. However there were two areas within the department that required review to ensure patient safety was being maintained (corridor holding area and resuscitation bay). Patients provided positive feedback about their experiences in the department and we found a passionate and committed staff team with effective and engaged senior management.

This is what we found the health board did well:

- Patients gave positive feedback about their care and treatment
- The department was well organised and teams demonstrated commitment, compassion and excellent multidisciplinary working
- The patient records we reviewed were accurate and complete and reflected the good care we saw being delivered in practice
- The use of the omnicell system (automated medicines system) supported staff in medicines management
- There was evidence of improvements to service, innovations and learning being trialled and implemented both at a department and health board level.

This is what we recommend the health board could improve:

- Full review of risks in the corridor holding area and resuscitation area to ensure patient safety is being maintained
- Ensuring easy accessibility to full sources of patient information and ensuring that patients can more easily access existing feedback channels
- Challenges regarding the physical environment and lack of space to support the delivery of safe and effective care (with the exception of MIU)
- Ongoing challenges with providing timely care to patients following triage due to demand. The health board should review and ensure that all patient flow systems are working effectively
- Ensuring consistency in checks being carried out for emergency equipment trolleys and controlled drugs stock checks in majors.

4. Findings

Quality of the patient experience

Patients made very positive comments about the care and treatment they had received in the department. Despite pressures, we saw a well organised, caring and committed staff team who treated patients with respect and compassion. We also found that staff made efforts to maintain patients' privacy and dignity as far as possible. At the time of our inspection, we saw that some patients were waiting on trolleys in a corridor holding area. This presents challenges for staff in fully maintaining patients' privacy and dignity.

The health board had made improvements to the patient experience through recent refurbishment of the MIU, improvements to signage and introducing dementia friendly aspects within the environment. Information about the patient journey through the department was clearly displayed. Improvements are required in ensuring patients have easy access to other patient information, including complaints, and in being able to provide feedback on an ongoing basis. There were challenges to providing timely care following triage due to bed pressures and we identified that bed management meetings could be improved to assist with the patient flow process.

During our inspection we spoke with a number of patients informally about the care provided and also asked patients to complete HIW questionnaires to gain formal feedback. Ten questionnaires were completed in total. Overall, patient satisfaction was high, with all nine patients who gave the department a rating, rating it between eight to ten out of ten. All patients agreed that they felt the department was clean and tidy.

Two patients from the ten who completed questionnaires had been waiting over 12 hours, with most patients waiting either two hours or less or between two to four hours. Of the eight patients who had been brought into the department by ambulance, all patients were unanimously positive about the ambulance crew in terms of their manner, upholding of privacy and dignity, explanation of treatment and control of pain. Feedback about staff in the department was also very positive and patients indicated that staff were friendly and kind, listened to them, helped them to understand their medical conditions and provided care when they needed it.

Some comments from questionnaires included:

"Very good (staff)"

"There was a wait for the ambulance of 1.5hours and had to wait in ambulance outside A&E for some time. We appreciate the demands on the service and understand delays can't always be avoided"

"No seating when waiting in corridor"

"Very happy with care taken"

"Family member went to nurse to explain I was getting chest pain but took 10 minutes to come see me so I had to ask ambulance paramedic"

Dignified care

Standard 4.1 Dignified care

People's experience of healthcare is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

We found that staff treated patients and their carers with dignity, respect and compassion. We also found that staff made efforts to protect the privacy and dignity of patients who were attending the emergency department.

We saw staff being polite and courteous to patients and their carers. Those patients and carers we spoke with also confirmed that staff had been kind to them. There was a volunteer service active in the department (Age Cymru Gwent Red Robins Befriending Service) to assist with activities such as meal time support, chatting and reading to patients.

We saw staff making efforts to protect patients' privacy and dignity when providing care. Cubicles and designated assessment and treatment areas had privacy curtains and/or doors that could be closed for privacy. Due to the need for staff to observe patients, we saw that these were not always closed fully. However, wherever possible we saw that staff closed curtains and doors to maintain patients' dignity. Patients were appropriately dressed and were provided with blankets so that they were not exposed. We also saw both nursing and medical staff speaking sensitively and discreetly with patients to ensure that confidential information was not overheard.

At the time of our inspection, patients were, at times, waiting on trolleys in a corridor area leading from the ambulance entrance to the clinical observation area. This area provided little space between patients, with one set of doors dividing up the space, lacked equipment that is present in the main department and lacked privacy curtains. This presented staff teams with obvious challenges to maintaining the privacy and dignity of patients in these areas (especially at busier times) as they are not designed for providing patient care. Carers and relatives accompanying the patient were also not able to sit with their loved one in this area, due to the limitation of space. This meant that carers and relatives had to stand in this area or sit in the clinical observation area away from their loved one. We spoke with one carer who had been standing for three hours.

We saw that there were protocols in place which aimed to protect patients' dignity in this area, for example, staff took patients to toilets or to private assessment areas when needed. However, unwell patients waiting in corridors is not acceptable as it may compromise their privacy, dignity and safety.

Improvement needed

The health board is required to make arrangements to ensure patients can wait and be cared for in appropriate areas to promote their privacy, dignity and safety.

We saw that there were rooms available within the department which could be used to allow relatives, who had been given bad news about their loved ones, privacy.

Standard 4.2 Patient information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them make an informed decision about the care as an equal partner.

Standard 3.2 Communicating effectively

In communicating with people health services proactively meet individual language and communication needs.

We saw that a new patient journey board had been mounted as part of the recent refurbishment to assist patients in understanding their journey through

the department. This was positive in terms of providing an accessible visual aid at the first point of contact with the department

Once within the department, some patients indicated that they had not been provided with information about their ongoing care and treatment and did not feel informed or up to date. This was indicative of the challenges in managing the demands on the department. However, once patients were able to speak with staff they felt they were given the information they required. We saw that patient information leaflets were provided to patients on discharge.

We saw that there was patient information available in all cubicles regarding the patient journey through the department. However, other information, including health promotion, local support services and complaints information, was not easily accessible and the 'who's who' board and dementia board were displayed in areas that were not particularly visible to most patients.

Improvement needed

The health board should consider how to improve visibility and accessibility to patient information. This includes easy access to information regarding complaints. Improvements could be made in the range of health promotion and local support services information on offer and the visibility of the who's who board and dementia information board.

All patients who filled in questionnaires indicated that their language needs had been met and there was language services provision. We saw staff communicating with patients in individualised ways that met patients' communication needs.

