Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Follow-up Inspection (Unannounced)

Ysbyty Glan Clwyd, Emergency Department

Inspection date: 5 June 2018

Publication date: 5 September 2018

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Digital ISBN 978-1-78964-113-4

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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, follow-up inspection of Ysbyty Glan Clwyd Emergency Department within Betsi Cadwaladr University Health Board on 5 June 2018.

Our team, for the inspection comprised of one HIW Inspector, one clinical peer reviewer and one lay reviewer. The inspection was led by a HIW inspection manager.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service strived to provide safe and effective care. However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection of the department. However, some areas remained in need of improvement and these are referred to in more detail within the relevant sections of this report.

This is what we found the service did well:

- Clean and tidy environment
- Good staff interaction
- Provision of food and fluids
- Good multidisciplinary working
- Accessible and visible management team
- Good auditing processes.

This is what we recommend the service could improve:

- Waiting times
- Documenting of care needs and risk assessments
- Medication storage
- Some aspects of staff training

3. What we found

Background of the service

The Emergency Department of Ysbyty Glan Clwyd was opened in June 2014. It is attached to a busy general hospital and treats a high number of patients.

The ambulance arrival entrance is separate to the walk-in entrance. Walk in patients are triaged[1] after their arrival and are then seen in whichever clinical area is appropriate for their needs. Four treatment rooms are available adjoining reception in which a patient may be seen by the triage nurse, an Emergency Nurse Practitioner (ENP) or a doctor.

There are four resuscitation bays (including one paediatric), eight bays and two rooms in the major injuries unit, and seven bays in the minor injuries unit. The minor injuries unit also had space set aside for ambulatory patients who may be waiting for further assessment or treatment. There is a separate paediatric waiting room for children and three treatment rooms designated as paediatric rooms, which are also used as overspill for adult patients.

Attached to the ED were a number of other units and services

- The GP out of hours service is located next to reception. A GP is permanently based here.
- The Emergency Department Observation Unit (EDOU) had ten bays

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

(although staffed for eight). It was designed to hold patients according to strict criteria for a period of no more than 24 hours

- The Rapid Assessment Unit (RAU) and the Acute Medical Unit (AMU) are located together and comprise 24 beds for AMU and eight beds for the RAU. The RAU receives direct referrals from GPs for assessment and the AMU receives patients from both RAU and from ED to be seen by a consultant physician

- A Surgical Assessment Unit (SAU) is also attached.

HIW last inspected the Emergency Department on 15 and 16 November 2016.

The purpose of this inspection was to follow-up on the improvements identified at the last inspection.

During this inspection we visited the main Emergency Department, Emergency Department Observation Unit (EDOU), Acute Medical Unit (AMU) and Rapid Assessment Unit (RAU).

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.

Patients spoken with during the course of the inspection generally expressed satisfaction with the care and treatment received. Patients told us that staff were kind and caring. We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner. We saw staff attending to patients in a calm and reassuring manner.

The team worked well with other members of the multi-disciplinary healthcare team to provide patients with individualised care according to their assessed needs. However, patients expressed concerns about waiting times.

The emergency department environment was clean and tidy. However, some of the coverings on chairs within the main waiting area were ripped.

What improvements we identified

Areas for improvement identified at last inspection included the following:

- The health board must ensure that both the environment of care and staffing levels are sufficient to ensure the delivery of dignified care.
- The health board must ensure that there are adequate toilet and washing facilities for people using the department.
- The health board must ensure that people (patients and relatives) are supported to communicate to ensure a clear understanding of and involvement in their treatment plan.
- The health board must ensure that there is an emphasis on individualised care for all patients.

- The health board must ensure that all staff receive training and are fully aware of their obligation to meet equality, human rights, and Deprivation of Liberty standards.

- The health board needs to ensure that they capture and listen to patient feedback and that this is used to inform developments in care. What actions the service said they would take.

The service committed to take the following actions in their improvement plan dated 23 January 2017:

- Daily scrutiny of unit staffing levels by Nurse in Charge to ensure safe and equitable nurse staffing is in place across all areas of the department.

- Monthly scrutiny of approved E-roster to ensure compliance in relation to annual leave, study leave, sickness/absence, working restrictions and lost/unused hours.

- Undertake a skill mix review and benchmark skill mix against an agreed best practice acuity tool for Emergency Departments to ensure right staff, right place, at right time.

- Implement a 7 day house keeper service to ensure the release of core nursing time by maintaining core stock levels and providing assistance with IPC.

- Planning and the provision of toilet and washing facilities within the Emergency department have been designed to HBN-22 (Facilities for Adults and Children).

- An additional patient shower provision has been identified and added to Estates work plan for completion.

