

## **Hospital Inspection (Unannounced)**

Morrison Hospital-Emergency

Department/Abertawe Bro

Morgannwg University Health

Board

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

## **Our purpose**

To check that people in Wales are receiving good care.

## **Our values**

- **Patient-centred:** we place patients, service users and public experience at the heart of what we do
- **Integrity:** we are open and honest in the way we operate
- **Independent:** we act and make objective judgements based on what we see
- **Collaborative:** we build effective partnerships internally and externally
- **Professional:** we act efficiently, effectively and proportionately in our approach.

## **Our priorities**

Through our work we aim to:

**Provide assurance:**

**Provide an independent view on the quality of care.**

**Promote improvement:**

**Encourage improvement through reporting and sharing of good practice.**

**Influence policy and standards:**

**Use what we find to influence policy, standards and practice.**

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department at Morriston Hospital. The hospital is operated and managed by Abertawe Bro Morgannwg University Health Board.

Our team, for the inspection comprised of two HIW Inspection Managers (one of whom coordinated the inspection), two clinical peer reviewers and two lay reviewers. The HIW Head of NHS Inspections was also in attendance for part of the inspection visit as a shadowing opportunity.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

## 2. Summary of our inspection

Patients and their relatives/carers provided positive feedback about their experiences of using the Morriston Hospital Emergency Department, through the completion of HIW questionnaires and face to face discussions.

However, whilst there was a considerable emphasis on ensuring that patients received high quality care, we found evidence that the health board was not fully compliant with all Health and Care Standards associated with the Patient Experience, the Delivery of Safe and Effective Care and the Quality of Management and Leadership.

This is what we found the service did well:

- There was a well coordinated, calm and professional approach to the delivery of care and treatment to patients throughout the inspection
- The approach adopted by the Emergency Department ED in relation to sepsis screening was commended by the inspection team
- The support provided by newly recruited, additional healthcare assistants and Red Cross volunteers, meant that more time could be spent providing practical support and advice to patients and their families

This is what we recommend the service could improve:

- The health board must ensure that there are sufficient numbers of paediatric nurses working within the Morriston ED in response to patients' needs at all times
- The health board is required to ensure that the patient capacity in the minor incident area does not compromise the ability of the allocated nursing/medical staff to provide safe and effective care
- There needs to be consistency and improved details, with regard to the recording of patients' assessments and plans of care

## 3. What we found

### Background of the service

Abertawe Bro Morgannwg University Health Board was formed on 1st October 2009 as a result of a reorganisation within the NHS in Wales and consists of the former Local Health Boards (LHBs) for Swansea, Neath Port Talbot and Bridgend and also the Abertawe Bro Morgannwg University NHS Trust. The Health Board covers a population of approximately 500,000 people.

The Health Board has four acute hospitals providing a range of services. These are Singleton and Morriston Hospitals in Swansea, Neath Port Talbot Hospital located at Baglan Moors, Port Talbot and the Princess of Wales Hospital in Bridgend. There are also a number of smaller community hospitals and primary care resource centres providing clinical services outside of the four main acute hospital settings.

The Emergency Department (ED) at Morriston Hospital is the main unit for South West Wales and provides a 24 hour facility for the assessment, examination, treatment, and referral of all accident victims, and patients with acute illnesses. The hospital's catchment area is both rural and urban, with heavy influences from surrounding industry and agriculture.

The Morriston ED is designated for the receipt of patients following major incidents, chemical, and radioactive incidents. As part of the partnership with the Flying Doctors squad (launched in 2015), the department provides a trauma flying squad to attend the scene of entrapment incidents, such as serious road collisions; and a mobile medical team for major incidents and mass gatherings.

Patient attendance figures for the Morriston ED have been steadily rising every year. Currently, there are over 89,000 patient attendances per annum, over 20,000 of which are children.

The department is divided into the following areas:-

Triage<sup>1</sup>

REACT<sup>2</sup>

Treatment Area and Theatres

Trolley Bay

Resuscitation area

Paediatric area

The Emergency Department will be referred to as the ED throughout this report, for ease of reference.

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<sup>1</sup> Emergency department triage is used to identify patients' level of urgency in order to treat them in a timely way, and in accordance with identified need.

<sup>2</sup> The hospital ED uses a Rapid Evaluation and Commencement of Treatment (REACT) approach to patients who arrive by ambulance. An allocated REACT nurse meets ambulance admissions at the designated area of the ED in order that prompt patient assessment can take place.

## Quality of patient experience

*We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.*

Overall, patients and their relatives commented that they were content with the care and treatment provided at the ED. We also found that the ED team worked well with ambulance services and other hospital staff as a means of ensuring that patients received care and treatment in a timely way.

At the time of our inspection, the ED was very busy, but well coordinated and calm which was indicative of the professionalism and dedication of the staff team.

Improvements identified included the need for prompt and greater access to Community Mental Health Teams<sup>3</sup> (CMHTs) and better arrangements regarding the transition of care for children who need to access adult services. In addition, patient access to disabled toilets in the ED needed to be improved.

During our inspection, we distributed HIW questionnaires to patients attending the ED to obtain their views about the care received from this part of the hospital service. As a result, we received nine completed questionnaires from a combination of people who attended the department for assessment and treatment, relatives and carers.

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<sup>3</sup> Different mental health professionals work in a CMHT. These professionals are from health and social care backgrounds and can include psychiatrists, psychologists, community psychiatric nurses, social workers, and occupational therapists.

Feedback provided within the questionnaires was positive in relation to the care and treatment provided by staff. Patients and their relatives/carers also agreed that staff within the ED were kind.

We spoke with Red Cross volunteers, who described the support they provided to patients and staff through the agreed Support and Discharge Service; which aimed to improve patients' experience whilst attending the Morriston Hospital ED. Specifically, Red Cross staff spent time with patients and their families/carers whilst they were waiting for treatment. They also spoke with medical staff on patients' behalf in accordance with their expressed wishes and provided practical assistance such as contacting patients' relatives and bringing drinks, food and blankets, as required. Other aspects of the support they provided related to the provision of transport from the hospital back to patients' homes (following a referral from medical staff). Information leaflets about this service were available within the ED. The presence of such support was commended by the inspection team.

## **Staying healthy**

Patients and relatives who spoke with us said that they had noted information on large screens within the ED that related to the promotion of people's health and well-being. They did, however, say that the information was repetitive.

We saw that information available to the public within the large screens was bilingual. Such information was supported by the availability of a wide range of information leaflets that patients and their families could take away with them for future reference.

## **Dignified care**

Most patients and their relatives/carers who completed a HIW questionnaire agreed that ED staff were always polite and listened to them, and to their friends and family. In addition, patients and relatives who spoke with us during the inspection told us that they had been treated with dignity.

We found, overall, that ED staff interacted well with patients, were courteous and professional, although clearly working to capacity, and at times over capacity. This was due to the number, and complex needs of, patients who presented at the department.

Responses within completed questionnaires also indicated that ambulance staff treated people with dignity and respect.

