Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Medical Emergency Assessment Unit, University Hospital Llandough

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In writing:

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

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Medical Emergency Assessment Unit (MEAU), at the University Hospital Llandough, as part of its programme of assurance work. Patients are referred to the MEAU from General Practitioners (GP) and 999 ambulance patients, within a designated geographical area who fit into the admission criteria.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID-19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Senior Nurse, Emergency and Acute Medicine Directorate, on 8 December 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that governance and staffing arrangements are effective and support the provision of safe and effective care? What changes, if any, have been made to these arrangements in light of COVID-19?
- How do you ensure that the risk of healthcare associated infection is assessed and managed to keep patients, visitors and staff safe? What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How do you ensure that the environment is safe for staff, patients and visitors and that it maintains dignity and provides comfort for patients? What changes have you made to the environment in light of COVID-19 to ensure it is safe for staff, patients and visitors?
- What is the process to ensure that the flow of patients through the Assessment Unit is

timely, safe and effective?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the service on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

A number of measures to ensure social distancing were described to us, this demonstrated that the MEAU was confident in applying a range of environment measures to reduce the risk of COVID-19. This included moving trolley and bed spaces to make this possible. Staff areas were taped out with crosses and ticks on chairs, also chairs and tables were removed to create additional space. There were signs and marks on the floor to assist patient flow, staff wore masks as a minimum to reduce risk as much as possible. The senior nurse also referred to the increase in the cleaning schedules to ensure regular and extensive cleaning.

We were told that visitors were only permitted in exceptional circumstances including end of life care and where patients had specific needs such as a learning disability or a cognitive impairment. In these circumstances, staff assisted and guided visitors on how to apply personal protective equipment (PPE) to protect themselves and patients. Arrangements were in place to ensure regular communication with patients' relatives. This included designating one family member to be called by staff. Staff also provided patients with tablets and cordless telephones to contact relatives. These were cleaned between uses.

The following areas for improvement were identified:

We were provided with evidence of pressure damage and falls audits that showed that compliance with the areas covered in the audit was under 75%. We were advised that the senior nurse spot checks had increased and reminders had been issued to staff. We were told that the lack of compliance was due to documentation errors. Any learning would be shared in safety briefings and staff meetings. There was no mechanism in place to monitor which staff had received reminders and lessons learned, for example if they were on leave.

The health board must put a mechanism in place to ensure that all staff receive reminders and lessons learned from any incidents and from HIW quality checks. This system must include written evidence that all staff receive the relevant information. Additionally, to ensure future compliance with the required standards such as completing patients notes in full.

The unit were unable to provide evidence of an environmental risk assessment, although we were provided with a copy of the last fire safety audit dated February 2019. As a result the unit have potentially missed opportunities to formally identify issues with the environment which could pose a risk to patient and staff health and safety.

The health board must ensure that an environmental risk assessment is carried out, with a regularly updated action plan. The risk assessment must be updated regularly, at a frequency which ensures that risks are identified. An environmental risk assessment must be undertaken at the earliest opportunity and sent to HIW, once complete.

Infection prevention and control (IPC)

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of PPE.

The following positive evidence was received:

We were provided with the self-assessment for the unit, which stated that all patients attending the MEAU were triaged and assessed for any infectious symptoms. Hand hygiene and bare below the elbow were maintained throughout the unit and levels of compliance with this were audited on a monthly basis. We were told that staff were trained and assessed in Aseptic Non Touch Techniques[1] (ANTT) and were expected to use the correct PPE in cases of infection and in general unit duties. If there were visitors, they were encouraged to wash their hands and use alcohol gel and PPE as required.

Patients were nursed on ambulatory chairs, trolleys or beds and these areas were screened off with curtains. We were told that each trolley area has a call bell to alert staff when help was needed. Risk assessments were carried out on admission. These were audited on a monthly basis to ensure compliance and best practice was maintained. Patients' nutrition and hydration was supported by staff and a dedicated catering team. Hot meals were provided at all meals times throughout the day and food provided when required during the night.

We were told that the unit had adapted to the current pandemic by redesigning areas of the department and implementing additional measures for IPC. This included setting out two areas into amber and purple areas. The purple area accommodated patients with suspected COVID-19 whereas the amber area accommodated COVID-19 negative patients.

[1] ANTT (Aseptic Non Touch Technique) ANTT is a comprehensive Practice Framework for aseptic technique used for all invasive procedures from major surgery to maintenance of invasive devices.

The senior nurse stated that tests for COVID-19 were readily available for staff and patients. Staff could request a rapid test for patients in the purple area. The results would available within two hours. All other patients received a standard swab test which could take up to 48 hours for the results to be available. There were processes in place to move patients safely between areas. These included ensuring test results were returned before transfer. Patients were asked to wear face coverings where they were able.

One of the areas within the unit was the Enhanced Care Unit (ECU), for acutely unwell patients. There were four beds that were all centrally monitored as well as supporting five telemetry channels[2]. Access to computerised tomography (CT) scanning[3] and facilities was available and specialised interventions, such as thrombolysis[4], could be provided if needed in a time critical way.