- Review all admission and Intentional Rounding documentation to identify the opportunity to reinforce effective communication with patients and relatives to ensure a clear understanding of and involvement in their treatment plan - provide any recommendations for improvement to the Secondary Care Nurse Director.

- Communication boards to be placed above patient beds clearly identifying the patients nurse and doctor, the patients preferred name, the patient's dietary requirements, expected admission ward, and/or expected date of discharge/transfer.

- Adherence to the “Hello My Name Is...” campaign to be monitored monthly by Matron Quality and Safety audits and every visit to the clinical areas.

- Formalise expected Standards of Communication for the department and in collaboration with service users produce a public facing guide for patients and relatives with regards to what to expect, and the provision of services in ED.

- A 10 Minute Teaching Pack to be provided to all staff to remind them of the findings of the inspection and areas in need of improvement. To be delivered via the department/ward safety brief which takes place 3 times per day.

- Implement a collaborative pilot with British Red Cross in the Emergency Department to provide a befriending service and hospital at home scheme.

- Set up a Task and Finish Monitoring Group to oversee the completion of the HIW Improvement Plan and provide monthly reports to:

    1. Glan Clwyd Hospital Quality and Safety meeting

    2. Secondary Care Divisional Quality and Safety committee meeting.

- Remind all staff via the safety briefing that all patients are to have a risk assessment and that the frequency of Intentional Rounding is to be clearly identified within 1 Hour of arrival.

- Monitor via quality assurance assessments that the patient risk assessments have been undertaken and that Intentional Rounding frequency has been clearly identified and adhered to in order to ensure individual care needs are identified and met.

- Equality and Diversity Champions (minimum of two) are to be identified for the department.

- Gap analysis assessment of current equality and human rights standards to be conducted in Emergency Department by Head of Equality, Diversity & Human Rights.

- Baseline training needs analysis to be undertaken by the Emergency Department Practice Development Nurse to identify medical and nursing staff requiring Deprivation of Liberty standards training

    1. Glan Clwyd Hospital Quality and Safety Meeting

2. Secondary Care Divisional Quality and Safety Committee Meeting.

- Roll out of 'real time' patient feedback system across the Health Board by 1 July 2017 to capture patient experience.
- Liaise with the Patient Experience team and invite a patient representative as a core member to the monthly Emergency Department Safety and Governance (SAGE) meeting in order to:

  1. Embed a culture of patient participation

  2. Ensure that the voices of patients can be heard and that their views positively influence the work that we do.

- Communicate the dates of future SAGE meetings to all staff via the staff notice board, staff email accounts and Twitter account and encourage staff to attend and share the learning in relation to patient safety and experience incidents.
- Provide monthly SAGE exception reports to the Glan Clwyd Hospital Quality and Safety Meeting.
- Engage positively and proactively with patients and relatives by displaying feedback in a public facing manner in order to demonstrate a department that listens and acts. This will be achieved through:

  1. Quarterly ED newsletter that is to be available in all public areas

  2. Patient/relative suggestion boxes

  3. "You Said, We Did" information boards, updated monthly.

What we found on follow-up

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection of the department relating to the quality of patient experience. However, some areas remained in need of improvement and these are referred to in more detail below.

Additional findings

Staying healthy

We saw good interactions between staff and patients with staff attending to patients' needs in a discreet and professional manner. Patients we spoke with commented positively on the way staff carried out their duties.

Dignified care

We found that patients were treated with dignity and respect by the staff team.

We observed staff being kind and respectful to patients. We saw staff making efforts to protect patients' privacy and dignity when providing assistance with personal care needs. Patients confirmed that staff were kind and sensitive when carrying out care.

The environment within the department was clean and tidy, adding to the sense of patients' well being. However, some of the coverings on chairs within the main waiting area were ripped. Not only is this unsightly, but it also increases the risk of cross infection as the chairs cannot be easily cleaned.

Improvement needed

The ripped chairs within the main waiting area should be repaired or replaced.

Patient information

Bilingual health promotion information for patients and their families/carers was displayed and available within waiting areas through out the department. Notice boards were provided in prominent areas within the department order to display audit results. However, some results were awaiting translation into Welsh before being posted.

Communicating effectively

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner.

Patients told us that staff took time to explain things to them.

Timely care

The team worked well with other members of the multi-disciplinary healthcare team to provide patients with individualised care according to their assessed needs.

However, patients expressed concerns about the waiting times.

Improvement needed

The health board must continue to monitor waiting times and explore ways to further improve patient flow through the department.

Individual care

Planning care to promote independence

We found that there were generally good care planning processes in place which took account of patients' views on how they wished to be cared for.

Through our conversations with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their care needs.

People's rights

We saw that staff provided care in a way to promote and protect patients' rights.

We found staff protecting the privacy and dignity of patients when delivering care. For example curtains were used around individual bed/treatment areas when care was being delivered.