Timely care

Standard 5.1 Timely access

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

We found staff teams worked together to ensure that patients' immediate care needs were identified via a triage system and attended to according to need. We found that initial triage and assessment within the department was happening in a timely way.

During the course of our inspection, we saw that the department experienced busy periods and some patients experienced long waits (over 12 hours). We saw that waiting times were monitored and patient flow coordinators worked in liaison with the nurse in charge and hospital management team to assist with reducing waiting times as much as possible.

Senior staff explained how patient flow through the hospital was monitored and managed and we saw that protocols were in place to escalate according to All Wales guidance and legislation. The standard operating procedure for triage and assessment required review and updating. We attended one bed management meeting to observe how beds were identified to assist patient flow through the hospital from the emergency department. We found that this process could be improved in terms of having a more consistent approach to providing challenge and agreeing on actions to investigate and confirm potential beds through the hospital.

Improvement needed

The health board should review bed management meetings to ensure that the forum consistently supports sufficient challenge and that meetings are fully effective in identifying and acting upon potential beds, to assist with patient flow and timely care.

Individual care

Standard 6.1 Planning care to promote independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being.

We reviewed five sets of patient records. All five patients were unwell and requiring hospital admission and we found clear evidence of transfer of care planning as patients were awaiting transfer to wards and other facilities.

We found that staff were promoting self care where this was appropriate and possible. We found that oral care plans were in place for patients where required and oral care needs were being addressed. Further detail on the assessment of patients' needs in terms of pressure care, nutrition and hydration and falls is detailed under the relevant Health and Care standard in the sections below.

We found excellent organisation within the department with allocated staff teams for each area and evidence of excellent multidisciplinary team working. A positive culture between nursing and medical staff was reported. We observed ward rounds and handovers which supported this and we saw effective use of patient safety briefings. The Patient Status At a Glance (PSAG) boards were also clear in terms of tracking the current status and plan for each patient.

Standard 6.2 Peoples rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

We saw that patients were accompanied by their carers whilst waiting to be seen by healthcare staff. This meant they were able to maintain their involvement with their family whilst waiting in the emergency departments.

Comments we received from patients were positive regarding the attitude and approach by staff. We also saw staff being respectful to patients and mindful of their rights.

Staff were aware of the protocols to follow should they be unclear about whether a patient had capacity to consent to care and treatment.

We saw that some work had been done to improve signage and to make the environment dementia friendly, for example, there were dementia friendly clocks and a box that staff could use to provide resources for patients with dementia. We saw that accessible facilities were available in the reception area.

Standard 6.3 Listening and learning from feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

The health board had some arrangements in place to allow for patients and their carers to provide feedback on the care they had received at the department. Staff told us that the Robins volunteer service completed questionnaires with patients on an ad hoc basis and within MIU some provision for feedback was being introduced by ENP staff. We heard that arrangements were in place to pass on thanks to staff members who were named in compliments.

However, feedback mechanisms were reactive rather than proactive and there was a lack of formalised provision to allow for patients to provide feedback on an ongoing basis.

Improvement needed

The health board should empower patients and their carers to provide feedback on services provided on an ongoing basis and display clear information about how they can do so.

There were systems in place to consider feedback and identify themes, once received. Senior staff described a process for reviewing feedback from patients and their carers with a view to improving the service provided. A process was also described for dealing with concerns and incidents in accordance with *Putting Things Right*[2]. All staff who responded to HIW questionnaires indicated that where they had experienced any errors, near misses or incidents in the last 12 months, they had reported these. Some staff indicated that they had not received feedback following the reporting of an incident. This is addressed below. There was a lack of complaints information on display and we have asked the health board to address this (above).

[2] *Putting Things Right* are the arrangements for dealing with concerns about NHS care and treatment in Wales.

Delivery of safe and effective care

We found that the staff team was committed to providing patients with safe and effective care. Despite the recent refurbishment of the MIU, challenges remained in the physical environment, due to demand and limited space, in providing safe and effective care. There were two areas within the department that required review to ensure patient safety was being sufficiently maintained (corridor holding area and resuscitation bay). We asked the health board to address this through our immediate assurance processes.

The department was clean and arrangements were in place to reduce cross infection. Consistency in the use of personal protective equipment (PPE) and hand hygiene adherence could be improved.

We found that staff triaged patients to identify and prioritise their care needs to promote patients' wellbeing and safety. Patient records overall reflected the good standard of care that we saw being delivered in practice.

We saw that medication was managed safely with the use of an omnicell system (automated medicines system). We found some gaps in the controlled drugs stock level checks and emergency equipment checks in the majors area and have asked the health board to address this.

Safe care

Standard 2.1 Managing risk and promoting health and safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented.

The physical environment provided challenges to staff in terms of there being sufficient space to provide safe and effective care, with the exception of the MIU which had recently undergone a complete refurbishment and was purpose built affording ample space. The main waiting area had recently undergone refurbishment, however, was still limited in space to cater for the number of patients presenting to the department at times. We saw that signage had been improved and televisions also provided some entertainment and rolling information, for patients. There was no separate, quieter, child-friendly waiting area but plans were being considered to convert some space in the new MIU

for this purpose. There was a child friendly waiting area in the paediatric assessment unit. We saw that the lack of space within the department particularly impacted upon the clinical observation area and staff advised us how they managed this, for example, by attempting to limit the number of relatives able to wait with the patient.

We saw that doors leading into the department from waiting areas were kept secure, as were doors throughout the department where appropriate, to prevent unauthorised access. Further security measures had been considered and improved as a result of learning from incidents and through specific 'Violence and Aggression' meetings. Security staff could be called upon by department staff for assistance with security matters if needed. Staff told us they had recently seen improvements in security measures and response.

Overall, we saw that the department was free from obvious safety hazards, with corridors being clear of equipment. Waste, cleaning equipment and supplies were stored in lockable rooms that remained secure for the duration of our inspection. We saw that the use of new storage rooms assisted the department in reducing on clutter. Within these rooms we saw that there were still boxes on the floor which required packing away and staff should ensure that these rooms are kept clear to allow for adequate cleaning.

We found two areas within the department where attention was required to ensure risks were being managed on an ongoing basis to ensure patient safety:

- **Ensuring safe practice for the care and treatment of patients in the corridor area**

  During the evening visit on 7 March 2017 we found that patients in the corridor area were not being sufficiently monitored by staff. On investigation we found that the ambulance liaison officer monitored patients in this area by day. However, during the night time there was no designated staff member(s) monitoring the corridor area. We found that the health board had highlighted this area of practice as a risk.