It was evident that staff made every effort to ensure that curtains around individual areas were closed at times when patients were being examined and/or treated. Staff also explained that there were occasions when curtains remained open, for the purposes of patient safety and observation.

However, we saw that call bells were not always within easy reach of patients; members of the inspection team moving their position to assist people on a number of occasions. This matter was brought to the attention of senior staff, so that they could remind staff of the importance of placing call bells within easy reach of patients.

### Patient information

One patient who had been assessed as being in need of further care and treatment was assisted back to an ambulance to wait, although the patient thought they were going home. The patient concerned, therefore told us they would have appreciated more information about the decisions that had been made about their care, at that time.

Another patient told us that staff had kept them fully informed and they understood the information that had been provided and a relative described the efforts made by staff to understand the needs of a patient with a diagnosis of dementia.

The above meant that there was an inconsistent approach to providing people with full information about their care at times.

### Communicating effectively

Patients and their relatives/carers who completed a HIW questionnaire agreed that staff had talked to them about their medical conditions or helped to understand them. However, one patient described some anxiety about having to get from a patient bay area to a telephone within the ED, to contact their relative (whilst still experiencing discomfort following a leg injury). Two patients also provided the following comments with regard to communication with staff:

*“People are lovely but go to and fro, and not understanding it all is a strain”*

*“His personality [the patient] has changed, no one has explained stuff or offered me information on how to cope”*

Of the nine patients who completed a questionnaire, five had arrived at the hospital by ambulance. Patients and their relatives/carers were positive about the care provided by the ambulance staff. For example, patients told us that the

ambulance crew were reassuring and explained the care and treatment to be provided in a way that they could understand.

Patients and their relatives/carers agreed that their language needs had been met while at the hospital.

We found that there was a hearing loop available at the ED reception to support individuals with hearing difficulties. We did not find evidence of any other form of support for patients with a sensory loss or communication difficulties (for example, signs in braille or pictorial images).

There was a tannoy system in regular use, to keep patients informed of current waiting times within the ED.

## **Timely care**

On arrival during the evening of day one of our inspection, Morriston ED was at escalation level four<sup>4</sup>; with more than six ambulances in the designated bays. Despite the ED working to full capacity, the general ambience throughout was that of a calm, well co-ordinated service.

Every patient was seen and assessed by a nurse, a process known as triage, to sort out which individuals needed to be seen as a matter of clinical priority. In addition, the department had a REACT centre for triaging some patients who arrived by ambulance. This element of the service was supported by a team of triage nurses for every 24 hour period.

The REACT centre had three patient bays where staff continually strived to provide patients with rapid assessment and treatment. The day to day operation of this part of the ED was supported by a clear and detailed protocol, to support staff to fulfil their responsibilities. We did however; identify the need for the health board to ensure that all ambulance and ED staff were aware of the document and its content. This was, in order that there was consistent application of the requirements of the protocol.

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<sup>4</sup> Health board escalation status levels range from 1-4 (levels 5 and 6 referring to ambulance services only). Level 1 (green) is regarded as a steady state, whereas level 4 is associated with extreme service pressures where all contingencies are fully operational to recover the situation.

One patient, who spoke with us, had been in the ED for over 24 hours; another person for 18 hours waiting for a bed within a surgical ward at the hospital. Other patients, who spoke with us, described their time in the ED, to be around three to four hours to be seen by a triage nurse; a further wait then following, to see a doctor. However, patients generally understood that care and treatment needed to be provided in accordance with the severity of people's condition.

However, although patients generally understood that care and treatment would be provided in accordance with the severity of their condition, some people, relatives and carers who completed a HIW questionnaire, and those we spoke with, had concerns about the length of time they had waited to be seen after arrival at the hospital. Most patients had waited in the ED for at least two hours; with one patient reporting a wait of more than 12 hours. Patient comments within HIW questionnaires about waiting times included:

*"It is a long wait when you are feeling unwell"*

*"Once we saw a healthcare professional I could not fault the care my mother received. However, the wait beforehand is not acceptable for an elderly person"*

*"Although here a long time, I understand why"*

We were able to confirm that every effort was made to ensure that children were seen promptly by a paediatric nurse for triage purposes. The dedicated area of the ED was open to provide services for most of the inspection. There was, however, a period during day three, when a paediatric nurse was not available. This resulted in children being assessed outside of the paediatric area (but still apart from adult waiting zones). We saw that this resulted in some delay in the children concerned receiving further advice, care and treatment.

The above matter was discussed with senior ED staff who told us that the health board were aware of this ongoing issue, and were, in the process of seeking ways of preventing this happening. Further reference to this matter however, is made within the section of this report entitled Quality of Management and Leadership as the health board must ensure the availability of paediatric nurses and the appropriate use of the paediatric area.

Conversations with ED staff highlighted that there was insufficient provision of CMHT services and ongoing difficulties with supporting children who attend the ED who needed to make the transition to adult services. Whilst HIW acknowledges that other health boards across Wales are experiencing similar challenges, this health board is required to ensure that suitable action is taken

now, and in the future, to mitigate any risks to patients' health, safety and welfare.

We found that ED reception staff were required to place a red mark/flag on patient record cards on arrival, in accordance with departmental guidance. This was, in order to highlight any patients considered to be in need of urgent assessment. However, conversations with relevant individuals revealed that reception staff had not received any formal training to fulfil this responsibility; having only been provided with some basic guidelines which did not offer sufficient information to make safe decisions about patients' clinical presentation. We therefore brought this to the attention of the health board in order that this matter could be addressed. This was to ensure that the health and well-being of patients was not compromised at this crucial point in the care pathway.

The health board subsequently provided HIW with a clearer guide for reception staff within 24 hours of our inspection. We were also made aware that the health board intended to provide any new reception staff with appropriate training in the application of red flag alerts.

It was evident throughout our inspection that the ED and Welsh Ambulance Services Trust worked very well together to support patients to receive timely, appropriate care.

Staff described a new initiative which had been set up to support individuals who attended the ED with mental health issues. Specifically, such patients were now referred promptly to see a psychiatric liaison officer for assessment and advice, from the point of nurse triage (until 10:00pm, seven days per week). This was, provided no other medical interventions were required.

#### Improvement needed

The health board is required to provide HIW with a description of the action taken/to be taken to ensure the following:

- Improved patient access to CMHT services
- Improved and timely transition of care arrangements for children who need to access adult services

## Individual care

## Planning care to promote independence

We found that the recording of patients' plans of care and ongoing management/discharge arrangements was limited in a number of instances. More specifically, records meant to show the presenting needs, care provided and re-assessment of individuals admitted to the ED, required more detail. This was needed so that all staff who may be involved in people's care were clear and up to date about what needed to happen to ensure the delivery of safe and effective care.

Reference to the need for improved recording within patient's ED records can also be found within the next section of this report under the sub heading of record keeping.