We found that Mental Capacity assessment and Deprivation of Liberty Safeguards (DoLS)[2] assessments were being conducted on patients with

[2] DOLS are a part of the Mental Capacity Act 2005 that provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm.

diagnosed mental health needs. However, such assessments were not being conducted for patients presenting with other conditions such as dementia, head injury or general confusion.

Improvement needed

The health board must ensure that Mental Capacity assessments are undertaken on patients presenting with conditions such as dementia, head injury or general confusion.

Listening and learning from feedback

Patients and their representatives had opportunities to provide feedback on their experience of services provided, through face to face discussions with staff. There was also an electronic 'real time' patient feedback screen located within the main waiting area. Information gathered was collated on a monthly basis and a report produced by the department matron. We were provided with a copy of the matron's report for May 2018. Patient responses were varied with the main area of concern being waiting times.

There were good systems in place for managing complaints and we were told by staff that the number of complaints received about the service were low.

There was a formal complaints procedure in place which was compliant with Putting Things Right[3].

[3] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

Delivery of safe and effective care

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

We found that the staff team were committed to providing patients with safe and effective care.

Suitable equipment was available and being used within the department to monitor patients' condition and to help prevent patients developing pressure sores and to prevent patient falls.

The department was clean and tidy and arrangements were in place to reduce cross infection.

There were formal medication management processes in place. However, we found that some elements of medication management required addressing.

We found that improvement was needed in the patient assessment and review process.

What improvements we identified

Areas for improvement identified at last inspection included the following:

- The health board must ensure that all patients are both assessed for their risk of developing pressure area damage and that appropriate and timely care and intervention occurs.
- The health board must ensure that all patients are assessed appropriately for risk of falls and actions taken as needed.
- The health board must ensure that it adheres to the All Wales Code of Practice for Infection Prevention and Control.
- The health board must ensure that mealtimes in the ED, in particular the EDOU area, are co-ordinated and that patients receive meals and assistance to eat, where required, in a timely manner.

- The health board must ensure that both the National and the health board policies for all aspects of medicines management are applied in practice at all times.

- The health board must continue to support the development of and the addition to the team of staff with specialist paediatric training.

- The health board must ensure that all patients receive the right care to meet their individual needs and that this is appropriately documented The specific areas that we found on inspection include: The need to ensure effective fluid balance monitoring and recording, effective monitoring and recording of blood glucose in patients with diabetes, and the safe positive identification of all patients receiving care and medication.

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

- Emergency Department (modified) Unified Assessment to be implemented across the Health Board Emergency Departments.

- All patients attending the department will receive:

  1) An initial high level assessment of need within 1 hour of arrival clearly identifying the frequency of Intentional Rounding

  2) The Modified Unified Assessment of need in 4 hours of arrival

  3) A full individual assessment of need within 12 hours of arrival.

- Assistant Directors of Nursing to undertake peer review Quality Rounds in the Emergency Departments across the Health Board.

- Matrons to undertake peer review audit of pressure area assessments and the implementation of the All Wales Integrated Pressure Area Pathway.

- Establish a Standard Operating Procedure to ensure that staff have timely access to appropriate pressure relieving equipment 24 hours per day.

- Baseline training needs analysis to be undertaken by the Emergency Department Practice Development Nurse to identify staff requiring training in relation to falls.

- Training in relation to falls to be delivered to all the staff identified through the baseline training needs analysis. Training progress to be reported monthly to the:

    1. Glan Clwyd Hospital Quality and Safety Meeting

    2. Secondary Care Divisional Quality and Safety Committee Meeting.

- All patients attending the department will receive:

    1. An initial high level assessment of need within 1 hour of arrival clearly identifying the frequency of Intentional Rounding

    2. The Modified Unified Assessment of need in 4 hours of arrival

    3. A full individual assessment of need within 12 hours of arrival.

Assistant Directors of Nursing to undertake peer review Quality Rounds in the Emergency Departments across the Health Board.

- Matrons to undertake peer review audit of Falls risk assessments and the implementation of the Falls Pathway.
- Launch of the updated BCUHB Falls Policy in November 2016.
- Launch of the updated BCUHB Falls Pathway in December 2016 detailing the assessment and intervention of all patients.
- Local infection prevention improvement plan implemented and monitored via local infection prevention group.
- Compliance in relation to 10 Key Standards visible to the public and at the entrance to each ward/clinical area.
- Quarterly Glan Clwyd Hospital Infection Prevention exception report provided to the Health Board Strategic Infection Prevention Group identifying areas of good practice and areas in need of improvement.
- Weekly infection prevention walkabout with any immediate issues highlighted and actioned.
- Daily commode audits undertaken by Nurse in Charge to ensure 100% compliance against Infection Prevention Standards.
- A Nutritional Task and finish group to be established to set standards to include:

1. All nursing staff expected to assist at patient mealtimes

2. Daily identification of a designated member of staff, delegated by the Nurse in Charge, to oversee the timely distribution of meals.