  There was a holding protocol in place which staff adhered to. We reviewed the current risk assessment regarding the provision of care and treatment to patients in this area. We found that it did not give adequate assurance that risks (such as those highlighted above) had been fully assessed or were adequately monitored and managed. The risk assessment had limited detail, conflicting detail regarding the risks identified (for example how many patients could be safely held in the corridor area), was not reviewed or updated on an ongoing basis and had not been fully or comprehensively completed.

We therefore required assurance from the health board that safe practices were currently in place regarding the care and treatment of patients in the corridor area. Our concerns regarding this were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Further details of this are provided in Appendix A.

- **Ensuring safe practice in the resuscitation bay**

  We inspected the resuscitation bay which currently has four cubicles. We found that the physical environment presented challenges to providing safe care in this area, for example, the paediatric bay does not lend itself to easy monitoring of patients. We found that a paediatric pump, although accessible from elsewhere within the department, was not currently accessible and available within the bay.

  Staff told us there were times when the four cubicles were used to accommodate up to seven patients. The area did not have the required equipment to be able to safely treat this number of patients at any one time within this area. There was also a lack of appropriate space to safely treat patients or to protect patients' dignity when used in this way.

  We reviewed the current risk assessment regarding working practices in the resuscitation area. We found that it did not give adequate assurance that risks (such as those highlighted above) had been fully assessed or that risks were being adequately monitored and managed on an ongoing basis. There was also a lack of a comprehensive risk assessment regarding the current physical environment and access to appropriate equipment.

  We spoke with senior management and saw that plans were in place to make the area safer and more fit for purpose which would mean some building work. Plans had been drawn up but were in the beginning stages.

  We therefore required assurance from the health board that safe practices were currently in place regarding the care and treatment of patients in the resuscitation bay. Our concerns regarding this were dealt with under our immediate assurance process. Further details of this are provided in Appendix A.

Standard 2.2 Preventing pressure and tissue damage

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

Our review of patient records included consideration of how the prevention of pressure and tissue damage was implemented.

We saw that all patients had risk assessments in place in terms of their risks of developing pressure sores and appropriate skin assessments. Where higher risks were identified for two patients, appropriate care plans had been developed and documented. We saw staff assisting patients to reposition in line with care plans and providing ongoing monitoring and assessment of pressure areas.

Staff told us that they were able to obtain pressure relieving devices to put on trolleys for vulnerable patients and pressure relieving mattresses were in situ where required.

Standard 2.3 Falls prevention

People are assessed for risk of falling and every effort is made to prevent falls and reduce avoidable harm and disability.

Our review of patient records included consideration of how the prevention of falls was implemented.

We saw that all patients had risk assessments in place in terms of their risks of falling. Where higher risks were identified for two patients, appropriate and comprehensive care plans had been developed and documented. There was a specialist falls service available within the health board which was easily accessed by emergency department staff.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

Overall, we found effective arrangements in place for infection prevention and control with two aspects requiring improvement.

We saw that personal protective equipment (PPE), for example aprons, were being used, however the approach to using PPE was not consistent. We saw times when PPE was used by some staff for specific tasks whilst not used by other staff for the same tasks. Hand washing sinks and hand sanitisation gel were available. However, we saw inconsistency with adherence to hand hygiene guidelines.

Improvement needed

The health board must ensure that all staff are aware of, and implement, the consistent use of personal protective equipment and consistently adhere to hand hygiene guidelines.

The department overall appeared clean and tidy. We spoke with housekeeping staff and found that appropriate cleaning schedules were in place and they had access to all necessary cleaning equipment. Cleaning products were securely locked away. We observed some chips to walls and floors in some areas. However, the newly refurbished MIU provided an exemplary environment to allow for adherence to infection prevention and control measures.

The department had single rooms available that could be used to isolate patients for infection control reasons. We also found an excellent decontamination unit in place which was used in the event of a chemical outbreak.

We saw that medical sharps[3] had been disposed of using designated, secure sharps bins for safety. We found one instance where contaminated needles were being disposed of in a yellow sharps box instead of the designated orange box.

Improvement needed

The health board must ensure that in relation to the disposal of medical sharps, they are segregated consistently, according to infection control guidelines.

[3] Medical sharps are needles, blades and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin.

Standard 2.5 Nutrition and hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury (Standard 2.5).

Patients were provided with food and drinks. Overall, their intake was being monitored by staff where this was required.

We saw that there was a food trolley service in place during the day and all patients were offered hot/cold meals and snacks/drinks at set times during the day. We saw that patients were offered choices which met their dietary and spiritual needs. Staff told us that, due to a lack of central food services overnight, they sometimes ran low on snacks during evening shifts which limited choices and availability of food.

Improvement needed

The health board must ensure that nutritious food stocks are accessible for patients (who may be experiencing long waits) 24hours a day and specifically overnight when central food services are closed.

We saw that water jugs were available for most patients, although in some cases these were out of easy reach. There were significant challenges in ensuring patients waiting in the corridor were able to easily access water.

Improvement needed

Staff must ensure that patients' hydration needs are met by ensuring that water jugs/sources are made easily available to all appropriate patients.

Through our review of patient records we saw that short term food and fluid intake and output charts were used when necessary to monitor and support patients' nutrition.

Standard 2.6 Medicines management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

Overall, we saw that medicines were managed safely within the department. The health board had a policy for the management of medicines. We were told that staff teams could access this via the health board's intranet.

We saw that in general medicines were securely stored when not being used. However, on the evening of 7 March 2017, we found medicines left unattended in the nurses' station in the paediatric assessment unit and prescription eye drops left out and being stored in an unlocked cupboard in the eye room. We brought this to the attention of staff who secured these medicines immediately. New signage was put in place to inform staff not to store eye drops in the identified cupboard. Doors to medicines rooms were kept secured at all times during our inspection and could be accessed by a fob card only. An omnicell system (automated medicines system) was used which provided enhanced security, allowing access to medicines storage by thumbprint only.

Medicine fridges were linked to the omnicell system and set off an alarm if temperatures changed to levels that were unsafe. Fridge temperatures were not documented due to reliance on the omnicell system.

We saw that there was a system in place to carry out controlled drugs stock level checks. These were completed daily. However, we found a gap in recordings between 27 February – 3 March 2017 in the majors area.

Improvement needed

The health board should explore the reason for the gap in controlled drugs stock level checks in majors between 27 February – 3 March 2017 and ensure there is a system in place which ensures checks are carried out consistently on an ongoing basis.

