Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection(Unannounced)

Ysbyty Gwynedd,

Betsi Cadwaladr University Health Board,

Emergency Department

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 Ysbyty Gwynedd, Bangor, within Betsi Cadwaladr University health board on 25 and 26 June 2019.

Our team, for the inspection comprised of three HIW Inspectors, one of whom acted as lay reviewer, and two clinical peer reviewers. The inspection was led by a HIW inspection manager.

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

Overall, we found evidence that the service provided safe and effective care.

We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner.

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

We found very good management and leadership at department level, with staff commenting positively on the support that they received form the department managers and matron.

However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

This is what we found the service did well:

- Staff interaction with patients
- Timely care following triage
- Multidisciplinary working
- Management overview and clinical governance
- Communication.

This is what we recommend the service could improve:

- Staffing levels and skill mix
- Patient information and seeking patient feedback
- Care of mental health patients
- Audit reports
- Some aspects of staff training
- Some aspects of care documentation.

3. What we found

Background of the service

Ysbyty Gwynedd is run by the Betsi Cadwaladr University Health Board, which provides a full range of primary, community, mental health and acute hospital services for a population of around 678,000 people across the six counties of North Wales, as well as some parts of mid Wales, Cheshire and Shropshire. The Health Board has a budget of £1.3 billion and a workforce of approximately 16,500.

Ysbyty Gwynedd is a district general hospital in Bangor, Gwynedd. It opened in May 1984, replacing Caernarfon and Anglesey Infirmary.

In February 2017, the Health Secretary, Vaughan Gething, approved £13.89 million funding for improvements to emergency and urgent care services at Ysbyty Gwynedd. This funding was intended to pay for infrastructure improvements to create more capacity to deal with peaks in demand while improving the environment for patients, staff and visitors alike. The investment will fund:

- A single point of entry to the department
- Three triage rooms
- A four bay resuscitation area plus a separate isolation bay with external access
- Eight cubicles plus two treatment rooms
- Eight chairs in minor injuries
- An assessment unit including relatives' waiting room
- Paediatrics facilities including three assessment rooms and dedicated waiting rooms.

The work was on-going at the time of the inspection and was expected to be completed by August 2019.

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 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 environment was clean and tidy despite the ongoing refurbishment work.

During our inspection, we distributed HIW questionnaires to patients attending the emergency department to obtain their views on the standard of care they have received here. In total, we received six completed questionnaires, the majority from patients in the department, and some completed on behalf of patients by their relatives or carers.

Feedback provided in the questionnaires was positive with regards to the care and treatment provided by staff in the department. Patients and their relatives/carers agreed that staff were kind and sensitive when carrying out care and treatment and agreed that staff provided care to patients when they needed it. All of the patients told us that they were also given a choice by staff about which method they could use if they needed the toilet, and agreed that when necessary staff helped with their toilet needs in a sensitive way so they didn't feel embarrassed or ashamed.

Patients and their relatives/carers that completed a questionnaire did not have any concerns about the length of time waiting to be seen after arrival at the hospital. All but one of the patients had been waiting in the emergency department for two hours or less.

Staying healthy

We found that patients were involved in the planning and provision of care, as far as was possible. Where patients were unable to make decisions for themselves, due to their presenting physical/mental conditions or memory problems, we found that relatives were consulted and encouraged to make decisions around treatment planning and care provision in accordance with the Health and Care Standards.

We saw good interactions between staff and patients, with staff attending to patients' needs in a calm, discreet and professional manner.

The Butterfly[1] scheme was in operation within the department, whereby butterfly symbols were used to identify patients with a diagnosis of dementia or cognitive impairment, and who required additional support or a different approach to the provision of care. However, we found that the scheme was not being applied consistently.

Improvement needed

Ensure that the Butterfly scheme is applied consistently throughout the department.

Dignified care

We found that patients were treated with dignity, respect and compassion 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 treatment was being given

[1] The Butterfly Scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.

and 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, despite the on-going refurbishment work. However, the layout of the department especially in the resuscitation area was very cramped and therefore did not lend itself to privacy and dignity. Nevertheless, staff were doing everything they could to maintain patients' privacy and dignity within this area despite the limitations. It is recognised that this is a short term arrangement and that the resuscitation facility will be re located to a more suitable and spacious area once the refurbishment work is complete.

All of the patients and relatives that we spoke to confirmed that the staff they encountered were polite, friendly and had treated them (or their loved ones) with respect.

Comments made by patients included:

'We've seen a few [staff] and they've been great.'

"I think they've handled me very well.

"I appreciate all of the help and support I've received."

"They're lovely"

Patient information

We found that the main entrance into the emergency department was not prominently signposted at the front of the hospital and some patients were finding difficulty in locating the entrance and were having to ask for directions. We also found that patients and visitors were confused by the often changing layout within the department due to the on-going refurbishment. Temporary signage, consisting of printed, laminated A4 size posters, had been put in place to direct patients and visitors in to various areas within the department. However, the signage was not always effective. Whilst this is a temporary issue, the health board should take further measures to ensure that patients are directed appropriately in, out and around the department. This is to ensure the safety of staff, patients and visitors.