3. All patients who need assistance are identified at hand over and assistance is offered.

4. An effective method for the collection of meals by patients' relatives where appropriate.

- Baseline training needs analysis to be undertaken by the Emergency Department.
- Practice Development Nurse to identify staff requiring medicine management training in relation to Second Checker.
- Accredited Second Checker training to be delivered to staff identified through the training needs analysis to ensure the consistent application of local and national polices in relation to medicine management.
- Stop Notice issued and in place from November 2016 to ensure no Health Care Support Workers second check medications whilst the Medicine Code was reviewed.
- Weekly unannounced spot checks to ensure 100% compliance undertaken for 4 weeks following the Stop Notice (November/December 2016).
- All nursing staff to receive a copy of the BCUHB Medicines Code (MM02.1). This has been sent via e-mail with read receipts.
- Revised draft of Health Board Medicine Code (MM02.1) to be taken to the January Policy and Procedure meeting. The revised code will make explicit the following standards:

  1. The exceptional circumstances when a Health Care support Worker (HCSW) could act as a second checker for controlled drugs.

  2. The training, authorisation and control required if second checking is allowed by HCSW in specific areas.

- The department has an identified champion for Safeguarding Children and Children's Rights.
- Implementation of a Clinical Supervision model in relation to Safeguarding Children.
- E-roster rules to ensure an APLS /PILS trained member of staff is on every shift and clearly identified at the beginning of every shift by the shift lead.
- Emergency Department (modified) Unified Assessment implemented across the Health Board Emergency Departments.
- All patients attending the department will receive:

    1. An initial high level assessment of need within 1 hour of arrival clearly identifying the frequency of Intentional Rounding

    2. The Modified Unified Assessment of need in 4 hours of arrival

    3. A full individual assessment of need within 12 hours of arrival

- Standards of safe positive identification to be included at each level of assessment.
- Assistant Directors of Nursing to undertake peer review Quality Rounds in the Emergency Departments across the Health Board and report to the Secondary Care Divisional Quality and Safety Committee.
- Matrons to undertake peer review audits to include effective monitoring of fluid balance, blood glucose in patients with diabetes and the safe identification of all patients receiving care and medication and report monthly to the Glan Clwyd Hospital Quality and Safety Meeting.

What we found on follow-up

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection of the department relating to the delivery of safe and effective care. However, some areas remained in need of improvement and these are referred to in more detail below.

Additional findings

Safe care

Managing risk and promoting health and safety

General environmental audits and risk assessments were being undertaken on a regular basis in order to reduce the risk of harm to patients and staff. These were being formally reported to senior managers. However, the most recent audit results were not being displayed within the department for patients to see as they were awaiting translation into Welsh.

We found that overfilled sharps bins were stored on the floor within the corridor in the minor injuries area of the department. These presented a risk to patients and staff.

There was an Escalation Policy in place to manage patient flow through the department and to manage patients treated on trolleys in corridor areas. We found that there was generally good overview of patients treated on trolleys within corridor areas with a registered nurse, on every shift, designated to those areas. However, there was some confusion as to who was meant to oversee patients waiting to see the Emergency Nurse Practitioner.

We found that there was good communication with ambulance crews and good overview of patients waiting within ambulances. Emphasis was on moving patients off ambulances into the department as soon as possible to free up the vehicles.

Improvement needed

The health board must ensure that sharps bins are not overfilled and that they are stored off the floor.

The health board must ensure that staff are aware of who is responsible for overseeing patients waiting to see the Emergency Nurse Practitioner.

Preventing pressure and tissue damage

We saw that staff assessed patients regarding their risk of developing pressure damage to their skin within the AMU and EDOU but we found little evidence of such assessments being undertaken within the minor and major injuries areas. This was highlighted as an issue during the previous inspection. This was brought to the attention of the matron and we found some improvement in risk assessments towards the end of our visit.

We confirmed that staff were taking appropriate action to prevent patients developing pressure and tissue damage through provision of pressure relieving equipment and regular positional changes.

Improvement needed

The health board must ensure that pressure area risk assessments are consistently completed within all areas of the Emergency Department and that such assessments are accurately documented and reviewed.

Falls prevention

From examination of a sample of individual care files, we found little evidence to show that risk assessments were undertaken in a timely fashion to reduce the risk of falls. Where such risk assessments had been completed, these had not been reviewed on a regular basis. This was highlighted as an issue during the previous inspection. This was brought to the attention of the matron and we found some improvement in risk assessments towards the end of our visit.