We looked at a sample of patients' medication administration records and saw that these had been completed fully. We advised staff to ensure they recorded 'nil' when patients did not have allergies to make this aspect clearer. We saw patient identification wristbands being used to help staff to correctly identify patients prior to giving medication. We observed nursing staff administer medication to patients safely and saw that they conducted checks to ensure the correct patient received the correct medication at the correct time.

Staff working within the department told us that a pharmacist was available to provide advice and support on medication related queries. Pharmacy support was available for one hour/day Monday to Friday except in MIU where there was a full time pharmacist and technician. There was no evidence of ongoing medicines audits being carried out and a lack of clarity about responsibility and accountability for this between department and pharmacy staff. Staff told us omnicell could run reports if needed or if discrepancies were found although

there was no system in place to ensure the approach to this remained consistent. The pharmacist advised that they picked up on transcribing and prescription errors and ensured these were communicated, and where required, reported through the health board's incidents system.

Improvement needed

The health board must ensure there is clarity about where responsibility lies for medicines audits and ensure these are being carried out.

We were unable to check training records for medicines management as staff were not able to access a central database where this was recorded. This improvement is addressed below.

There was a pharmacy project running which aimed to improve patient flow. This targeted specialities needing beds, for example, if cardiology beds were needed, the pharmacist attended the relevant ward to assist with patient discharge in terms of medicines. This was positive given the limited designated pharmacy support, reported to us, as being available to the department overall.

Standard 2.7 Safeguarding children and adults at risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

We found arrangements were in place to protect the welfare and safety of children and adults who become vulnerable or at risk.

We spoke to a number of staff working in the department. They demonstrated an understanding of the process to follow should they suspect abuse. Staff told us there was a rolling training programme. However, there were challenges in staying up to date with this training, which is addressed below. We saw that reporting arrangements, local guidelines and contact numbers were easily accessible to staff, both in the emergency department and connected paediatric assessment unit.

At the time of our inspection, we were told that no patients were subject to a Deprivation of Liberty Safeguards[4] (DoLS) authorisation.

Staff told us that there was now a Children and Adolescent Mental Health Service (CAMHS) available seven days a week. Although adult psychiatric liaison had extended their hours to midnight, night staff advised that they felt more support for mental health patients at night was required. We saw that one interview room on MIU had been made ligature free in an effort to provide a safe space that could be used for mental health assessment.

Staff told us that there was no way currently to flag child protection cases on the electronic patient system. The health board should consider how to make child and adult protection cases easily identifiable to staff.

Standard 2.8 Blood management

People have access to a safe and sufficient supply of blood, blood products and blood components when needed.

Although we did not fully inspect this standard for the purposes of this inspection we found that policies and systems were in place for the safe management of blood.

Standard 2.9 Medical devices, equipment and diagnostic systems

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.

We saw that a range of medical equipment was available within the department. Equipment was visibly clean and appeared well maintained, although we were aware that two pieces of equipment were broken at the time of our inspection. These were being borrowed from other areas of the hospital.

[4] The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

Staff described a system of reporting faulty equipment and ordering new equipment. Staff told us they were able to access required equipment in a timely way but it sometimes took longer for faulty equipment to be collected. All equipment labels checked for servicing were within date.

Some staff, particularly in staff questionnaires, indicated that they did not have adequate materials, supplies and equipment to do their work, e.g. IV sets and pads. The health board should explore the reasons for this with a view to resolving any issues identified.

Staff carried out checks on the emergency equipment (crash) trolleys. However we found there were some gaps in checks for the trolley in majors.

Improvement needed

The health board must ensure that emergency equipment trolley checks (in majors) are consistently carried out.

As previously mentioned, we found a need for additional equipment in the resuscitation area.

Effective care

Standard 3.1 Safe and clinically effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

A triage system was in place and we found that patients were triaged in a timely manner using a recognised assessment tool. Nursing staff conducted an initial assessment of patients to ensure that they were seen by a doctor in order of priority according to their care and treatment needs. Arrangements were in place to refer patients for investigations such as X-rays and for further assessment by other members of the multidisciplinary healthcare team.

We saw evidence, on review of five sets of patients' documentation, that pain was being measured, actioned and evaluated. Pain assessment tools were in place and being appropriately completed. We saw that patients were being provided with appropriate pain relief.

As part of the inspection we reviewed the care pathways for sepsis, fractured neck of femur and stroke. We found that the sepsis bundle was being

completed and used appropriately. As part of the ongoing work around the fractured neck of femur pathway there was a plan in place to ring-fence beds on a ward within the hospital to ensure a more seamless pathway of care for patients and a faster flow from the department to the wards.

A recent reprovision of stroke services had taken place within the health board with the closure of stroke pathway provision at Nevill Hall Hospital. This meant there had been an increase in the number of stroke patients presenting to the department at Royal Gwent Hospital. At the time of our inspection, we saw that upto 10-11 stroke patients were presenting to the department each day. Although there was appropriate stroke pathway documentation in place, there was a risk of this impacting on patient flow through the department due to increased demand.

Improvement needed

The health board must provide HIW with an update in terms of how increased demand for stroke provision at Royal Gwent Hospital will be managed on an ongoing basis.

We saw that practices and the environment in the MIU had been reviewed and overhauled. It was running particularly well following the refurbishment and provided a positive patient experience, led mainly by emergency nurse practitioners.

Staff told us about a number of initiatives that had been trialled on the emergency department to try to ensure the most effective system of care and treatment was in place. For example, a pilot had been run which had trialled consultant-led triage. This meant the department was proactive in evolving their practice to promote safe and clinically effective care.

Standard 3.3 Quality improvement, research and innovation

Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

It was positive to note that there were a number of innovations and service developments that were being implemented by the emergency department team. We found good practice at both a departmental level and health board level. For example, at department level we saw that there had been the

development of an effective and robust redirection policy and staff told us about the trialling of consultant-led triage. We also heard, at a health board level, about projects carried out in partnerships with others such as the physicians response unit whereby an ED consultant and Welsh Ambulance Service Trust (WAST) paramedic worked together to provide appropriate care at home and prevent admissions.

Standard 3.4 Information governance and communications technology

Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services.

Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.

Overall we were satisfied with the information governance systems in place.

On several occasions we saw that computer screens were left unlocked through the department and patient identifiable information was visible. Staff must ensure that patient information is protected at all times.

Improvement needed

Staff must ensure that patient identifiable information is not left visible on computer screens.

Standard 3.5: Record keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

We reviewed five sets of patient records and overall found them to be of a good standard, reflecting the good care that we saw being delivered in practice. At first glance we found records difficult to navigate. However, once staff explained how the records were organised we found them easier to navigate and one

agency staff member confirmed that they felt able to understand the needs of the patients from the records in place.