There were signs in place on toilet doors to help patient with sensory problems to locate such areas. Signs to, from and within the department were present to assist patients find their way around. However, some were small and located too high for some patients with visual impairment to see; a small number being handwritten and not placed in areas to assist patients. The health board was therefore verbally advised to consider making improvements in this regard.

In addition, two patients who completed a HIW questionnaire provided the following comments:

*“The toilets are unclean and the disabled toilet is not easy to access in a wheelchair”*

*“Disabled toilet in area not easy to manage to take wheelchair”*

### Improvement needed

The health board is required to provide details of how it could improve patient access to the disabled toilets within the ED.

## People's rights

We found that relatives were encouraged to remain with their family members; relatives' rooms being available for private discussions.

We saw that there were copies of the current version of Putting Things Right available to patients; such leaflets relating to the agreed arrangements in Wales for responding to concerns about NHS care.

## Listening and learning from feedback

We were able to confirm that patients could provide the ED with comments about their experience within the department and care received. This could be achieved through the use of the health board's website, online and via the Friends and Family<sup>5</sup> initiative. In addition, we saw blank comments cards at the ED reception, together with a red box which could be used for completed cards to be collected by health board staff.

A number of patients, who spoke with us, however, said that they would not know how to raise a concern, or make a complaint about their NHS care if needed.

We were informed that there had been an increase in the receipt of patient feedback via the Friends and Family initiative during the past year; all comments being analysed on a weekly basis by nominated staff. In the event that a negative comment is received, the details are logged onto the health board's patient experience system. Patients are then subsequently contacted by a member of the Patient Advice and Liaison Service (PALS) team who take time to listen to patients and ensure that appropriate action is taken in response to the nature of the concern. Examples of such concerns have related to car parking arrangements and ED access times.

In addition, results from the Friends and Family initiative were displayed for staff to inform them of how the department was performing from a patient perspective. This demonstrated that there was an emphasis on encouraging openness and honesty among the staff team.

We were provided with a copy of a report prepared by senior managers for the Quality and Safety Forum (January 2018) which showed the emphasis placed on exploring the reasons for patients' concerns or lack of satisfaction with the services they received. The report also indicated that there had been a significant improvement in resolving patients concerns on the spot.

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<sup>5</sup> The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

We were also made aware that a children's play area had been created within a section of the main outpatient area at Morriston as a result of the views of, and collaboration with, one family who had experience of ED/other services at the hospital. This was regarded as an example of good practice.

## Delivery of safe and effective care

*We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.*

It was evident that the staff team within the ED and associated senior managers were focussed on the provision of effective and timely patient assessment/triage within a clean and safe environment.

In addition, there were clear and well understood systems and processes in place to guide staff and promote safe and clinically effective care based on best practice and professional guidelines.

### Safe care

#### Managing risk and promoting health and safety

There was a well established system in place for reporting, recording and investigating significant incidents.

All areas visited within the three days of inspection were free from trip hazards.

#### Preventing pressure and tissue damage

On looking at a sample of patient's records, we found that patients generally had an assessment of the condition of their skin shortly after their arrival at the ED. However, we found there was inconsistent ongoing recording of patients' skin checks, particularly in respect of those patients who arrived at the ED via ambulance, assessed within the REACT area and returned to the ambulance for supervision and monitoring until such time that a hospital bed was available.

More specifically, skin assessment (for those patients who were unable to move independently for various reasons) did not take place whilst patients were in ambulance vehicles for long periods of time (sometimes in the region of three to four hours). Such circumstances had the potential to result in skin damage as ambulance staff are not trained to monitor skin integrity.

The inspection team acknowledged that many patients were able to change their position on trolleys, independently, but for those who were unable to, the above matter must be addressed. The health board is also advised of the need to record times, when patients are assessed as being mobile and able to change their position freely and independently, to assist the wider team to be clear about their care needs.

### Improvement needed

The health board is required to inform HIW of the action taken/to be taken to ensure that every effort is made to prevent people who attend the ED from developing pressure and skin tissue damage.

### Falls prevention

We found that patients were not formally assessed for the risks of falling. This undermined their safety and the safety of others. The absence of this form of risk assessment is highlighted further under the heading of record keeping at the end of this section of the report.

### Infection prevention and control

Most patients and their relatives/carers who completed a HIW questionnaire agreed that the ED was both clean and tidy.

Examination of a sample of records indicated that patients were screened (using health board documentation) in relation to sepsis<sup>6</sup>. We also spoke with one of the hospital's sepsis coordinators who was able to describe the emphasis placed on identifying sepsis, together with the prompt and appropriate action to be taken in such circumstances.

We were able to confirm that personal protective equipment such as aprons, goggles and gloves, were readily available to staff within the ED and used by clinical staff at appropriate times. Conversations with clinical and housekeeping

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<sup>6</sup> Sepsis is a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream.

staff also revealed that stocks of such items was sufficient; clear verbal descriptions of cleaning procedures being provided.

Observations of the ED environment over a three day period demonstrated that all areas were visibly clean as a result of which, the housekeeping staff were commended. The only exception, related to one instance where patient toilets close to the main waiting area, were found to be in need of cleaning at a particularly busy time. However, shortly afterward, housekeeping staff were seen to be addressing this without any prompt from the inspection team.

We saw that there were hand wash basins, hand sanitiser and items for hand drying, available in all key clinical areas. In addition, it may be useful though, for the health board to undertake a risk assessment as to whether sanitiser stations at the entrances to the ED, would also be of benefit.

All of the above was in-keeping with required adherence to current professional guidelines regarding infection prevention and control (IPC).

We were told that the IPC lead person completed a monthly hand washing audit. We were also provided with the results of the most recent audit activity in this regard (this showed that 24 out of 30, 25 out of 30 and 22 out of 30 staff were compliant between October and December 2017 respectively). However, during our inspection, we saw that both medical and nursing staff did not always wash their hands at critical points during care provision (in-keeping with IPC guidelines). Additionally, a number of patient trolleys across the ED were in need of cleaning.

We saw full bags of used linen being pulled across areas within the ED. In addition, the sluice adjacent to the Majors area did not appear visibly clean throughout; (the door being constantly propped open throughout the inspection). This included the presence of a gel packet from a used pregnancy test, which could have been mistaken as a form of food by patients with cognitive impairment. This particular issue corresponds with known health board non-compliance with a National Patient Safety Alert <sup>7</sup> in this regard.

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<sup>7</sup> The National Reporting and Learning System (NRLS) and patient safety alerts enable patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

Our concerns regarding the need for the immediate cleaning of a soiled commode and the disposal/storage of toxic substances were dealt with using our immediate assurance approach. Details of the immediate improvements we identified are provided in within Appendix A of this report.

We saw that disposable curtains within the dedicated decontamination room, were dated 2011, which indicated that they had not been changed since that time. This area was seen to be in use on day three of our inspection. This matter needs to be addressed.

Conversations with staff indicated that they had completed mandatory training with regard to IPC. We were told (and saw), that sharps bins were dated; a well established process being in place for porters to remove them when full. Additionally, staff described how they would isolate patients who were suspected as being infectious. This was in order to prevent cross infection and protect patients and staff.