Bilingual health promotion information for patients and their families/carers was displayed and available in the department. There was a limited range of leaflets available for patients, relatives and carers in the main waiting area. The

information provided covered drug and alcohol dependency, post-natal care and mental distress. A large number of Choose Well[2] leaflets were available.

A Patient Status at a Glance board (PSAG)[3] was in use and located near the nurses' station within the majors area. The location of the board meant that the information entered on it, which included patients' names, could be seen by other patients and visitors. We were informed that this was a temporary arrangement and that a new 'hub' area would be formed as part of the refurbishment work and that board would be replaced with television monitors which would be out of the line of sight of patients and visitors and turned off when not in use. In the meantime, measures must be taken to maintain patient confidentiality by ensuring that the information on the PSAG board is not on public display.

Improvement needed

Further measures should be taken to ensure that patients are directed appropriately in, out and around the emergency department.

More patient information should be provided within the department.

Measures must be taken to ensure that patient information entered on to the PSAG board is kept confidential.

Communicating effectively

Patients and their relatives/carers were asked in the questionnaires whether they agreed or disagreed with a number of statements about the hospital staff. Every patient and their relatives/carers agreed that staff were always polite and listened, both to them and to their friends and family.

Patients and their relatives/carers agreed in the questionnaires that staff had talked to them about their medical conditions or helped them to understand them. One patient provided the following comment:

[2] http://www.choosewellwales.org.uk/home

[3] The Patient Status At a Glance board is a clear and consistent way of displaying patient information within hospital wards.

> "All staff have been extremely friendly and kind and speaking to my son in a child appropriate manner"

Two of the six patients who completed a questionnaire had arrived at the hospital by ambulance. Patients and their relatives/carers were asked in the questionnaires whether they agreed or disagreed with a number of statements about the ambulance staff. Patients and their relatives/carers were positive about the care provided to them by the ambulance staff. We were told that the ambulance crew were reassuring and that they explained the care and treatment provided to the patient in a way that the patient could understand. Patients and their relatives/carers also said that the ambulance staff did everything they could to help control the pain experienced by the patient and that the ambulance staff treated the patient with dignity and respect.

Patients spoken with during the course of the inspection visit demonstrated or told us that had been kept well informed about their care and treatment, including any next steps.

"When we ask the question, we get the answer".

However, a couple of patients indicated that they were not aware of what was happening beyond waiting to either be seen by a doctor or for test results, and were not given an indication of how long this would take. To help keep patients informed and to alleviate any frustrations, the heath board should consider developing a patient information leaflet, or poster in the waiting area, advising patients and visitors about the processes and different areas within the department. The information leaflet could also contain information about key staff within the department, how to raise a query or concern queries and explanation about the different coloured uniforms worn by staff.

Patients and their relatives/carers agreed that their language needs had been met while at the hospital. The majority of the staff working in the department were bilingual (Welsh and English). This allowed Welsh and English speaking patients to discuss their needs in the language of their choice.

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner. Patients were referred to according to their preferred names. Staff were observed communicating with patients in an inclusive manner.

For those with hearing difficulties, a hearing loop was available in the reception area and at the nurse station.

Reception staff confirmed that waiting times are not routinely communicated to patients either verbally or through other means. Patients can, however, access a live waiting times application on their mobile phones which will advise them of

waiting times within emergency departments and minor injuries units across the health board area. A patient spoken with during the inspection told us that they had used this application before attending the department.

We were informed that the health board was considering ways in which they better communicate waiting times to patients in the waiting area and were proposing utilising TV screens which could also be used to display health promotion and other useful information to patients and visitors.

Improvement needed

Develop a patient information leaflet, or poster in the waiting area, advising patients and visitors about the processes and different areas within the department.

Install TV screens in the waiting area to display waiting times, health promotion and other useful information to patients and visitors.

Timely care

We found that there were generally good assessment and care planning processes in place.

The department team worked well with other members of the multidisciplinary healthcare team to provide patients with individualised care according to their assessed needs. There were robust processes in place for referring patients' to other professionals and departments for further examination and treatment.

The majority of patients spoken with, who arrived by ambulance, told us that they were seen without delay. Furthermore, the majority of patients who had arrived at the department by other means indicated that the initial triage was carried out in good time and were overall happy with the time taken to be seen.

The department normally receives notification when an ambulance is on its way. When an ambulance arrives at the hospital the crew speak with the nurse in charge of the department who then allocates a space within the department or advises that the patient remains in the ambulance. If a space is available within the department then the ambulance crew formally hand over to staff working in that area.

We were told by ambulance crews that, if a decision is made for the patient to stay in the ambulance, then every effort is made for them to be assessed by a triage nurse or doctor so that any investigations or treatment can commence. On

the first day of the inspection, there were few delays with patients admitted within half an hour of arrival.