We found records to be accurate, up to date, complete, understandable and contemporaneous. However, we found that, although staff were signing and dating records, they were not printing their names to clearly identify who had made the entry.

Improvement needed

Staff must ensure that they print their names after signing patient records in line with record keeping standards.

Patient records were stored in a protected area within documentation slots that were compliant with data protection legislation.

Quality of management and leadership

We saw effective leadership and support being provided by senior nursing management and senior departmental staff. Despite pressures and challenges, staff teams presented as knowledgeable and demonstrated a commitment to providing high quality care to patients. There was evidence of improvements to service, innovations and learning being trialled and implemented both at a departmental and health board level. Overall, communication between senior and departmental staff was good although we found several aspects that could be improved.

Staffing numbers and skill mix appeared appropriate to meet the needs of the patients throughout our inspection, with the exception of the corridor holding area which has been addressed above. Vacancies had been filled but the department was awaiting start dates for new staff. Some staff told us they experienced difficulties in accessing their breaks due to demand and we saw that training compliance for nursing staff was low. The health board should review this to ensure staff are sufficiently supported.

Governance, leadership and accountability

Health and Care Standards, Part 2 - Governance, leadership and accountability

Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.

Management structures were in place and clear lines of reporting and accountability were described and demonstrated by senior staff.

During our inspection, we invited staff working within the emergency department to complete a HIW questionnaire. Through our questionnaires, we asked staff to provide their comments on a range of topics related to their work. In total, nine completed questionnaires were returned by a range of staff working within the department.

Throughout the course of our inspection, we saw effective leadership being provided by senior departmental staff. Senior nursing staff and hospital managers also made themselves available to support staff teams and facilitate the inspection process.

Overall, the staff who completed and returned questionnaires indicated their immediate managers were supportive and encouraged team work. Comments made within completed questionnaires indicated that staff were aware of whom their senior managers were and overall, felt that communication between senior managers and staff was effective. We also saw that senior management presence at night had been considered and there were systems in place to promote this further, for example, a senior nurse had now been appointed for out of hours three nights/week.

Responses varied in terms of feedback about the organisation with half of the questionnaires providing a positive perspective of the organisation and half of the questionnaires providing less positive feedback in terms of there being a culture of openness and feeling empowered to speak up and take action. Staff indicated that they felt overstretched and although committed to providing safe and effective care felt strongly that their position was compromised in terms of the physical environment and areas such as the corridor area and resuscitation area.

Senior managers told us they felt supported and empowered to take action, suggest and trial improvements and felt that more collaborative working was now in place, particularly between the Medical Assessment Unit and the emergency department. Senior staff described examples of ideas and innovations they had been authorised to trial, which had come from collaborative reflection through 'Divisional days' and we saw that there was a commitment to improving patient experience in this way.

Senior nursing staff described a system of regular clinical audit as part of the overall quality monitoring activity. We were told that results and themes of audits, incidents, complaints and feedback were discussed weekly at senior team meetings and were provided to senior hospital staff so that any areas identified as needing improvement could be escalated and addressed as appropriate. Structured meetings took place within the health board, such as Clinical Quality Group meetings, to further review and monitor themes and trends. A system for recording and investigating clinical incidents was also described. This was with a view to identifying any themes and to identify learning to promote patient safety and well being.

Whilst on the department we checked compliance with patient safety alerts and notices. We found compliance with these, however, staff told us that they were not aware of a formal system being in place to disseminate these to department staff.

Improvement needed

The health board must ensure that there is a robust system in place to communicate patient safety alerts to all relevant staff.

Over half of staff who responded to HIW questionnaires indicated that they had not been made aware of the revised Health and Care Standards that came into force in April 2015. We saw that Health and Care Standards meetings were happening at a health board level and consideration being given as to how to improve awareness.

Improvement needed

The health board should consider how to raise awareness of the Health and Care Standards 2015 with the staff team to ensure that all staff are aware of their responsibilities under these standards.

Some nursing staff and healthcare support workers (HCSW) told us that they would appreciate feedback when they have either reported an incident or made a suggestion to the department. There was a lack of awareness around developments that were happening, for example, on working towards the elimination of the practice of caring for patients in the corridor, which was an area staff felt passionately about. We saw that regular team meetings took place with band six and seven attendees tasked with reporting information back to the team. However, there was a lack of formalisation of this to support communication with frontline staff. HCSWs also had no structured forum in place, in which they were able to formally raise their views.

Improvement needed

The health board should consider how to formalise communication systems with frontline staff on the department to assist in closing the communication loop with incidents and keeping staff informed of ongoing developments. Consideration should be given to ensure HCSWs are able to raise views and be included in these communications.

We found that there were mechanisms in place to provide pastoral support to staff who had been involved in incidents or distressing situations. Staff told us there were excellent informal support mechanisms between team members. However, we heard that, in practice, there were challenges in ensuring appropriate debriefs were able to happen with all staff involved, due to capacity in the department.

Improvement needed

The health board should ensure that all staff are adequately supported following their involvement in incidents or distressing situations and that debrief systems are able to be carried out in practice.

Staff and resources

Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

The staff team in the department presented as knowledgeable and demonstrated a dedication, passion and commitment to providing high quality care to patients.

Although the department was busy, staffing numbers and skill mix appeared appropriate to meet the needs of the patients at the time of our inspection, with the exception of staffing of the corridor area which has been addressed above. Staff told us they felt considerable pressures in terms of meeting demand. However, we saw a staff team who were well organised, maintained an atmosphere of calm and worked effectively together, across disciplines. Some staff told us they were not always able to take breaks and particularly at night, did not feel that staff facilities were adequate, as there was no option to have a break anywhere else on site. The health board should consider the comments made by staff to review whether improvements can be made.

At the time of the inspection there were no vacancies for nursing staff but the department was awaiting start dates for a number of staff, which was having an impact on staffing and pressures. The health board had introduced schemes to encourage staff within the department to pick up extra shifts. Senior staff told us that additional staff could be requested via the health board's nurse bank or an agency as needed. During our inspection, agency and bank staff were working in the department. Comments from some staff indicated that they felt pressured in terms of meeting demand and that more staff would be beneficial to promote patient safety and wellbeing. The health board may wish to explore this and take action as needed. We saw that sickness levels were on a downward trend and senior staff described protocols in place for managing sickness.

We explored medical cover and found a clear structure with appropriate arrangements in place.