We were satisfied that there were suitable arrangements in place in response to needle stick<sup>8</sup> injuries and commended medical staff for prompting members of the inspection team to ensure that their clothing was adjusted so that skin was bare below the elbow, as per health board and professional guidelines. This was to promote effective hand washing.

#### Improvement needed

The health board is required to inform HIW how it will ensure that:

- Patient trolleys are effectively cleaned to reduce cross infection
- Staff adhere to IPC guidelines with regard to effective hand washing
- There is a clear process in place to change disposable curtains
- Doors to sluices are kept closed and all hazardous substances stored

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<sup>8</sup> Needle stick injuries are wounds caused by needles that accidentally puncture the skin. Needle stick injuries are a hazard for people who work with hypodermic syringes and other needle equipment. These injuries can occur at any time when people use, disassemble, or dispose of needles.

in a lockable facility when not being used

### Nutrition and hydration

We saw that patients were provided with hot drinks and food, at various intervals during their time within the ED; drinks and snacks being available to visitors/relatives via vending machines, or within the visitors' room. We were also able to confirm that relatives had been offered food and drink as a result of the length of time they had been present in the ED with their relatives.

Patients' food was served promptly so that it did not get cold. We also saw Red Cross volunteers serving drinks to patients; nurses, healthcare assistants and relatives assisting patients to eat and drink, where required.

Whilst we did not see any water jugs available to patients, we saw that patients were provided with water in plastic cups during the inspection.

However, we found that assessment and recording of patients' consumption of food and drink was either inconsistent, or absent, as was the recording of urinary output. This matter has been highlighted as an improvement needed under the heading of record keeping at the end of this section of the report.

We also saw that patients, who were provided with a hot meal, had no means of resting the polystyrene tray in which food was served. This proved to be uncomfortable for some patients and presented difficulties to others, when trying to eat and balance the tray. This matter was highlighted by the local Community Health Council during their 2016 visit to the ED. We therefore brought this to the attention of senior managers once again, especially as patient trolleys within the ED of another ABMU hospital are fitted with appropriate equipment for the above purpose.

### Improvement needed

The health board is required to describe the action taken, to ensure that patients' consumption of food and drink is accurately and consistently recorded. This is to ensure that patients' needs are met and to maximise their recovery.

The health board is required to inform HIW of the action taken to ensure that patients are enabled to eat and drink safely, with the support of appropriate

equipment. In addition, HIW requires details of how the health board will ensure that patients' food and/or drink positioned within easy reach.

## Medicines management

We looked at six medication administration charts and found that all contained patients' full details and unique identification information. In addition, patients had identity wristbands in place. This assisted with the safe administration of medication.

Morrison ED had a secure electronic system for storing all prescribed medication (as well as making medication available to staff) for patient administration. The system was also capable of producing reports in terms of usage and incorporated a number of safety mechanisms to ensure that the system remained safe; preventing unauthorised access. Additionally, as stock was used, the pharmacy department was automatically alerted so that items could be promptly replaced.

However, we identified the need for improvement to aspects of medicines management as a result of the following matters and in accordance with the All Wales Prescription Writing Standards<sup>9</sup>:

- Three out of six charts failed to contain dates alongside medication prescribed. This constitutes non compliance
- The allergies section within one of the six charts was completely blank. Such situations pose a risk to patients who may be sensitive/allergic to certain substances/drugs
- Whilst HIW acknowledged that the recording of oxygen therapy within ED remains the subject of much debate, there is a need to record the

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<sup>9</sup> <http://www.awmsg.org/awmsgonline/app/sitesearch?execution=e2s1> Link to All Wales Prescription Writing Standards.

reasons for this prescribed item and the dose to be administered in accordance with individual patient need

- In the event that the ED continues to use a Controlled Drugs book as an additional means of checking drug stocks and for the purposes of prompt investigation of patient incidents, the content and recording must comply with professional guidelines and current legislation

We found that patient medication charts contained correct codes to indicate reasons for non-administration of prescribed medication. We also saw that staff were not disturbed when checking and administering medication to patients; no medication being left unattended at any point during the inspection. The administration of intravenous fluids was correctly recorded and updated as necessary.

Any medication knowingly brought into the ED by patients, was stored securely as seen. Additionally, some patients were able to self medicate following agreement with staff that this situation would be considered as low risk.

Conversations with staff confirmed that they had easy access to locate relevant policy documents and guidelines in relation to the safe management of medicines.

### Improvement needed

The health board is required to provide HIW with details of the action taken to ensure:

- Prescribed medication is always dated within patients' medication charts
- Clarity in relation to the administration of oxygen therapy
- Patients' allergies are always recorded within medication administration records
- Appropriate and ongoing use of the CD book

This is to ensure that people receive medication for the correct reason, the right medication at the right dose, and at the right time.

### Safeguarding children and adults at risk

We held discussions with staff and explored the information held within the ED in respect of staff training with regard to safeguarding. As a result, we were able to confirm that members of the ED team we spoke with, were confident in the use of the All-Wales safeguarding arrangements associated with adults and children.

However, on exploring compliance with staff training on the topic of safeguarding, we found that just fewer than 50 per cent of the ED staff had completed up to date training sessions on this topic. In addition, when we looked at the content of a number of patient's ED records, we found that mental capacity assessments were either absent, or provided limited information.

We therefore held further discussions with senior managers to explore those issues further, together with the application of Mental Capacity Act legislation. Consequently, we were informed that in instances when a person attended the ED and was subject to a Deprivation of Liberty Safeguards (DoLS)<sup>10</sup> authorisation (which had been initiated within a care home environment prior to admission to the ED), the provisions of the Mental Capacity Act (2005) would not apply. Whilst there has been no case law to specifically address this issue, there is some statutory and common law guidance available for staff to consider. It is therefore suggested that current and future staff training incorporates such guidance to assist staff with their decision making around what to do within the ED, especially at times when patients (who are subject to DoLS authorisations) are required to spend more than a few hours within the department.

Given the need for health services to promote and protect the welfare and safety of patients in accordance with the Mental Capacity Act, the above matter needs to be addressed.

We found that ED staff had ready access to details about children who may be vulnerable, or at risk. This meant that there was a particular emphasis on the provision of safe care and management of such situations.

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<sup>10</sup> The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.

Conversations with staff indicated that children who attended the ED were generally assessed and treated within a secure, designated area, away from other parts of the department most of the time. This ensured that they were seen and cared for within a protected, appropriate environment.

However, during our inspection, there were occasions when children were not able to receive care in the designated paediatric area of the ED. This was because of the lack of paediatric trained nurses available at that time. Whilst we were able to confirm that ED staff ensured children were seen and assessed away from the main waiting area, this situation, which was also highlighted by the local Community Health Council during their 2016 visit, must be addressed by the health board. This is to ensure the safety and welfare of children and their parents. Further reference to this matter can be seen within the section of this report entitled Quality of Management and Leadership.