Improvement needed

The health board must ensure that falls risk assessments are consistently completed within all areas of the Emergency Department and that such assessment are accurately documented and reviewed.

Infection prevention and control

There was a comprehensive infection control policy in place and we found that regular audits were being undertaken to ensure that staff were adhering to the policy and good practice principles. As previously mentioned, notice boards had recently been provided for infection control audit outcomes to be displayed in prominent positions within the department.

Staff had access to, and were using, personal protective equipment (PPE) such as disposable gloves and aprons to reduce cross infection. Hand washing and drying facilities were available. We also saw hand sanitising stations

strategically placed near entrances/exits for staff and visitors to use, to reduce the risk of cross infection.

We observed a member of staff entering a room where a patient was being barrier[4] nursed without following the correct procedure and wearing the protective equipment that had been provided outside the room. This was brought to the attention of the matron who agreed to remind staff of the need to adhere to procedure.

Improvement needed

The health board must ensure that all staff adhere to infection control polices and procedures and in particular when patients are being barrier nursed.

Nutrition and hydration

We saw that patients' eating and drinking needs had been assessed. We saw staff assisting patients to eat and drink in a dignified and unhurried manner. We also saw staff providing encouragement and support to patients to eat independently.

Patients had access to fluids with water jugs available by the bedside in the EDOU, AMU and RAU and there were cold water dispensers located in the department. However, when we looked at a sample of care records, we saw that monitoring charts were not always being used where required, to reflect that patients had been provided with fluids. This was highlighted as an issue during the last inspection.

The meals appeared well presented and appetising. Patients told us that the food was very good.

[4] Barrier nursing is a method for administering patient care while preventing the transmission of highly contagious diseases. This is done for two reasons: a patient can be isolated to prevent the spread of disease to others, or isolation is imposed to protect a patient with a compromised immune system.

Improvement needed

The health board must ensure that staff complete fluid intake and output charts consistently throughout the department.

Medicines management

We observed medication being administered to patients. We saw staff approaching the administration of medication activity in an unhurried way, taking time to ensure that patients were able to take their medication without becoming anxious or distressed. However, we saw four patients on the EDOU and others in the major injuries area without identification wrist bands. This was brought to the attention of the matron who took immediate steps to resolve the issue. This issue was highlighted during the last inspection of the department and resulted in the issuing of an immediate improvement letter to the health board. It is of concern that the same issue has been highlighted again during this inspection despite measures having been set in place by the health board to monitor the correct use of patient identification wrist bands.

We confirmed that health care assistants were no longer involved in the process of checking controlled medication and that this task was now being undertaken by two qualified nurses.

We found items belonging to patients being stored within the controlled drug cupboard within the major injuries area. This was brought to the attention of the nurse in charge and the items were removed immediately.

We found a syringe driver, was awaiting repair, in a treatment room, with giving set[5] containing potassium chloride still attached.

We noted that the medication storage rooms on both the minor injuries and major injuries areas felt very warm. It was not possible to determine the exact temperatures within these areas as regular readings were not being

[5] A giving set usually comprises of a bag and tubing which is used to administer intravenous fluids and medication to a patient.

undertaken. Doors leading into these areas were being propped open in an attempt to manage the situation.

Improvement needed

The health board must continue to audit the use of patient identification wrist bands.

The health board must ensure that controlled drugs cupboards are not used to store items of patients' property.

The health board must ensure that any item of equipment awaiting repair is stored safely.

The health board should monitor the temperature within the medication storage rooms on both the minor injuries and major injuries on a daily basis and take steps to ensure that medication is stored securely and within acceptable temperature parameters.

Safeguarding children and adults at risk

There were written safeguarding policies and procedures in place and the majority of staff had undertaken appropriate training on this subject.

Medical devices, equipment and diagnostic systems

The ward had a range of medical equipment available which was maintained appropriately and portable appliance testing was undertaken as required.

Effective care

Safe and clinically effective care

There was evidence of multi disciplinary working between the nursing and medical staff.

There were comprehensive policies and procedures in place to support staff in their work.

Information governance and communications technology

There was a robust information governance framework in place and staff were aware of their responsibilities in respect of record keeping and maintenance of confidentiality.

Through examination of training records, we confirmed that staff some staff had received training on information governance.

We were told that work was underway on developing an electronic records management system for use across the health board.

Record keeping

We viewed a sample of patient care notes and found them to be generally well maintained and relatively easy to navigate. However, progress notes on EDOU were brief and lacked detail. The progress notes were completed by staff at varying stages during their shift and not as soon as practicable following the provision of care or intervention.

Improvement needed

The health board must ensure that staff maintain detailed progress notes and that these are completed as soon as practicable following the provision of care or intervention.

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 services review and monitor their own performance against the Health and Care Standards.