We found that the department was facing challenges in supporting nursing staff and health care support workers to stay up to date with their training. For example, training compliance for statutory and mandatory topics ranged from 17 – 52%compliance. Senior staff told us that the reasons had been explored and it had been identified that the current staffing uplift was 4% but to effectively maintain training compliance, the uplift should be 8%. This was being given consideration.

Improvement needed

The health board must ensure that nursing staff and HCSWs are supported to stay up to date with their training. The reasons for low compliance with training should be explored and a training plan put in place to bring all staff up to date.

There was a practice educator assigned to the department who had mapped all staff's training. However, we found that difficulties remained in staff being able to access one central place where all training was accurately recorded and could be easily reviewed regarding compliance. Staff told us the electronic system used by the health board sometimes produced inaccurate data and the rolling training programme records were kept separately. This meant there were challenges in accessing and monitor training compliance for all staff.

Improvement needed

The health board must ensure that staff are able to easily access and monitor training compliance in order to ensure that they stay up to date with their training.

We found that teaching for medical staff was comprehensive. One fifth of all emergency trainee doctors in the Wales Deanery underwent a placement at the emergency department and their feedback was positive. ENPs also had their own training and development programme which they were mandated to undertake and we received positive feedback regarding this. It was also positive to see impromptu training taking place on the department by both medical and nursing staff.

The responses we received indicated that staff felt the training they had attended had helped them do their jobs and stay up to date with professional requirements.

When asked (via the HIW questionnaire) about an annual appraisal of their work, all staff told us that they had received an appraisal within the last 12 months. We saw that the number of staff having access to annual appraisals was increasing, currently being at 72% compliance, and this was being

monitored to ensure that all staff would receive an annual appraisal by the end of the year.

5. Next Steps

This inspection has resulted in the need for the health board to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The health board improvement plan should clearly state when and how the findings identified will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/units within the wider organisation.

The actions taken by the health board in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the health board's improvement plan remain outstanding and/or in progress, the health board should provide HIW with updates, to confirm when these have been addressed.

The health board's improvement plan, once agreed, will be published on HIW's website.

6. Methodology

We have a variety of approaches and methodologies available to us when we inspect NHS hospitals, and choose the most appropriate according to the range and spread of services that we plan to inspect. In-depth single ward inspections allow a highly detailed view to be taken on a small aspect of healthcare provision, whilst the increased coverage provided by visiting a larger number of wards and departments enables us to undertake a more robust assessment of themes and issues in relation to the health board concerned. In both cases, feedback is made available to health services in a way which supports learning, development and improvement at both operational and strategic levels.

The Health and Care Standards (see figure 1) are at the core of HIW's approach to hospital inspections in NHS Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The Standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1: Health and Care Standards 2015

NHS hospital inspections are unannounced and we inspect and report against three themes:

- **Quality of the patient experience:**
  We speak with patients (adults and children), their relatives,

representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to inspection.

- **Delivery of safe and effective care:**
  We consider the extent to which services provide high quality, safe and reliable care centred on individual patients.

- **Quality of management and leadership:**
  We consider how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also consider how health boards review and monitor their own performance against the Health and Care Standards.

We reviewed documentation and information from a number of sources including:

- Information held by HIW
- Conversations with patients, relatives and interviews with staff
- General observation of the environment of care and care practice
- Discussions with senior management within the directorate
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- Consideration of quality improvement processes, activities and programmes
- Responses within completed HIW patient questionnaires
- Responses within completed HIW staff questionnaires.

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the quality, safety and effectiveness of healthcare provided and the way which service delivery upholds essential care and dignity.

Hospital Inspection: Improvement Plan

Hospital: Royal Gwent Hospital

Ward/ Department: Emergency Department

Date of inspection: 7 – 9 March 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
IMMEDIATE ASSURANCE ACTIONS					
	Ensuring safe practice for the care and treatment of patients in the corridor area During the evening visit on 7 March 2017 we found that patients in the corridor area were not being sufficiently monitored by staff. On investigation we found that the ambulance liaison officer monitored patients in this area by day. However, during the night time there was no designated staff member(s) monitoring the corridor area. We found that the health board had highlighted this area of practice as a risk. We reviewed the current risk assessment regarding the provision of care and treatment to patients in this area. We found that it did not give adequate assurance that risks	2.1	The Health Board aims to eliminate the need for patients to be cared for in corridors as a result of congestion in the Emergency Departments. In order to avoid this congestion, a number of measures are being taken across the Health Board to improve patient flow. A Local Escalation Policy has been agreed with WAST. This identifies the actions to be taken when there are delays in handover to maintain patient safety. **(Please find copy attached at appendix 1)** The department has ensured that all staff are familiar with this policy. The Senior Nurse on duty is overseeing implement-tation and compliance with the policy, when there are patients are in the corridor.	Chief Operating Officer Senior Nurse Senior Nurse	1st July 2017 (reduction to 3) Immediate & in place Completed April 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
	(such as those highlighted above) had been fully assessed or were adequately monitored and managed. The risk assessment had limited detail, conflicting detail regarding the risks identified, was not reviewed or updated on an ongoing basis and had not been fully or comprehensively completed. The health board is therefore required to fully describe the action(s) taken/to be taken to ensure that safe practices are in place regarding the care and treatment of patients in the corridor area.		There is a designated member of the nursing team allocated to the corridor at all times when the Hospital Ambulance Liaison Officer (7:30-3:30 Monday to Friday) is not on duty. **(Please find copy attached at appendix 2)** There is a Standard Operating Procedure in place for majors, which includes the management of patients in the corridor. The Senior Nurse will ensure compliance. **(Please find copy attached in appendix 3)** A staff allocation board for the corridor is now on display, with a named member of staff responsible for each patient's care. Staffing of the corridor is reinforced at the handover Safety Briefings. Allocated staff are aware that they are to remain in the corridor when patients are being nursed in this area. The staff member allocated to the corridor wears a Vocera device to enable communication with the main department. The Corridor risk assessment has been reviewed by key clinical staff. This is now being disseminated to all members of staff and WAST. It will be reassessed at the end of June and discussed in the fortnightly ED Site Performance meeting	Senior Nurse Clinical Director & Senior Nurse Senior Nurse & Clinical Lead Team Senior Nurse Clinical Director & Senior Nurse Clinical Director & Senior Nurse	Completed April 2017 & in place Completed April 2017 & in place Completed April 2017 & in place Completed April 2017 Completed Completed April 2017 Review End of June 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
			chaired by the Chief Executive. **(Please find copy attached in Appendix 4)** Escalation to the Patient Flow Manager/ Site Lead takes place at the point of any patients being nursed in the corridor and at all site meetings An escalation action card to guide staff has been simplified and reviewed and incorporates steps to be taken by staff when holding patients in ambulances. Senior Nurse is monitoring compliance.	Clinical Director & Senior Nurse	Ongoing Ongoing
	SOP **Ensuring safe practice in the resuscitation bay** We inspected the resuscitation bay which currently has four cubicles. We found that the physical environment presented challenges to providing safe care in this area, for example, the paediatric bay does not lend itself to easy monitoring of patients. We found that a paediatric pump, although accessible from elsewhere within the department, was not currently accessible and available within the bay. Staff told us there were times when the four cubicles were used to accommodate up to seven patients.	2.1	The Health Board is progressing a business case to support the expansion of the Resuscitation room from 4 spaces to 6 The resuscitation risk assessment has been reviewed and updated and specifically targets risks when over-capacity. It will be reassessed at the end of June and discussed in the fortnightly ED Site Performance meeting chaired by the Chief Executive. **(Please see copy attached in appendix 5)** There is an action card for the Nurse in Charge, Consultant / Senior Doctor and Patient Flow Manager/ Site Lead when the resuscitation room is over capacity	General Manager & Service Lead Clinical Director & Senior Nurse Clinical Director / Senior Nurse	May 2017 Completed April & in place Review End of June 2017 Completed April 2017 & in place