#### Improvement needed

The health board is required to inform HIW of the action taken/to be taken to ensure that patients are subject to mental capacity assessments within the ED, in accordance with their presenting needs.

The health board is required to ensure that ED staff are fully aware of their responsibilities in caring for patients who are subject to DoLS authorisations. This is in accordance with the Mental Capacity Act 2005.

#### Medical devices, equipment and diagnostic systems

We saw that each patient bay/area had a good supply of equipment and consumable items (for example, for blood testing and patient monitoring). There was also spare equipment available in the event of malfunction or breakdown.

We saw that staff had access to moving and handling equipment and suitable patient mattresses.

We were able to confirm that equipment was maintained regularly, either by health board estates staff, or via external contracting arrangements. In addition,

we saw the application of equipment labels which showed that they had undergone timely portable appliance testing.

In instances where equipment faults were reported, there were no stated delays in action being taken, generally. Staff also described that they would complete a Datix<sup>11</sup> incident form, so that prompt action would be taken.

The above supported the delivery of safe and effective care.

## **Effective care**

### **Safe and clinically effective care**

Conversations with staff revealed that one of the Consultants had set up the Sepsis Group Morriston Emergency Department (SeGMED)<sup>12</sup> within the hospital. Since that time, staff education days had been arranged to raise awareness about sepsis. At the time of our inspection, approximately 900 staff had completed such training across a range of clinical disciplines. In addition, a sepsis screening tool had been developed and used within the ED, together with a programme of audit to check on whether the initiative was making a difference to patients who attended the department.

Statistics provided in terms of the use of the sepsis tool clearly showed that staff awareness of sepsis had improved. We also saw that results from audit activity were displayed within the ED staff area in relation to sepsis. The approach adopted by the ED in relation to sepsis screening was commended by the inspection team.

Patients and their relatives/carers who completed a HIW questionnaire said that ambulance staff did everything they could to help control their pain.

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<sup>11</sup> Datix enables incident reports to be submitted from wards, hospital departments, ambulance stations, GP practices and independent contractors, greatly improving rates of reporting & promoting ownership of risk.

<sup>12</sup> During 2017, Morriston hospital's Emergency Department set up a working group called SeGMED which launched an awareness campaign promoting early identification of sepsis. Sepsis occurs when the body's response to infection injures its own organs. Identification can be difficult because the symptoms often resemble other, less serious conditions, but early detection and treatment is the key to preventing deterioration.

In contrast, we looked at a sample of patient's ED records on two separate days and found that recording about patients' pain management needed to be improved. This was because, we saw a number of instances where patients' medical notes showed that they were experiencing pain, yet patients' ED records and observation charts failed to provide evidence of patients' pain scores/assessment/management and evaluation. The above meant that this aspect of patients' needs may not have been met.

We found that patients' other medical needs were assessed and recorded on admission to the ED, although we identified the need for improvements in the recording of patients' presentation and management within nursing notes.

The absence of such recorded assessments is also highlighted as an improvement needed at the end of this section of the report under the heading of record keeping.

We saw that ambulance admission boards were used and updated to identify patients due to arrive via incoming vehicles. This was a recognised system used to assist staff within the ED to plan the delivery of care, and to ensure that patients were seen in a timely way. We were also able to confirm that patient status information boards located away from areas occupied by the public, contained up to date and sufficient detail to assist staff in managing the flow of patients through the ED in a safe manner.

Conversations with staff indicated that there were occasions within the ED when patients were in receipt of care on trolleys within corridor areas. At such times, staff told us that although this created challenges in the delivery of safe and effective care, every effort was made to avoid such situations.

We did not see any patients in receipt of care in corridor areas during our inspection.

### **Record keeping**

We considered the content of a number of ED records in some depth, and four patient records in detail, during two of the three days of our inspection.

Overall, records were clear and easy to read, with the exception of the use of a small number of medical abbreviations. We also found that some records provided enough detail to assist bank or agency staff to understand patients' presentation and needs.

However, overall, there was limited information available within patients' ED records to highlight their agreed plans of care and action required. In addition,

assessment booklets contained a lot of loose, additional paperwork which could be mislaid.

We also advised of the need to ensure that all entries made within patients' records were signed and dated with the name and role of the person responsible for the entry. This is, in accordance with professional guidelines.

As already stated under various headings within this report, we identified the need for improvement in the use of core risk assessment documentation (particularly in relation to patients' nutritional needs, mental capacity, risk of falls, risk of damage to skin areas, and pain assessment/evaluation).

All the above matters were brought to the attention of the health board during the HIW feedback meeting, as a result of which we found there was a willingness to address the above matters in a prompt and robust manner.

### Improvement needed

The Health Board is required to provide HIW with details of how it will ensure that improvements are made in relation to the following:

- All pages of the assessment booklet used within the ED must contain unique identifying details of each patient
- Body maps must be present within assessment booklets in accordance with the presentation of patients
- There needs to be sufficient and consistent information within patients' ED records and other nursing/medical records
- All entries made within patients' ED records must be signed and dated and contain the name and role of the person concerned
- The health board is required to ensure that patient risk assessment documentation is completed in relation to oral care, pain relief (including monitoring and evaluation) and the use of rails attached to trolleys

This is to demonstrate that such aspects of care have been considered and to ensure that people receive safe and effective care in accordance with the Health and Care Standards.

## Quality of management and leadership

*We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.*

During our inspection, we found evidence of strong management and leadership associated with the day to day operation of the Morriston Emergency Department.

Senior medical and nursing staff were visible during our visit and staff were striving to deliver high quality safe and effective care to patients within an extremely busy clinical environment.

We also found the staff team to be very aware of the challenges they faced in providing care and treatment to patients. We also found the team and senior managers to be very keen to explore new and different ways of working for the benefit of patients and staff.

## Governance, leadership and accountability

Conversations with senior staff revealed that there were robust governance<sup>13</sup> arrangements in place to ensure that services within the ED were monitored; improvements being made for the benefits of patients, wherever possible. We were also provided with details of the Quality Improvement Plan associated with the ED for 2017-18, together with a verbal description of how actions that

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<sup>13</sup> Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

needed to be taken, would be monitored. Senior staff also clearly described the membership and purpose of forums and quality assurance groups established within the health board. We were also made aware of how quality, safety and patient experience information was gathered and shared across the health board's delivery units<sup>14</sup> so that lessons could be learnt and good practice shared.

The senior management team demonstrated a clear understanding of the issues and challenges facing the department as a result of increased demands for unscheduled care services. One particular challenge related to the insufficient numbers of paediatric nurses available to work within the designated children's area within the ED. To date, the hospital's paediatric assessment unit had often been able to provide trained nurses on an ad hoc basis. However, the health board must seek a more permanent solution to this ongoing matter.

We also found that there were many occasions when two registered nurses working within the minor injuries area of the ED, had to provide care for much larger numbers of patients than was intended. This situation reduced the ability of the staff to provide safe and effective care to patients. The health board must address this issue.