For patients who present with stroke symptoms there was a formal care pathway in place for timely transfer with ambulance staff, if required, supporting patients through the department to the CT scanning room.

One patient commented that, due to a lengthy wait at home for an ambulance, they took the decision to drive their relative to the department instead. The patient noted that, whilst the initial triage was carried out in good time, it then took approximately five hours for a bed to become available, adding that it was quite uncomfortable being sat in a chair for this period of time.

Patient flow meetings were held regularly throughout the day to discuss patient discharge in order to free up bed spaces and reduce waiting times within the department. Clear patient discharge targets were being set and monitored by senior managers.

Improvement needed

Continue to monitor waiting times and implement further strategies to improve patient flow through the department.

Ensure that patient comfort is maintained whilst they are waiting for assessment or allocation of a bed.

Individual care

Planning care to promote independence

We found that the care planning process took account of patients' views on how they wished to be cared. Through our conversations with staff, and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their treatment and care needs. Patients also told us that staff assisted them and provided care when it was needed.

All of the patients told us that they were given a choice by staff about which method they could use if they needed the toilet, and all but one agreed that, when necessary, staff helped with their toilet needs in a sensitive way so they didn't feel embarrassed.

Patients, if physically able, were encouraged to get up and walk to toilet etc. with assistance given if required.

Carers remained with one patient, who required additional support, throughout the night to assist with their care.

At the time of the inspection, there was limited space available for staff to hold conversations in private with patients' relatives. The psychiatric evaluation/interview room was being used in the interim until more suitable facilities are made available as part of the refurbishment. We were told that another room, on the observation unit, could be used if the evaluation/interview room was unavailable.

People's rights

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

Staff upheld the privacy and dignity of patients when providing treatment and delivering care. For example, curtains were used around individual bed/trolley areas and doors to treatment rooms were closed when care was being delivered.

We found that staff, in general, were aware of Deprivation of Liberty Safeguards (DoLS)[4] and we were informed that assessments were being conducted as required. However, we found the recording of mental capacity assessments to be inconsistent. This was in the main due to the fact that the Emergency Department Card recording system in use did not include a section for mental capacity assessment.

We found that Do Not Attempt Resuscitation (DNAR)[5] forms had been completed appropriately where required.

[4] 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.

[5] A Do Not Attempt Resuscitation assessment is conducted by a doctor, and tells the medical team not to attempt cardiopulmonary resuscitation (CPR). The assessment form is designed to be easily recognised and verifiable, allowing healthcare professionals to make decisions quickly about how to treat a patient.

Staff receive training on people's rights as part of their induction and staff spoken with during the inspection demonstrated an awareness of the rights of the patients to be treated with respect and dignity, to have high standard of care.

Improvement needed

Ensure that mental capacity assessment are consistently undertaken and recorded.

Listening and learning from feedback

Patients and their representatives had opportunities to provide feedback on their experience of the service provided through face to face discussions with staff or electronically on the health board's web page. There was also an electronic feedback screen located in the main waiting area. We were informed that the use of this facility was minimal.

There was little information displayed within the department to inform patients or relatives on how to raise a concern. We did not see any information relating to Putting Things Right[6] as a formal means of raising a concern or making a complaint, and we saw only one poster explaining how patients could submit feedback or concerns to the health board directly.

Any complains or concerns received were formally recorded on the Datix[7] system. These are then reviewed by the matron and processed/investigated thoroughly. A Datix feedback file was located in the staff room for staff to refer

[6] 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.

[7] Datix is a patient safety, web-based incident reporting and risk management system for healthcare and social care organizations.

to. In addition, any incidences and lessons learnt are discussed with staff at debriefing meeting and team meetings.

Patient feedback is shared with the Hospital Management Team (Directorate General Manager / Heads of Nursing and Matron) and then feedback to the directorate via Quality & Safety / Directorate meetings.

All the patients spoken with during the inspection indicated that they would talk to a member of staff should they have any concerns or issues.

Improvement needed

Ensure that adequate patient information on how to provide feedback and raising a concern or complaint is on display in the department.

Display an analysis / overview of any learning or improvements made following patient feedback.

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 treatment and care.

Suitable equipment was available and being used to help prevent patients developing pressure sores, and to prevent patient falls.

The department was clean and tidy, despite the on-going refurbishment work, and arrangements were in place to reduce cross infection.

There were formal medication management processes in place.

Patients' care needs had been assessed by staff, and staff monitored patients to promote their well-being and safety.

Safe care

Managing risk and promoting health and safety

We found that every effort was being made to ensure that the environment was free from any hazards to patient, visitors and staff safety during the on-going refurbishment of the department.

General and more specific risk assessments had been undertaken to ensure the safety of patients, staff and visitors whilst the work was underway. A member of staff within the emergency department had been designated as the link person between the department and the contractors who were undertaking the work. This meant that due consideration was being given to the continued effective running of the department and that any disruption to patient care and treatment was kept to a minimum.