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
	The area did not have the required equipment to be able to safely treat this number of patients at any one time within this area. There was also a lack of appropriate space to safely treat patients or to protect patients' dignity when used in this way. We reviewed the current risk assessment regarding working practices in the resuscitation area. We found that it did not give adequate assurance that risks (such as those highlighted above) had been fully assessed or that risks were being adequately monitored and managed on an ongoing basis. There was also a lack of a comprehensive risk assessment regarding the current physical environment and access to appropriate equipment. The Health Board is therefore required to fully describe the action(s) taken/to be taken to ensure that safe practices are in place regarding the care and treatment of patients in the resuscitation bay.		Escalation to the Patient Flow Manager (PFM)/ Site Lead takes place at the point when the last resuscitation space has been used with the expectation of immediate movement of a patient from the resuscitation room. Site meeting form amended **(Please find copy attached in appendix 6)** Symphony IT system is being adapted to allow recording of when patients are fit for transfer out of the resus area to highlight better use of the area and ensure that PFM can identify when and which patients are suitable for transfer to ward areas. In the interim the Patient Flow board in majors has been redesigned to capture this information. The resuscitation area is dual use for adults and paediatrics. There is a supply of 3 pumps at all times in the Children's Assessment Unit adjacent (CAU), which is integrated in the Emergency Department. Signage to this effect is displayed in the Resuscitation room. In addition the CAU staff are notified of the pre-hospital alert and attend with pumps and equipment to support a paediatric resuscitation. This prevents staff needing to exit the resuscitation room. Three additional mobile cardiac monitors have been purchased to ensure when more than 4 patients are in the area they	Chief Operating Officer / Patient Flow Manager /Nurse in Charge Clinical Director & Senior Nurse Senior Nurse Senior Nurse	Completed April 2017 August 2017 Completed April 2017 & in place Received & in department

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
			can be adequately monitored. When the Resuscitation room is over capacity, staff deployed from within the department.	 Senior Nurse	 Ongoing
Quality of the patient experience					
8	The Health Board is required to make arrangements to ensure patients can wait and be cared for in appropriate areas to promote their privacy, dignity and safety.	4.1	The Health Board aims to eradicate corridor waiting for unwell patients. The Corridor Standard Operating Procedure has been amended and includes use of the assessment area for investigations, treatments and hygiene needs.	Senior Nurse	Completed April 2017 & in place
9	The Health Board should consider how to improve visibility and accessibility to patient information. This includes easy access to information regarding complaints. Improvements could be made in the range of health promotion and local support services information on offer and the visibility of the who's who board and dementia information board.	3.2; 4.2	Putting Things Right information is available in both waiting areas and the corridor. How to complain posters and leaflets are also in clinical assessment area. Signage in the waiting room & corridor. There is a health promotion board in majors. Bone healing and smoking cessation advice has been added to the Television There is a Dementia board in Majors "This is me" as well as leaflets for carer support services. This will be duplicated in others areas of the department to ensure easy access and visibility by all.	Senior Nurse Senior Nurse	Completed April 2017 & in place Completed April 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
			Staff Uniform Identification Guide to be established – Who's who poster in progress.		May 2017
10	The Health Board should review bed management meetings to ensure that the forum consistently supports sufficient challenge and that meetings are fully effective in identifying and acting upon potential beds, to assist with patient flow and timely care.	5.1	Benchmark visit to observe Bed Management processes elsewhere undertaken on 4th April 2017. Findings discussed at the Urgent Care Board 6th April 2017. Review of roles & responsibilities of the Patient Flow team and dedicated Escalation tiers to support flow'.	Assistant Chief Operating Officer / General Managers	April 2017
12	The Health Board should empower patients and their carers to provide feedback on services provided on an ongoing basis and display clear information about how they can do so.	6.3	Patient satisfaction surveys uploaded to Health & Care Standards national website Notice in departmental waiting areas to encourage patients to provide feedback on their experience.	Senior Nurse	Completed April 2017 & ongoing Completed April 2017 & in place
Delivery of safe and effective care					
17	The Health Board must ensure that all staff are aware of, and implement, the consistent use of personal protective equipment and consistently adhere to hand hygiene guidelines.	2.4	Hand hygiene audits take place on a weekly basis and are uploaded to Health & Care Standards national website. Discussions taken place in the Clinical Leads Meeting. Hand hygiene day to raise awareness Posters are in place regarding Hand Hygiene & Bare Below Elbow.	Senior Nurse Senior Nurse	Ongoing weekly Completed April 2017 Completed April 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
			Danicare Centres are appropriately placed to promote the use of personal protective clothing. Staff have been reminded in the safety brief and the staff communication book. The use of protective clothing will be audited at the same time as hand hygiene audits on a weekly basis.		Completed April 2017 Ongoing and weekly
17	The Health Board must ensure that in relation to the disposal of medical sharps, they are segregated consistently, according to infection control guidelines.	2.4	Orange lids for sharps boxes now readily available to ensure segregation of sharps.	Senior Nurse	Completed April 2017 & in place
18	The Health Board must ensure that nutritious food stocks are accessible for patients (who may be experiencing long waits) 24hours a day and specifically overnight when central food services are closed.	2.5	Meals trolley x3 per day and sandwiches left daily. Cereal, bread, milk, tea, coffee in floor 1 kitchen at all times. Sandwiches available at all times.	Senior Nurse	Completed April 2017 & in place
18	Staff must ensure that patients' hydration needs are met by ensuring that water jugs/sources are made easily available to all appropriate patients.	2.5	Hydration needs are checked during 'One patient, one day' audits. This is undertaken on a daily basis by the Nurse in Charge or delegated Registered Nurse. All Registered Nurses have been reminded of their duty of care to ensure patients are adequately hydrated whilst in their care and drinks are easily accessible. The Senior Nurse will ensure compliance and undertake spot checks. Water jugs are changed twice a day by the domestic team.	Senior Nurse	Completed April 2017 & in place Completed April 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
19	The Health Board should explore the reason for the gap in controlled drugs stock level checks in majors between 27 February – 3 March 2017 and ensure there is a system in place which ensures checks are carried out consistently on an ongoing basis.	2.6	The Aneurin Bevan University Health Board drug check for controlled drugs is weekly. The Emergency department is compliant with this arrangement. The Emergency department now undertakes checks on a daily basis due to amount used and ease of checking back if any inaccuracies. The Safety Brief has been amended to incorporate checking of the three Controlled Drug areas in the Emergency department as per Health Board policy. This is being audited on a monthly basis.	Senior Nurse	Completed April 2017 Completed April 2017
20	The Health Board must ensure there is clarity about where responsibility lies for medicines audits and ensure these are being carried out.	2.6	There is shared pharmaceutical input into the Emergency Department, however, this currently does not allow for medicines audits to take place. A case for pharmacist and technician input has been developed and has been included in the Integrated Medium Term Plan, this would incorporate medicines audits. In the interim the department is working with the pharmacy department to establish a means of audit, utilising the current resource available.	General Manager Unscheduled Care & Head of Pharmacy	April 2017 May 2017
22	The Health Board must ensure that emergency equipment trolley checks (in majors) are consistently carried out.	2.9	Patient Safety Brief / shift handover document amended to separate resuscitation trolley checks to prompt or remind in paediatrics, resuscitation, minors and majors areas	Senior Nurse	Completed April 2017 & in place