Overall, we found good management and leadership within the department, with staff commenting positively on the support that they received from the department managers.

Staff told us that they were treated fairly at work and that an open and supportive culture existed. Staff also told us that they were aware of the senior management structure within the organisation and that the communication between senior management and staff was generally effective.

What improvements we identified

Areas for improvement identified at last inspection included the following:

- The health board must deal promptly with all concerns and complaints and effectively implement the All Wales putting things right guidance.
- The health board must review the staffing of the EDOU to ensure that the needs of patients in this area are met at all times.

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

- There has been a focus on reducing the number of complaints open over 6 months with the intention of having no cases open over 6 months (unless beyond the control of the Health Board).
- The Health Board position at the end of December 2016 was that there were 24 complaints over 6 months open in total, all of which are

either beyond the control of the Health Board or scheduled to close in January 2017.

- MHLD and all Area divisions have no cases over 6 months.
- There will be zero tolerance to >6 months complaints moving forward.
- There is a continuing focus on those cases waiting over 3 months to provide the head room to prevent complaints (unless beyond the control of the Health Board) waiting beyond 6 months.
- The Corporate Concerns Team are making direct contact with complainants where possible and agreeing issues to be investigated and responded to and including these in the acknowledgment letter.
- The Concern Process is being reviewed and revised January and will be re-launched. A training needs analysis and training programme will be developed to support the implementation of this and Putting Things Right process.
- 1:2:1 coaching available for staff that are new to the concerns investigation process.
- The BCUHB Ward Manager Leadership Programme, Generation 2015, now includes a full day session with regards to dealing with concerns to improve the timeliness of investigations and learning from patient experience Managing Concerns forms part of the Health Board induction programme for new starters.
- The divisions are reviewing and revising their governance structures to improve the timeliness of investigations into concerns.
- The measures described above will equally relate to incident management. In addition there has been additional capacity (Nov-Jan 17) within the corporate concerns team to support the focus on closing overdue WG reported incidents.
- Information regarding the open reported incidents is provided on a monthly basis to services and departments to aid performance management.
- Local KPIs for the Corporate Concerns Teams are in place and monitored monthly.
- Datix hierarchies being revised and updated to allow accurate and prompt allocation of incidents Patient Advice and Support Service (PASS) to be implemented (Spring 17) at Glan Clwyd Hospital.

- Daily Scrutiny of unit staffing levels by Nurse in Charge to ensure safe and equitable nurse staffing is in place across all areas of the department.
- Monthly scrutiny of approved E-roster to ensure compliance in relation to annual leave, study leave, sickness/absence, working restrictions and lost/unused hours.
- Undertake a skill mix review and benchmark skill mix against an agreed best practice acuity tool for Emergency Departments to ensure right staff, right place, at right time.
- Implement a 7 day house keeper service to ensure the release of core nursing time by maintaining core stock levels and providing assistance with IPC.

What we found on follow-up

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection of the department relating to the quality of leadership and management. However, some areas remained in need of improvement and these are referred to in more detail within this section.

Additional findings

Governance, leadership and accountability

We found that there were well defined systems and processes in place to ensure that the health board focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Key staff from the department and senior hospital manager met every two hours to discuss the prevailing situation within the department with view to heading off any emerging issues before they escalated. Staff reported that this process was effective in managing the pressures on the department and patient flow.

During discussions with staff, we were told that there were good informal, day to day staff supervision and support processes in place within the department.

Staff and resources

Workforce

We found friendly, professional staff throughout the department who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and were knowledgeable about the care needs of patients they were responsible for.

We viewed copies of the staff rota which showed us that there was a good skill mix of staff on duty each shift within the different areas of the department. Rotas were drawn up with due consideration to numbers of staff required and their experience and competency. Suitable arrangements were in place to ensure that staff were able to take their entitled breaks.

We were told that a number of experienced staff had left recently, the majority moving on to other areas within the health board. This had resulted in a number of new staff being employed, some of whom had little experience of working in an emergency department. This had put additional pressure on the remaining experienced staff. There was also a reliance on agency staff to cover both nursing and medical vacancies.

We were informed that the health board were actively recruiting nursing and medical staff. However, recruitment remains challenging within the national context of nurse/doctor shortages.

There was an emergency department development programme in place designed to provide continuing practice and professional development for nursing staff to enhance fundamental skills, leadership and management abilities and to foster wellbeing and resilience. Health care support workers development was facilitated by means of the emergency department Skills to Care Programme which has been designed to develop the skills required to provide safe, high quality and compassionate care to patients.

A training needs analysis had been undertaken and a list of core and additional practice and professional development requirements for the department staff drawn up.