Any identified risks and emerging issues were discussed during daily whole site safety meetings which are attended by managers from all departments in the hospital.

There were systems were in place to report environmental hazards that required attention and repair.

Security officers worked within the department who could protect staff and patients if needed. There were good links with the police who have appointed a dedicated member of staff as the link between North Wales Police and the health board.

There was a notice board within the department displaying outcomes of recent audits on falls, pressure ulcers etc. However, not all the audits displayed were fully competed and up to date.

Improvement needed

Ensure that outcomes of recent audits are up to date and accurately displayed within the department.

Preventing pressure and tissue damage

We looked at a sample of care records and found little documented evidence to show that staff were assessing and reviewing patients regarding their risk of developing pressure damage to their skin. However, we were able to confirm that staff were taking appropriate action to prevent patients developing pressure and tissue damage with trolley mattresses designed for pressure relief in the interim and air mattresses used for those patients at risk of pressure area or tissue damage.

Staff told us that ambulance trolleys were extremely hard and uncomfortable and that every effort was made to transfer patients on to more suitable trolleys or beds as soon as possible. If timely transfer was not possible, then suitable pressure relieving mattresses would be made available for use by patients waiting on ambulances.

Written pressure area risk assessments were not routinely completed immediately on admission into the department. However, assessments were completed when patients were moved to the longer stay areas within the department.

Improvement needed

Ensure that pressure area risk assessments are routinely completed on the patient's admission into the department.

Falls prevention

From examination of a sample of individual care files, we found little evidence to show that that assessments were being undertaken to reduce the risk of falls. However, we saw evidence that staff were taking action to reduce the risk of falls through regular monitoring of patients at risk and the use of safety rails on trolleys and beds.

We were informed that there was a dedicated falls team within the hospital for patients at risk of falls to be referred to and that the support of physio therapists and occupational therapist could be accessed if needed.

Any falls sustained by patients are reported on the Datix system with any learning following incidents shared with staff.

Improvement needed

Ensure that falls risk assessments are routinely completed on the patient's admission into the department.

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.

Infection control audit outcomes were displayed on a notice board 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.

There were designated rooms within the department for the treatment of patients with infections and a dedicated decontamination room which could be access directly from outside.

Most patients and their relatives/carers strongly agreed in the questionnaires that they thought the emergency department was both clean and tidy even though building work was in progress. One patient commented:

"Difficult to tell due to the building work going on but staff keeping things clean and orderly"

Nutrition and hydration

We saw that patients' eating and drinking needs had been assessed. We also saw staff assisting patients to eat and drink where required. We looked at a sample of care records and saw that monitoring charts were being used where required, to ensure patients had appropriate nutritional and fluid intake.

We saw food and drink being offered to patients, at suitable times, throughout the day.

Light meals were available for patients at breakfast and lunch. At breakfast, cereal was available, whereas at lunch there was hot soup, sandwiches and drinks.

Ambulance staff told us that fluids were taken out to patients waiting on ambulance and that they are able to request sandwiches for their patients. Fluid and food intake is then recorded on the patient care report.

All patients indicated that they had access to food and water. All the patients spoken with told us that they were satisfied with the food provided. We found that patients' fluid intake was being monitored and recorded. However, there was no evidence of food intake being recorded within patients' care files.

Improvement needed

Ensure that food intake is routinely recorded on patients' care files.

Medicines management

We found the medication management process to be generally in line with the health board's policy. However, we found that oxygen was being administered to patients without being prescribed.

A pharmacist visits the department on a regular basis throughout the day (Monday to Friday) to undertake medication, restock the electronic medication dispenser and to offer guidance and support to staff. An on-call pharmacist was available out of normal day time work hours and during the weekends.

Improvement needed

Ensure that Oxygen is formally prescribed prior to administration.

Safeguarding children and adults at risk

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

There was a dedicated safeguarding liaison officer within the department. Any safeguarding issues are referred to the safeguarding liaison officer who is also informed of any and any children attending the department.

We were told that there were no active safeguarding issues within the department at the time of the inspection.

A separate children's area had been provided within the new build. This comprised of a spacious waiting room and treatment rooms. However, this area was not being used to treat children at the time of the inspection.

Blood management

There was a formal blood management policy in place. Blood for transfusion was stored in the pathology department and, when required, is collected, checked and administered by two staff who have been specifically trained in the administration of blood.

Medical devices, equipment and diagnostic systems

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

The equipment was regularly serviced and maintained by staff working in the hospital's medical electronics department.

The unit was well stocked with the necessary equipment. Staff receive training on the use of any new equipment brought into the department

On inspection, we found that the contents of the resuscitation/cardiac arrest trolleys were not being checked on a regular basis.

Improvement needed

Ensure that the contents of the resuscitation trolley is checked on a regular basis and that an accurate record is maintained.