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
23	The Health Board must provide HIW with an update in terms of how increased demand for stroke provision at Royal Gwent Hospital will be managed on an ongoing basis.	3.1	The Health Board Stroke Pathway for Nevill Hall Hospital (NHH) was updated 10th March 2017 and now includes patients with either resolved symptoms, stroke symptoms of more than 3 days can now remain at NHH. The volume of stroke patients attending the Royal Gwent Hospital continues to be monitored.	Executive Director of Therapies & Sciences	Completed March 2017
24	Staff must ensure that patient identifiable information is not left visible on computer screens.	3.4	An addition to the Symphony I.T system (Imprevata) is now in place and assists in the reduction of time information is displayed on computer screens.	Clinical Director	Completed April 2017 ongoing
25	Staff must ensure that they print their names after signing patient records in line with record keeping standards.	3.5	Staff reminded of the need to print names after signatures via the Patient Safety Briefing / handover. Nurse In Charge undertaking spot checks	Senior Nurse	Completed April 2017 ongoing
Quality of management and leadership					
28	The Health Board must ensure that there is a robust system in place to communicate patient safety alerts to all relevant staff.	Governance Leadership and Account-ability	Clinical Director receives all alerts Alerts disseminated to clinical team via email and displayed on the staff room notice boards and discussed in the patient safety briefing. Communication folder including news and alerts is in place in the new staff room.	Senior Nurse	Ongoing Completed April 2017
28	The Health Board should consider how to raise awareness of the Health and Care Standards 2015 with the staff team to ensure that all staff are aware of their responsibilities under these standards.	Governance, Leadership and Account-ability	Health & Care Standards (H & CS) discussed in Senior Nurse meeting 7th April. These discussions were reported to the Clinical Leads meeting in the Emergency department on 2nd May.	Senior Nurse	Completed April 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
			Risk register aligned to Health & Care Standards. Poster for H&CS on staff notice board and communication folder.		
28	The Health Board should consider how to formalise communication systems with frontline staff in the department to assist in closing the communication loop with incidents and keeping staff informed of ongoing developments. Consideration should be given to ensure HCSWs are able to raise views and be included in these communications.	Governance, Leadership and Account-ability	All frontline staff (including HCSWs) are being asked to add their Health Board email address to Datix reporting form to ensure they receive feedback. All Clinical Leads encouraged to give feedback to all frontline staff. All staff to be encouraged to seek feedback when involved in an incident Senior Nurse to operate a 'Staff Surgery- open door 2-4pm on a weekly basis commencing 10th May 2017 for all staff members.	Senior Nurse	Completed April 2017 & ongoing Ongoing
29	The Health Board should ensure that all staff are adequately supported following their involvement in incidents or distressing situations and that debrief systems are able to be carried out in practice.	Governance, Leadership and Account-ability	A debrief is held as close to an event as possible, this can be during the same shift to ensure all staff on duty are available to participate. In addition debrief meetings which extend to wider multi-disciplinary members are scheduled and details are advertised in the staff room. Whilst staff attend these voluntarily, should there be a need to offer additional staff support the employee well being service is regularly accessed. The clinical lead team are also available Mon-Fri 7am to 1pm to discuss any incident/event concerns.	Senior Nurse	Ongoing
30	The Health Board must ensure that nursing staff and HCSWs are supported to stay up to date with their training. The	7.1	With effect from 4th June 2017 staff rosters will include dedicated study leave to complete on line statutory and mandatory	Practice Educator ED	June 2017

Page number	Improvement needed	Standard	Health board action	Responsible officer	Timescale
	reasons for low compliance with training should be explored and a training plan put in place to bring all staff up to date.		training. Compliance will be monitored by the Senior Nurse. In the prolonged absence of the Practice Educator a dedicated staff member has been identified to oversee teaching and clinical supervision. With effect from 11th June 120 hrs study time has been arranged per week and focuses on - Major Incident training / Plastering /Basic Life support for HCSWs / minor injuries and x-ray requesting.	Senior Nurse & Clinical Lead team	May 2017 June 2017
30	The Health Board must ensure that staff are able to easily access and monitor training compliance in order to ensure that they stay up to date with their training.	7.1	ESR used – new IT infrastructure available in new resource room for staff to have easier access. Staff are being made aware of the intranet ESR portal available from June accessible whilst on duty or from home	Senior Nurse	In place June 2017

Health Board Representative:

Name (print): **Lin Slater**

Title: **Assistant Director Nursing (Deputising for Director of Nursing, Bronagh Scott)**

Date: **11h May 2017**