We were provided with information relating to mandatory training. This showed that 47% of nursing staff had undertaken Mental Capacity Act training, 77% Equality, Diversity and Human Rights training, 33% Infection Prevention and Control training, 33% Information Governance training, 67% Level 2 Child Safeguarding training, 65% Adult Safeguarding training and 16% Intermediate Life Support training. Healthcare Support staff training was shown as 73%

Mental Capacity training, 100% Equality, Diversity and Human Rights training, 60% Infection Prevention and Control training, 53% Information Governance training, 100% Level 2 Child Safeguarding training and 60% Adult Safeguarding training. We were not provided with a similar breakdown in relation to medical staff but were informed that mandatory training compliance was around 44%.

Improvement needed

The health board must continue with efforts to ensure that all staff complete mandatory training.

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 conduct follow-up inspections

Follow-up inspections can be announced or 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. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

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 will also highlight any outstanding areas of improvement that need to be made.

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 summarises 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
We saw four patients on the EDOU and others in the major injuries area without identification wrist bands.	This presented a risk of harm to patients particularly with regards to administration of medication as staff could not properly identify patients in line with good practice guidance and the health board's medication administration policy.	This was brought to the attention of the matron.	All patients who required identification wrist bands were provided with them.

Appendix B – Immediate improvement plan

Service: Ysbyty Glan Clwyd, Emergency Department

Date of inspection: 5 June 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
No immediate assurance issues were highlighted during 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

Service: Ysbyty Glan Clwyd, Emergency Department

Date of inspection: 5 June 2018

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The ripped chairs within the main waiting area should be repaired or replaced.	4.1 Dignified Care	The ripped chairs within the ED waiting room have been replaced. Walkabout by the Head of Nursing undertaken on the14th August 2018 confirms action complete. Waiting room chairs will be monitored as part of daily environment checks conducted by housekeeper with the standard being all damaged chairs will be immediately removed and replaced.	ED Matron	Complete
The health board must continue to monitor waiting times and explore ways to further	5.1 Timely access	Actions to improve the provision of services in order to improve patient flow	Emergency Quadrant (EQ)	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
improve patient flow through the department.		through the department include: • Introduction of a formal Streaming Service prior to Triage. Patients are seen more rapidly on pre-agreed pathways or services. This includes referral direct to specialties, redirection to local Minor Injury Units and other primary and community resources. • Reorganisation of the flow and allocation of staffing within the Emergency Department has ensured a dedicated Fast Track Minors / Minor Illness Service. This has resulted in patients being able to access our Emergency Nurse Practitioner service more quickly seven days per week. • Increased capacity of our Ambulatory Care and Fit to Sit areas within the department to facilitate the	General Manager EQ Head of Nursing	

Improvement needed	Standard	Service action	Responsible officer	Timescale
		active treatment of patients who clinically do not require a trolley. • Close working continues with our WAST colleagues to promote the use of the clinical capacity in the local minor injury units. The development of a Standard Operating Procedure has supported the direct admission to local minor injury units by ambulance to reduce conveyances to the main ED. • The development of the Frequent Service Users (FSU) service, with formal MDT pathways supported by dedicated clinical psychologist to reduce FSU attendees and admissions. • Increased our Emergency Department workforce to 8 fulltime Consultants/Associate Specialist and extended their working hours until 22.00. • Financial resource has been		End of