Effective care

Safe and clinically effective care

There was evidence of very good multidisciplinary working between the nursing, medical staff and other professionals.

We found that the Adult Nursing Assessment documentation had been fully completed on admission to the ward. Pain assessments were also being undertaken as required.

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

There is evidence of pain relief being given in a timely manner and the patients are being assessed for the need of pain relief. However, there was little documented evidence of staff reviewing the effectiveness of pain relief.

The GP out of hours service was located adjacent to the emergency department. There were good working relationship between the out of hours GP service and the emergency department. However, one GP we spoke with expressed concern about procedures which directed them to refer patients to the emergency department for further examination, tests and admission, rather than the GPs being able to make such referrals and decisions themselves.

We were concerned about the delay in assessing patients who presented at the department with mental health care needs. During the inspection we were alerted to two patients with mental health care needs who were admitted during the night, and were being monitored by police officers whilst they awaited further assessment by a psychiatrist. The delay in such patients being assessed ties up police resources and means that patients are being accommodated in an area of the hospital that is not suitable for them or in the best interest of other patients within the department.

Improvement needed

Regularly review and document the effectiveness of pain relief.

Review the policy relating to GP out of hours decision making and referral process.

Monitor and review responsiveness of the service for patients presenting with mental health care needs.

Information governance and communications technology

There was a robust information governance framework in place and staff were aware of their responsibilities in respect of maintaining patient confidentiality.

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

The use of electronic records management systems through the department were very limited and mainly consisted of arrival check in, triage and Datix information. All other records were maintained in paper format and there was no electronic patient tracking system in place.

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

Improvement needed

Implement an electronic records management and patient tracking system.

Record keeping

Patient care notes were found to be generally well maintained. Care files were, in the main, organised and easy to navigate. However, some documentation,

such as intentional rounding[8] charts and medication administration charts, were not always securely attached within patients' care files. This could result in information being lost or miss placed.

We also found that care files were stored in an unlocked trolley in bays and were not always in sight of staff.

Improvement needed

Ensure that all documentation is securely attached within patient care files.

Ensure that the trolley containing patients' care files is locked when not in use.

[8] Intentional Rounding is a structured process whereby nurses in hospitals carry out regular checks, usually hourly, with individual patients using a standardized protocol to address issues of positioning, pain, personal needs and placement of items.

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.

We found very good management and leadership at department level, with staff commenting positively on the support that they received form the department managers and matron.

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.

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.

During discussions with staff, we were told that there were good informal, day to day staff supervision and support processes in place in the department with regular, formal, recorded staff meetings taking place on a regular basis.

We found very good internal communication between the multidisciplinary team.

There are regular meetings throughout the day which includes managers from other departments across the hospital site, and between them they escalate any concerns and agree on any actions required.

We were told that, if an issue arises that requires escalation, the nurse in charge of the department will contact the department matron and inform her of the situation. In the absence of the matron, staff are able to contact the site manager directly.

The staff spoken with confirmed that they were aware of the escalation process and told us that they would refer any concerns to the department matron, when she is on site, and out of hours, to the designated bronze on call who would then escalate further up the management chain if necessary.

Staff complete daily shift reports showing how many staff were on duty, workload, number of patients seen and number of ambulances waiting/on way in. These reports were then used by managers to manage patient flow and staff resources.

We were told that a considerable amount of the matron's time was being taken up by additional work stemming from the ongoing refurbishment of the department, and that there had been little adjustment made to her usual workload to off-set this. The health board should monitor and review the matron's workload during the duration of the refurbishment work in order to ensure that the matron has sufficient time set aside to attend to her routine clinical governance and management responsibilities.

Improvement needed

Monitor and review the matron's workload to ensure that she has sufficient time set aside to attend to her routine clinical governance and management responsibilities.

Staff and resources

Workforce

We found friendly, professional staff team working in 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 were told that there was not always a good skill mix of staff on duty each shift. This was mainly due to the recruitment of a number of newly qualified nurses. On the first day of the inspection, we found that four of the eight nurses on duty were newly qualified.

We viewed copies of staff rotas which showed that there was generally sufficient staff on duty to cover shifts. However, when staffing shortages are identified, then these are escalated to senior management and steps are taken to secure additional staff. A closed Facebook page was used to contact staff in order to requests cover for absences etc. and if no one was available then agency staff would be secured.

Staff we spoke with told us that they sometimes feel vulnerable due to patients having high clinical needs and the expectation that nurses take on expanded roles, such as phlebotomy, whilst still required to provide care. Nurses are also expected to accompany patients during transfer on to wards, which can take time, leaving the department a staff member down for the duration.

During the inspection, we distributed HIW questionnaires to staff working in the emergency department to find out what the working conditions are like and to obtain their views on the standard of care.

We received 17 completed questionnaires. Ten of the responses were from nurses, one from a team leader, two from housekeeping staff, one from a secretary, one from a ward clerk and two from receptionists.