We were provided with a copy of a recent weekend plan, which informed site managers and clinical staff of the key contacts and plans in place at Morriston Hospital to assist with the provision of safe and effective care to patients. This document was detailed and included relevant information about elective admissions for the weekend period, potential discharges, and internal transfers to patient beds outside of Morriston Hospital. This demonstrated that there was considerable emphasis on ensuring that patients received care at the right place at the right time.

We found that there were well established arrangements in place in an attempt to ensure that appropriate action to improve services was taken in response to inspection/external review from organisations such as HIW, The Public Services Ombudsman for Wales and the local Community Health Council

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<sup>14</sup> The NHS Wales Delivery unit assists with the development and improved performance of patient services.

(CHC), (although, as stated earlier in this report, some matters raised by the CHC during 2016, have yet to be addressed by the health board).

The health board was pro-active in monitoring services provided to patients, in accordance with the requirements of the Health and Care Standards.

Staff who spoke with us said that multidisciplinary working was generally good, the wider hospital staff teams working well with those within the ED, to ensure that the flow of patients from the ED to home, or to a ward, was managed well.

Discussions with senior staff provided us with information about the current winter planning/service initiative called Breaking the Cycle. The main aim of the initiative was to improve the patient journey from hospital admission to discharge by facilitating efficient and quick communication between different services and functions. This was, with a view to improving the quality and delivery of services at the hospital overall. In order to achieve that, we found there was clear involvement of staff at all levels, who were required to work together to focus on patient care, in ways which included:

- Ensuring ward based care assessments were kept up to date in order that decisions could be made about the next steps in patients' care
- Placing a particular emphasis on expected date of discharge
- Using non-clinical staff as ward liaison officers to provide extra support to clinical colleagues. The aim of the ward liaison role was to support the safe and timely discharge of patients (for example, by contacting members of the wider multidisciplinary team to provide assessment and advice and/or contacting patients' relatives

Early outcomes indicated that the initiative had generated a positive impact on patient flow, especially through the use of ward liaison officers and the effective collaboration between all staff concerned.

Discussions with senior staff with regard to the management and resolution of complaints handling revealed an improved and prompt approach to such matters.

#### Improvement needed

The health board is required to inform HIW of the action to be taken to ensure that there are sufficient numbers of paediatric nurses working within the Morriston ED in response to patients' needs.

The health board is required to provide HIW with full details of the action

taken/to be taken to ensure that the patient capacity in the minor injuries area does not compromise the ability of the allocated nursing staff to provide safe and effective care.

## **Staff and resources**

### **Workforce**

During our inspection of Morriston Hospital we distributed HIW questionnaires to staff working in the Emergency Department to find out what the working conditions were like, and to understand their views on the quality of care provided to patients.

As a result, we received six completed questionnaires from staff undertaking a range of roles within the ED. The following issues were highlighted:

- Staff indicated that they weren't always able to meet all the conflicting demands on their time at work
- Staff felt that they didn't always have the adequate materials, supplies and equipment to do their work
- The majority of staff who completed a HIW questionnaire said that they were able to make suggestions to improve the work of their team or department
- The majority of staff indicated that they were usually satisfied with the quality of care they gave to patients

Conversations with senior managers revealed that staff were able to access support from the ED Staff Wellbeing Project for help and advice, as and when needed.

We were also made aware of the planned quarterly Morriston Get Together sessions, the purpose of which was to provide staff with a voice in terms of delivering the best patient care and also to encourage staff to get together informally.

Staff told us that the organisation regularly encouraged teamwork, their manager was always supportive in a personal crisis, and managers could be counted on, to help them with a difficult task at work.

In addition, the majority of staff members who completed a questionnaire agreed that their organisation encouraged them to report errors, near misses or incidents, and believed that when they were reported, the organisation would take action to ensure that they did not happen again.

We were provided with a practical demonstration of how staff training was recorded and monitored. As a result, we saw that training records were kept up to date; compliance with agreed health board mandatory training being regularly monitored. This meant that there was an emphasis on ensuring that staff were confident and competent in the delivery of care and treatment within the ED. We did, however, find that compliance with staff training on the topics of safeguarding and the Mental Capacity Act 2005, needed to be improved. In addition, we found that Band 7 registered nurses were currently unable to access level 3 training on the topic of dementia.

We were able to confirm that new staff received an induction within the ED, records being available to demonstrate relevant competencies. Senior staff also described that training was provided through a mixture of e-learning, classroom style sessions and self directed learning.

Conversations with staff (and responses within six HIW questionnaires) confirmed that they had undertaken a wide range of training, learning and development whilst working at the hospital in the last 12 months. Training topics included infection prevention and control, fire safety and on how to maintain the privacy and dignity of older persons in their care.

Staff generally agreed that the training or learning and development they had completed, helped them to do their job more effectively, stay up to date with professional requirements, and ensured that they delivered a better experience for patients.

Registered nurses and the member of the clinical staff leading and managing the department were visible at all times; arrangements for the safe planning and coordination of patient care being clear to all staff.

Conversations with staff revealed that staff sickness levels were low, as was staff turnover. There were occasions when agency staff needed to be used to assist at times of unforeseen staff sickness/absence and we were told that every effort was made to request the same staff. This was to assist with consistency and continuity of care to patients.

We were informed that the department had recently secured agreement to recruit 11 additional health care assistants to work within the ED, to improve the provision of contact with individuals and their relatives. This arrangement was

already considered to have made a positive impact on the delivery of safe and effective care to patients. A senior manager also provided us with details about how the health board continually reviewed staff levels and skills within the ED.

All staff attended a 1:1 appraisal session which assisted with determining individual and departmental training needs. Senior managers acknowledged however, that attendance at such sessions had been difficult in recent months, due to the increased demands on unscheduled care.

#### Improvement needed

The health board is required to inform HIW of the action taken/to be taken to ensure that staff complete the following training:

- Level 3 dementia training for Band 7 staff
- Up to date training with regard to the MCA (2005)/DoLs/safeguarding

## 4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

## 5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the [Health and Care Standards 2015](#). We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about [how HIW inspects the NHS](#) can be found on our website.

## Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
<p>The need for the removal of gel packets from the sluice near REACT area. (which contained toxic substances) These were present as part of the routine packaging associated with pregnancy tests and other consumables.</p> <p>Prompt cleaning of a commode was required due to the presence of bodily fluids. The issue was made known to staff on discovery, so that remedial</p>	<p>The gel packets could have been accessed by unauthorised persons, including patients with cognitive impairment who may potentially, have mistaken the contents of the packets, for a form of food.</p> <p>Failure to clean such equipment in a prompt manner could have resulted in cross infection.</p>		

action could be taken.			
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## Appendix B – Immediate improvement plan

**Hospital:** Morriston Hospital  
**Ward/department:** Emergency Department  
**Date of inspection:** 15 16 and 17 January 2018

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
We did not identify any immediate concerns at this inspection.				