Improvement needed	Standard	Service action	Responsible officer	Timescale
		identified to support the permanent appointment of EQ Head of Nursing and EQ General Manager in addition to the existing management structure. The new posts will focus on patient pathways and patient flow through EQ. • Two extended Scope Physiotherapist have been recruited in order to support patients with musculo-skeletal injuries, this ensures minor injuries are assessed promptly with a specialist treatment plan. • The Emergency Quadrant unit is supported by a multi-disciplinary team consisting of Occupational Therapists, Physiotherapists, Social Workers and District Nurse (The ADT) who work 7-days per week supporting patients and families with discharge. • In addition to the above we are		October 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		actively recruiting additional ED junior medical staff and Advanced Nurse Practitioners (ANP) to support key parts of the 24 hours when there is increased demand. • The Emergency Department has introduced 2 hourly Safety Huddles in order to review all patients currently waiting in the department.		
The health board must ensure that Mental Capacity assessments are undertaken on patients presenting with conditions such as dementia, head injury or general confusion.	6.2 Peoples rights	MCA training compliance within the ED currently stands at 75% for levels 2 & 3 and actively working towards full compliance in this area ED documentation will be revisited to capture the detail required on admission to the department.	ED Matron/Practice Development Nurse Head of Nursing Medicine	31st October 2018
Delivery of safe and effective care				
The health board must ensure that sharps bins are not overfilled and that they are stored off the	2.1 Managing risk and promoting	Sharps bins are now mounted onto the wall within all areas. The large boxes	ED Matron	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
floor.	health and safety	used in resus area are housed in a mobile frame The checking of the sharps bins has been added to the daily checklist for the housekeepers. Compliance to sharps safety will be monitored via the monthly matron walkabout using the Safe Clean Care Matron proforma and feedback provided to the team.		Monthly audit checks
The health board must ensure that staff are aware of who is responsible for overseeing patients waiting to see the Emergency Nurse Practitioner.		The Emergency Department has introduced 2 Hourly Safety Huddles which will review all patients currently waiting in the department. This includes patients waiting to see the Emergency Nurse Practitioners. Currently under review the establishment for Health Care Support Workers (HCSW) within the department to ensure that there is always a member of staff within the waiting area overseeing the fundamentals of care for patients.	ED Matron	30th September 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that pressure area risk assessments are consistently completed within all areas of the Emergency Department and that such assessment are accurately documented and reviewed.	2.2 Preventing pressure and tissue damage	Monthly audits are undertaken within the department on completion of pressure area risk assessments feedback provided to the team at time of audit.	ED Matron	30th September 2018
The health board must ensure that falls risk assessments are consistently completed within all areas of the Emergency Department and that such assessment are accurately documented and reviewed.	2.3 Falls Prevention	Please see action 2.2 with attached document regarding July compliance above	ED Matron	Monthly reviews ongoing
The health board must ensure that all staff adhere to infection control polices and procedures and in particular when patients are being barrier nursed.	2.4 Infection Prevention and Control (IPC) and Decontamination	The Health Board will ensure that infection control policies are reiterated in relation to barrier nursing and in addition will review the policy to ensure its robustness	ED Matron and Infection Prevention Team	30th September 2018
The health board must ensure that staff complete fluid intake and output charts consistently throughout the department.	2.5 Nutrition and Hydration	The review of staffing within the department is ongoing to agree additional HCSW Monthly audits will continue to monitor fluid intake and output charts with	ED matron/Practice Development Nurse	30th September 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		feedback and discussion with team to ensure compliance and understanding. Targeted and ongoing in-house training will be delivered by the practice development nurse to ensure that all staff registered and unregistered understand the importance of monitoring fluid balance and maintain good record keeping		
The health board must continue to audit the use of patient identification wrist bands.	2.6 Medicines Management	Wrist bands are provided to all patients booking into the department. A wristband audit is undertaken monthly as a spot check within the ED. The last 2 audits for July and June 2018 showed 100% compliance	ED matron	Complete
The health board must ensure that controlled drugs cupboards are not used to store items of patients' property		There is a Safe for storage of valuables within the department and all staff have been reminded/alerted to its location. An issue was raised where patients own medication (brought into hospital) were stored in the CD cupboard for safe keeping. ED Matron is in discussion with	ED Matron ED Matron/ Pharmacy Patient Safety Lead	Complete End September 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Pharmacy regarding the feasibility of patients own lockers above each trolley space		
The health board must ensure that any item of equipment awaiting repair is stored safely.		There is a housekeeper on duty in the department over a 7 day period. All staff have been reminded of the importance of checking all equipment, reporting equipment requiring repair, and ensuring the safe storage. Daily checks will continue and reported on in the monthly Matron walkabout in line with the Safe Clean Care (SCC) 90 day plan	ED Matron	Complete
The health board should monitor the temperature within the medication storage rooms on both the minor injuries and major injuries on a daily basis and take steps to ensure that medication is stored securely and within acceptable temperature parameters.		All fridges within the minors, majors and resuscitation room are checked daily. 100% compliance on spot check 14th August 2018. This will continue to be monitored monthly in the Matron walkabout in line with the Safe Clean Care (SCC) 90 day plan	ED Matron	Complete
The health board must ensure that staff maintain	3.5 Record	All staff have been reminded via safety	ED Matron/ED	30th

Improvement needed	Standard	Service action	Responsible officer	Timescale
detailed progress notes and that these are completed as soon as practicable following the provision of care or intervention.	keeping	briefs and emails of the importance of good record keeping. Monthly audits are to be commenced by the Practice Development Nurse in relation to NMC/GMC record keeping standards. Nursing staff will be asked to provide examples of good record keeping ahead of appraisal	Clinical Lead	September 2018
Quality of management and leadership				
The health board must continue with efforts to ensure that all staff complete mandatory training.	7.1 Workforce	All staff have been reminded of mandatory training requirements All staff are to be 100% complaint with Mandatory Training All staff will be offered Time Owing/Overtime to ensure that mandatory training is undertaken and completed Mandatory training compliancy to be monitored via appraisal and weekly progress reviews	ED Matron	31st October 2018

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): Alison Griffiths

Job role: Site Nurse Director, Ysbyty Glan Clwyd

Date: 14th August 2018