Staff had been working at the unit from eight months to 37 years and the majority of staff had worked there for between 4 to 15 years.

Staff members, generally, commented positively on the working conditions and the support that they receive from their line manager. Staff also commented positively on the availability of training with nearly all respondents answered that training has helped them do their job more effectively, stay up to date with professional requirements and helped them to deliver better patient experience.

Nearly a third of staff members who completed a questionnaire told us that there were never enough staff on duty.

Most staff who completed a questionnaire agreed that patient care was their organisation's top priority and that the organisation acts upon concerns, and very few disagreed. A minority agreed that they would recommend their organisation as a place to work. However, a quarter of staff who completed a questionnaire disagreed. Most staff indicated that they would recommend the organisation to a relative seeking treatment and none said they would not.

Nearly all the staff who completed a questionnaire stated that they knew who their senior managers are and around half said that communications were effective. A minority of staff said that management involved them in decisions. A third of staff who completed a questionnaire said that management never act on feedback and around half said they sometimes do. Around half of staff who completed a questionnaire agreed that senior managers are committed to patient care.

Staff comments included:

> *"A Datix was made recently on how mis-communication with senior management directly affected patient care. Senior managers rarely on shop floor/introduce themselves/support"*

“Senior management changes regular. There is a member who is daily in the majors area, hasn't introduced themselves or visited minors when I've been on shift”

“My manager, up to a few weeks ago, was based on the other side of the hospital, therefore, the above questions are not applicable as very little contact had been made in my last 12 months of employment”

“There was always lack of communication-much improved now/lately”

Only around half of staff who completed the questionnaire said that they were aware of the revised health and care standards.

A minority of staff who completed a questionnaire agreed that their job was good for their health, but around half disagreed. Around half of staff agreed that management took an interest in their health. Around half of the staff agreed that their organisation took positive action on health and well-being.

Staff comments included:

“I feel I'm expected to do more than normal for my banding”

“In regards to the off duty, I would like to say that sister does everything possible to accommodate requests and urgent shift swaps”

“Very stressful job”

Around half of the staff who completed a questionnaire agreed that they were offered full support in a challenging situation.

Around half of the staff who completed a questionnaire said they had seen errors/ near missises that could have hurt staff, and around half said they had seen errors/ near missises that could have hurt patients.

The majority of staff who completed a questionnaire said that staff who reported errors were treated fairly. Most staff agreed that the organisation encouraged staff to report incidents and near misses. Nearly all staff said that they were aware of the incident reporting system, although only around half agreed they had received sufficient training on that system. A majority agreed that the organisation treats such reports confidentially.

Around half neither agreed nor disagreed that the organisation does not blame or punish people who are involved in errors or near misses, although around a third disagreed or strongly disagreed with this. A majority said when errors are reported, the organisation takes action to ensure they won’t happen again and

that they were informed about errors and near misses. The majority of staff said that they receive updates about changes made as a result of feedback. Around half of the staff said they receive updates about issues they have raised.

All the staff who completed a questionnaire stated that they knew how to report unsafe practice and most said that they would feel secure reporting, and that they were confident the organisation would address concerns.

Most staff who completed a questionnaire said that their organisation acted fairly on career progression and the majority of staff said that they had not experienced discrimination from patients. However, around a quarter said they had.

The majority of staff said that they had not experienced discrimination from management.

We viewed a sample of staff files which confirmed that there was formal staff recruitment process in place which was managed centrally by the health board's human resources department. New staff are expected to undertake formal induction training. There were formal processes in place to support and supervise student nurses on placement within the department.

We viewed a sample of staff performance, appraisal and development review records (PADR) records seen and found that the process was well managed with over 80% of reviews completed and in date. There was some expected slippage due to sickness and staff on maternity leave.

Improvement needed

The management team and health board should reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.

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, measurable, 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 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
No immediate concerns were identified during this inspection.			

Appendix B – Immediate improvement plan

Hospital: Ysbyty Gwynedd

Ward/department: Emergency Department

Date of inspection: 25 and 26 June 2019

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 improvements 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