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

### Service representative:

**Name (print):**

**Job role:**

**Date:**

## Appendix C – Improvement plan

**Hospital:** Morriston Hospital  
**Ward/department:** Accident and Emergency  
**Date of inspection:** 15 16 and 17 January 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
<b>Quality of the patient experience</b>				
<p>The health board is required to provide HIW with a description of the action taken/to be taken to ensure the following:</p> <p>Improved patient access to CMHT services</p> <p>Improved and timely transition of care arrangements for children who need to access adult services</p>	5.1 Timely access	<p>Access to CMHT is via the hospital based Psychiatric Liaison Service who would act as the 'bridge' between ED and community based mental health teams</p> <p>In terms of children and younger adults with mental health issues, an All Wales review is taking place regarding the wider service provision for CAMHS service across Wales and how these will be accessed in the future.</p> <p>This service is hosted by Cwm Taf Health Board.</p> <p>Open communication and strong relationships with the CAHMS head of nursing is established</p>	Head of Nursing ECHO, Morriston	May 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		and any incidents are discussed.		
The Health Board is required to provide details of how it could improve patient access to the disabled toilets within the Emergency Department.	6.1 Planning Care to promote independence	<ul style="list-style-type: none"> <li>• There are currently 4 disabled toilets in the Emergency Department. 1 in the main waiting room, 1 in allocated GP Out of Hours and 2 in the trolley area. A review of access to these toilets to be undertaken for patients in wheelchairs and required improvements made.</li> <li>• A full review of all Emergency Department signage (including toilets) to be undertaken to ensure these are clearly visible to all patients regarding location and signage updated where required</li> </ul>	<p>Estates Manager, Morriston Hospital</p> <p>Estates Manager, Morriston Hospital &amp; Matron Emergency Care, Morriston</p>	<p>May 2018</p> <p>May 2018</p>
<b>Delivery of safe and effective care</b>				
The Health Board is required to inform HIW of the action taken/to be taken to ensure that every effort is made to prevent people who attend the Emergency Department from developing pressure and skin tissue damage.	2.2 Preventing pressure and tissue damage	<p>Focused multi agency (including Welsh Ambulance Service Trust &amp; Tissue Viability Nurses) project group set up to review tissue viability pathway and documents. All agreed actions to be fully implemented including:</p> <ul style="list-style-type: none"> <li>• Additional (unfunded) staffing resource within REACT to ensure full pressure area</li> </ul>	Head of Nursing, ECHO Morriston & Matron Emergency Care, Morriston	30 <sup>th</sup> April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>check &amp; remedial action is part of REACT process – longer term funding plan required.</p> <ul style="list-style-type: none"> <li>• Revised training and awareness raising with all Emergency Department staff</li> <li>• Pressure relieving Repose devices purchased</li> <li>• Engage with WAST regarding risk reduction measures whilst on ambulances</li> </ul> <p>An Emergency Department Nurse Establishment Review was undertaken in 2017 identifying what nursing resource is required to ensure all appropriate patient checks and care can be provided. Funded nursing establishments require amending to meet the agreed safe staffing levels. Health Board to consider reviewing Morriston Emergency Department funded establishment in line with establishment review outcomes.</p>	<p>Associate Finance Director, Hospital Service Group Manager, ECHO</p>	
<p>The Health Board is required to inform HIW how it will ensure that:</p> <p>Patient trolleys are kept clean at all times</p>	<p>2.4 Infection Prevention and Control (IPC) and Decontamination</p>	<p>Monthly meetings with porters highlighted the</p>	<p>Matron Emergency</p>	<p>January 2018</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
<p>Staff adhere to IPC guidelines with regard to effective hand washing</p> <p>There is a clear process in place to change disposable curtains</p> <p>Doors to sluices are kept closed and all hazardous substances stored in a lockable facility at all times</p>		<p>issues and action taken</p> <p>Daily check lists completed by porters with Weekly assurance checks to be implemented and undertaken by Matron.</p> <p>Domestic to supply the rolling rota for curtain change to Matron and ensure this is maintained as part of weekly checks.</p> <p>Posters/signs laminated in sluice &amp; staff to be spoken to, to ensure all stores / hazardous substances are safely sorted, stored and locked away where required and that the doors are kept closed at all times. Matron to include in weekly checks.</p>	<p>Care, Morriston</p> <p>Matron, Emergency care, Morriston &amp; Domestic Team Manager, Domestic</p> <p>Matron, Emergency care, Morriston</p>	<p>March 2018</p> <p>March 2018</p>
<p>The Health Board is required to describe the action taken, to ensure that patients' consumption of food and drink is accurately and consistently recorded. This is to ensure that patients' needs are met and to maximise their recovery.</p> <p>The Health Board is required to inform HIW of the action</p>	<p>2.5 Nutrition and Hydration</p>	<p>Matron to remind all nursing staff of the importance of using the nutrition and fluid intake stickers in the patient records and accurately recording the patient's diet and fluid intake. Monthly compliance audits to be undertaken, implemented and appropriate professional action taken when any areas of non-compliance</p>	<p>Matron, Emergency care, Morriston</p>	<p>March 2018</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
<p>taken to ensure that patients are enabled to eat and drink safely, with the support of appropriate equipment. In addition, HIW requires details of how the Health Board will ensure that patients' food and/or drink is positioned within easy reach.</p>		<p>are identified.</p>	<p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p>	<p>June 2018</p>
		<p>In April 2017 an introduction to food record E-learning as a mandatory one off learning requirement. ED nursing staff currently 73% compliant with training. 100% nursing staff compliance to be achieved.</p>		<p>August 2018</p>
		<p>100% nursing staff compliance required with fluid intake E-learning training.</p>		<p>Completed: March 2018</p>
		<p>Red Cross staff have been trained in Food Hygiene and have been reminded of the importance of use of patient food stickers.</p>		<p>August 2018</p>
		<p>All HCSW to complete Food Handling and Hygiene Training</p>		<p>By March 2018</p>
		<p>Red cross staff have been reminded to discuss patient's nutritional needs with the nurse in charge of the patients care. Red Cross to be given access to the E- Learning Food &amp; Nutrition Training Tool.</p>		<p>June 2018</p>
		<p>Trolleys have been purchased so that patients can easily reach their food/drink.</p>		<p>Completed March 2018</p>
		<p>New patient buzzers to be purchased to ensure</p>		<p>Completed</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>there is a back-up for any patient buzzers that have been sent for repair.</p> <p>All nursing staff have been reminded to always ensure patients have call bells at hand.</p>	<p>care, Morriston</p> <p>Matron, Emergency care, Morriston</p>	<p>March 2018</p> <p>Completed March 2018</p>