Hospital: Ysbyty Gwynedd

Ward/department: Emergency Department

Date of inspection: 25 and 26 June 2019

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				
Ensure that the Butterfly scheme is applied consistently throughout the department.	1.1 Health promotion, protection and improvement	• Matron walkabout reviews to check that the butterfly scheme is applied. • Dementia lead nurse in post and will provide refresher training on a rolling programme in line with best practice and recommendation from HIW • Review possibility of sticker to be applied onto name band to allow visual display and rapid identification.	Lyn Roberts	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Patients with a diagnosis of dementia are identified on the PSAG board • Team to engage with newly appointed Dementia Consultant Nurse who has a background in ED and will provide further expert advice		
Further measures should be taken to ensure that patients are directed appropriately in, out and around the emergency department.	4.2 Patient Information	• Signage supplied in Welsh & English as part of a build scheme. There are few ceiling or finished walls to attach custom printed direction signage when HIW on site temporary signage was supplied but not able to produce format larger than A3 in house. To build signage consistent throughout department and with dementia friendly geographical artwork markers and signposts • Patient journey illustrations are being created and developed for	Sian Gruffydd	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the new build to support the patient's journey. • New Build signage proposed to be approved by CHC, service users and consultant Dementia nurse. Discussed in ED project board last week.		
More patient information should be provided within the department.		• Digital signage was installed as part of a bigger project (only screen in use at the time of HIW was limited functionality) now has fully functioning RSS data feeds IPTV and patient information signage, phase 3 build adds total from 4 to 10 screens. Wayposting project also adds vinyl wall applications to the same strategy, and leafleting areas	Sian Gruffydd	September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
Measures must be taken to ensure that patient information entered on to the PSAG board is kept confidential.		• PiMS enhancement was in development and digital mapping application from that data feed has been applied. • The move to the final phase of the new build will enable the PSAG board to be more appropriately placed to maintain confidentiality	Sian Gruffydd	Interim Oct 2019, Final Nov 2020.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Develop a patient information leaflet, or poster in the waiting area, advising patients and visitors about the processes and different areas within the department.	3.2 Communicating effectively	• 'Wayposting' digital and print signage ongoing, walls not final finish to apply. Will need Welsh translation and requires significant redraw in some instances re-formatting of digital imagery delays in this production. • Ops team creating a patient journey leaflet to support the journey and this will also be issued post booking in to the ED to advise patients of their journey in Emergency care.	Geraint Farr	October 2019
Install TV screens in the waiting area to display waiting times, health promotion and other useful information to patients and visitors.		• Already provided, as part of build and separate business case incorporated IPTV, Digital Signage and RSS feeds. Supplier unable to provide for live TV as described, has meant loss of Subtitling- meeting arranged to address the HTML defect in supply and what services were purchased and server hosting	Sian Gruffydd	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Screens currently functioning in Minors waiting area and being supported for the main waiting once licensing issue has been resolved.		
Continue to monitor waiting times and implement further strategies to improve patient flow through the department.	5.1 Timely access	• Ongoing escalation process signed off and implemented and went live 5th August 2019. • Business case finalised for submission to the HB for increasing staff to support flow and demand during peak periods. • SAFER Model ongoing to support improving the discharge picture to support flow • EDQDF Standards now being developed pan Wales which encompasses escalation and improving flow through the ED.	Geraint Farr	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that patient comfort is maintained whilst they are waiting for assessment or allocation of a bed.		• Named nurse is allocated to maintain waiting room checks, along with placing CCTV in the triage to allow a visual view of the waiting room. • Staff in major's areas continue with comfort rounds and record in the nursing notes. • Comfort checks are recorded on the Nurse in Charge handover document • Reception staff as part of their shift also review and check the waiting room for cleanliness • Shine document has been implemented for patients delayed in the ambulance and ongoing audit of compliance to be monitored daily (at breach review) and reported to directorate Quality and safety meeting monthly.	Lyn Roberts	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that mental capacity assessments are consistently undertaken and recorded.	6.2 Peoples rights	• Matron to liaise with Safeguarding Team to arrange rolling training programme to support staff development • Add onto the safety brief MCA numbers and plans for all staff on shift to be aware	Lyn Roberts	November 2019
Ensure that adequate patient information on how to provide feedback and raising a concern or complaint is on display in the department.	3.2 Communicating effectively	• Governance lead for ED supporting patient experience PALS officers recently appointed, the PALS teams will provide real time feedback which will enable the team to provide a more timely response • EDQDF are funding patient survey go live with touch screen feedback. • Patient experience is currently measured via the Viewpoint system which is in situ in the department. Further engagement with the patient experience team is needed to provide alternative	Geraint Farr	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		means of feedback. The comments are reviewed on a monthly basis and tabled at the Monthly directorate Q&S meeting. • Creation of ED Concerns/Feedback email to support real time issues and allow for rapid feedback/Concerns process		
Display an analysis / overview of any learning or improvements made following patient feedback.		• You said we listened approach being developed with Patient experience team once appropriate informatics gained will become part of the monthly ED newsletter. • Visual poster display being created to support newsletter	Geraint Farr	October 2019
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that outcomes of recent audits are up to date and accurately displayed within the department.	2.1 Managing risk and promoting health and safety	• Audits are displayed on the staff corridor (Sepsis/Tarn) • Staff members allocated to audit to support and update on a daily basis. • Audit dashboard to be created and placed on display board on the staff corridor. • EDQDF, creation of ED standards to support audits in line with Local and RCEM standards and creation of dashboard.	Lyn Roberts	October 2019
Ensure that pressure area risk assessments are routinely completed on the patient's admission into the department.	2.2 Preventing pressure and tissue damage	• Nursing risk assessment tool which incorporates falls/Pressure area risk assessments being implemented • SHINE Document in use for patients delayed in ambulance waiting to access the department	Sian Hughes Jones	Immediate

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that falls risk assessments are routinely completed on the patient's admission into the department.	2.3 Falls Prevention	• Nursing risk assessment tool which incorporates falls/Pressure area risk assessments to be introduced and compliance to be audited and monitored with assurance reported to the monthly Directorate Quality and safety group.	Sian Hughes Jones	Immediate
Ensure that food intake is routinely recorded on patients' care files.	2.5 Nutrition and Hydration	• Risk assessment tool will identify the cohort of patients requiring routine food intake monitoring (MUST Score). • SHINE Document in place to document food and fluid intake if patients wait in the ambulance for admission.	Sian Hughes Jones	Immediate
Ensure that Oxygen is formally prescribed prior to administration.	2.6 Medicines Management	• Emergency oxygen administration is administered rapidly in line with ALS/ILS standards as only for short	Lyn Roberts	Immediate

Improvement needed	Standard	Service action	Responsible officer	Timescale
		duration during initial resuscitation (15ltrs). • Constant Oxygen administration (2ltrs/4ltrs) prescribing audit to be completed to identify themes and trends and presented back to all staff, to allow for an appropriate TNA.		
Ensure that the contents of the resuscitation trolley is checked on a regular basis and that an accurate record is maintained.	2.9 Medical devices, equipment and diagnostic systems	• Checklist forms part of the shift handover, and to be emphasised on the safety brief. • Spot audit to be completed weekly initially and monthly thereon (Matron walkabout) to identify themes and trends with support from the Resus service. The above will be audited monthly	Lyn Roberts	Immediate
Regularly review and document the effectiveness of pain relief.	3.1 Safe and Clinically Effective care	• Nurse evaluation to record pre and post pain relief • Spot audit to be completed on the documentation pertaining to administration of and	Lyn Roberts	Immediate October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		effectiveness of pain relief to look at themes and trends and develop a TNA.		
Review the policy relating to GP out of hours decision making and referral process.		• GP OOH service currently undergoing a consultation, unable to complete further action until consultation is completed. • Patient acceptance criteria already in place and reviewed by ED Consultants and OOH GP in 2018. GPOOH management team provide update and table any concerns or discrepancies in the monthly Directorate Quality & Safety meetings to ensure joint working to improve the patients journey • Clinical lead (1SPA) in post to review and provide feedback	Geraint Farr	October 2019
Monitor and review responsiveness of the service for patients presenting with mental health care needs.		1. Frequent attendees profile functioning and allowing for care plans to be created.	Sian Hughes Jones	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		2. ICAN service functioning and accessing the low risk patients. 3. Joint governance meetings held monthly with Mental Health and Learning Disabilities division to monitor and review responsiveness of MH service, discuss issues and jointly find solutions		
Implement an electronic records management and patient tracking system.	3.4 Information Governance and Communications Technology	• PIMMS being developed to support patient tracking, informatics creating a visual floor plan (New build) to support patient journey. • Training programme being created for users • Symphony being rolled out November 2020 WG funded	Geraint Farr	September 2019
Ensure that all documentation is securely attached within patient care files.	3.5 Record keeping	• Review of EC documentation being implemented in line with EDQDF to create a user friendly booklet.	Lyn Roberts	September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Ring binders to be implemented once in new build (Sept 2019)		
Ensure that the trolley containing patients' care files is locked when not in use.		• Trolley is constantly in use, elements above will support patient confidentially of ensuring paperwork is securely filed. Measures taken to support Information Governance are: to ensure that case notes trolleys stored in each clinical are within supervisory view of staff, Clinical areas are never left unattended and the main department can only be accessed by swipe	Lyn Roberts	September 2019
Quality of management and leadership				
Monitor and review the matron's workload to ensure that she has sufficient time set aside to attend to her routine clinical governance and management responsibilities.	Governance, Leadership and Accountability	• Matron has been removed off the matron of the day rota. • New build development and implementation has been led on by the PDN.	Sian Hughes Jones	Immediate

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• An improvement/development plan has been implemented to support the matron in developing and fulfilling her leadership role, daily tasks and ensuring appropriate time management.		
The management team and health board should reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and inform HIW of the action to be taken to address the issues highlighted.	7.1 Workforce	Listening in action events being created to support workshops Focused staff engagement via Pioneer project Focused Leadership development opportunities for senior staff All areas in relation to the questionnaire are being reviewed and addressed, in line with EDQDF Picker report from the staff survey 2018	Geraint Farr Sian Hughes Jones	October 2019

Governance:

- All of the above will be managed via an action tracker that will be reviewed weekly as part of the Unscheduled Care Group / EDQDF forum, and this will feed into the Directorate Quality and Safety meetings which in turn, will report into the site assurance reports for Quality and Safety for YG.

- The action tracker will be live and available for review by the Health Board the week commencing 27th August 2019

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): Geraint Farr

Job role: Directorate General Manager (DGM) for Emergency Care

Date: 13th August 2019