<p>The Health Board is required to provide HIW with details of the action taken to ensure:</p> <p>Prescribed medication is always dated within patients' medication charts</p> <p>Clarity in relation to the administration of Oxygen Therapy</p> <p>Patients' allergies are always recorded within Medication Administration Records</p> <p>Appropriate and ongoing use of the CD book</p> <p>This is to ensure that people receive medication for the correct reason, the right medication at the right dose, and at the right time.</p>	<p>2.6 Medicines Management</p>	<p>Nursing staff have been reminded of the Medication Policy and the need to tenure an accurate recording when administration of medication, with necessary signatures and dates, that oxygen not covered by PGD is prescribed, importance of ensuring allergies are recorded and managing CDs in line with Controlled Drugs Policy. MDT Monthly audits covering all of the above areas to be undertaken to ensure compliance</p> <p>Medical staff to be reminded when completing medication chart to ensure medication is dated and signed, that allergies must be recorded on the medication chart and that oxygen must be prescribed.</p>	<p>Matron, Emergency care, Morriston</p> <p>Associate Medical Director</p>	<p>March 2018</p> <p>March 2018</p>
<p>The Health Board is required to inform HIW of the action taken/to be taken to ensure that patients are subject to mental capacity assessments within the Emergency</p>	<p>2.7 Safeguarding children and</p>	<p>MCA and DoLs training compliance is currently 25% - 100% of staff to receive MCA and DoLs training. To be facilitated by the Emergency</p>	<p>Matron, Emergency care, Morriston</p> <p>Associate Medical</p>	<p>August 2018</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
<p>Department, in accordance with their presenting needs. This is in accordance with the Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005.</p> <p>The Health Board is required to ensure that Emergency Department staff are fully aware of their responsibilities in caring for patients who are subject to DoLS authorisations. This is in accordance with the Mental Capacity Act 2005.</p>	adults at risk	<p>Department Clinical Educator.</p> <p>All grades have Dementia Champion in Emergency Department and this includes reception staff. These have been on the Champion Training. 100% of staff in Emergency Department to have undertaken Dementia Training.</p> <p>The number of HCSW Dementia Champions have been increased since the review</p> <p>Champions to do a “focus” board on DoLS and Butterfly Scheme in the educational hub.</p>	<p>Director</p> <p>Matron, Emergency care, Morriston &amp; Associate Medical Director</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p>	<p>August 2018</p> <p>Completed March 2018</p> <p>April 2018</p>
<p>The Health Board is required to provide HIW with details of how it will ensure that improvements are made in relation to the following:</p> <p>All pages of the assessment booklet used within the Emergency Department must contain</p>	3.5 Record keeping	<p>All staff have been emailed in relation of importance of:</p> <ul style="list-style-type: none"> <li>• Signing and printing their name on patient records and using their unique number that they are assigned in Emergency Department.</li> </ul>	Matron, Emergency care, Morriston	Completed March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
<p>unique identifying details of each patient</p> <p>Body Maps must be present within assessment booklets in accordance with the presentation of patients</p> <p>There needs to be sufficient and consistent information within patients' Emergency Department records and other nursing/medical records</p> <p>All entries made within patients' Emergency Department records must be signed and dated and contain the name and role of the person concerned</p> <p>The Health Board is required to ensure that patient risk assessment documentation is completed in relation to oral care, pain relief (including monitoring and evaluation) and the use of rails attached to trolleys</p> <p>This is to demonstrate that such aspects of care have been considered and to ensure that people receive safe and effective care in accordance with the Health and Care</p>		<ul style="list-style-type: none"> <li>• Accurate and timely documentation and correct use of Skin Bundles and Body Maps</li> <li>• Completion and updating of the rails and pain assessment.</li> </ul> <p>From March 2018 All Bank / Agency Nurses have been asked to sign and print their name in the diary on the day they work in the department to ensure there is a robust audit trail</p> <p>100% of nursing staff to complete Oral Care E-Learning.</p> <p>ED has an Oral Care Champion - All staff to be reminded of the importance of ensuring that a complete oral assessment is undertaken if indicated, if required on admission. Oral Care Champion to take the lead.</p> <p>Pain score is currently being audited monthly. Pain assessment undertaken on NEWS charts. Audits have identified gaps in the reassessment after pain relief. Appropriate professional action to be taken for ongoing non-compliance.</p>	<p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston</p> <p>Matron, Emergency care, Morriston &amp; Sister Emergency Department</p> <p>Matron, Emergency care, Morriston</p>	<p>Completed March 2018</p> <p>August 2018</p> <p>March 2018</p> <p>March 2018</p> <p>March 2018</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
Standards.		All areas of documentation outlined above to be audited monthly and appropriate professional action to be taken for individuals with areas on ongoing non-compliance.	Matron, Emergency care, Morriston	
<b>Quality of management and leadership</b>				
<p>The Health Board is required to inform HIW of the action to be taken to ensure that there are sufficient numbers of paediatric nurses working within the Morriston Emergency Department in response to patients' needs.</p> <p>The Health Board is required to provide HIW with full details of the action taken/to be taken to ensure that the patient capacity in the Minor Injuries area does not compromise the ability of the allocated nursing staff to provide safe and effective care.</p>	Governance, Leadership and Accountability	<p>Emergency Department has actively tried to recruit into Paediatric posts. A recent advert for Paediatric Trained Nurses to work in Emergency Department was unsuccessful due to the vacancies in Paediatric Units and available workforce. Ongoing active recruitment to be undertaken.</p> <p>Plan to work with delegated staff who have a keen interest in paediatrics to give them specialist training is being worked through. This will done in conjunction with the Emergency</p>	<p>Head of Nursing, ECHO</p> <p>Matron &amp; Lead Advanced</p>	<p>Ongoing active recruitment Monthly</p> <p>May 2018 &amp; Monthly Recruitment</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>Care Paediatrics Clinical Lead</p> <p>Currently we have a piece of work ongoing to offer rotational posts across Emergency Department and Paediatrics. The Clinical Educators are working on clinical competencies alongside the Clinical Lead for Emergency Department and Paediatrics to help up-skill nursing staff in Emergency Care Paediatrics while we continue to work towards filling the workforce gaps with appropriately paediatric trained staff.</p> <p>Joint clinical training is being currently undertaken in Emergency Department with the paediatrics medical and nursing teams in areas such as resuscitation training and pain scoring.</p>	<p>Practitioner</p> <p>Head of Nursing, ECHO</p> <p>Clinical Lead (Paediatrics) / Consultant Emergency Care and Paediatric Lead</p>	<p>Days</p> <p>Underway &amp; to be continued</p> <p>Underway &amp; continuing BI monthly</p>
The Health Board is required to inform HIW of the action	7.1 Workforce			

Improvement needed	Standard	Service action	Responsible officer	Timescale
<p>taken/to be taken to ensure that staff complete the following training:</p> <p>Level 3 Dementia Training for Band 7 staff</p> <p>Up to date training with regard to the MCA (2005)/DoLs/Safeguarding</p>		As outlined above		

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

### Delivery Unit Representatives:

**Name (print):** Rebecca Carlton, Nicola Williams, Mark Ramsey

**Job role:** Unit Directors

**Service Representative:** Rebecca Gammon

**Job role:** Head of Nursing, ECHO

**Date:** 07.03.18