There were daily COVID-19 updates shared with staff via email from the chief executive officer and on the clinical portal or intranet. This ensured that staff could access the most recent and up to date guidance. We were told that there was not a generic health board IPC policy, health board guidance was developed for specific topic areas which staff could access on the health board intranet. The health board provided a number of other systems and links for staff to use to access guidance. There was a link on the staff intranet IPC page for staff to access the National Infection Prevention and Control Manual on the Public Health Wales Website and the National Institute for Health and Care Excellence (NICE)[5] prevention of healthcare-associated infections in primary and community care. The health board had chosen not to have its own specific policy for COVID-19 due to the rules being frequently revised. Instead, a dedicated page had been set up on the health board intranet for staff to access COVID-19 advice and guidance. Staff were directed through the links to the Welsh Government and Public Health Wales and Public Health England website.

The following areas for improvement were identified:

As mentioned above, there was not a generic health board IPC policy, health board guidance was developed for specific topic areas which staff could access on the health board intranet. We selected two documents from a list provided from the hospital shared computer drives. The Infection Control Procedure for Methicillin Resistant Staphylococcus Aureus (MRSA)[6] in

[2] Telemetry, the practice of sending electronic signals from one place to another. It allows hospital personnel to monitor heart rate, heart rhythm, breathing, and other things both by the patient's bed and at a remote location like a nursing station.
[3] A CT scan uses X-rays and a computer to create detailed images of the inside of the body.
[4] Thrombolysis is a procedure to dissolve or break up a blood clot. A blood clot can block blood flow to areas of your body and become life-threatening. Thrombolysis can return blood flow and reduce harm to areas such as your brain, heart, or lungs.
[5] The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in England, which publishes guidelines (for use in both NHS England and Wales) in four areas, one of which is clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions)

[6] MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.

Acute Hospitals was not due for review until December 2020. This procedure set out the requirements for MRSA screening plus the management of patients found to be MRSA positive. However, the Infection Control Procedure for Infectious Incidents and Outbreaks in University Health Board Hospitals, was overdue for review, with a review date of March 2019. The aim of this procedure was to ensure that all staff of the health board understood the implications of outbreaks of infections in healthcare and were enabled to contact the correct personnel to manage or prevent an outbreak. Also that outbreak management was facilitated through an appropriately constituted outbreak control group.

The health board is to ensure that out of date policies are reviewed, amended and re-issued as necessary. The health board is to further inform HIW of why these are not reviewed on time, when this will be completed by and what process they will put in place to ensure that these important documents are reviewed on a regular basis in the future.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

As stated above, the self-assessment provided, showed that the MEAU consisted of ambulatory areas, trolley areas and an ECU. Since the onset of COVID-19 the MEAU had been required to separate steams of patients. These streams were suspected COVID-19 patients (Purple) and low suspicion of COVID-19 (Amber). We were told that this led to a reconfiguration of the unit, the staffing level, areas and equipment were also described.

A rotational model for staffing was described as being in place between the MEAU at University Hospital Llandough and the other health board hospitals with minor injuries, emergency departments and an assessment units. This ensured that staff maintained differing sets of skills and assisted senior staff in filling gaps in staffing due to short term sickness.

We were told that the staffing of the unit was planned several weeks in advance and a daily staffing meeting was held to assess and deploy staff on a risk basis. There were several vacancies on the unit. However, we were told that the unit had recently recruited ten qualified members of staff starting in the New Year. To fill any shortages in the meantime, bank staff were used when required, also permanent members of staff regularly worked overtime to ensure cover for sickness and leave.

The All Wales COVID-19 Risk Assessment Tool[7] was in use and the senior nurse stated that this had been completed for every staff member. This ensured that staff who were clinically vulnerable were identified and mitigations put in place to protect the staff members. A number of staff had, due to their level of risk, been redeployed to other lower risk areas. This had impacted on staffing within the unit. Pregnancy risk assessments were also in place for staff who were pregnant.

We saw evidence that core mandatory training averaged at 73 percent across all subjects. We were told that all training requiring face to face teaching had been suspended. The health board should consider all options to address the risks of not keeping up to date with mandatory training. This could include continuing to look for available internal or external providers to deliver face to face training when this mode of delivery has been assessed as safe and appropriate. When this was not achievable, the health board should consider whether the training could be delivered via digitally enabled means such as through webinars, video conferencing or e-learning programmes.

We were told that supervision was in place and performance appraisal and development reviews (PADR)[8] were still taking place with 67% completion to date. These will be undertaken as a values based approach[9] in the future, with all band 7's having completed this training, to improve the preview process. We were also told of the plan in place to ensure full compliance by the end of January 2021. HIW would expect these to be completed as agreed and would see ensuring compliance with completion rates for future PADR's to be a priority for the health board.

The senior nurse told us that wellbeing had been significantly affected by the pandemic. Increased communication had been put into place including newsletters and information videos. Access to occupational health practitioners was available to all staff. A wellbeing strategy team was in place and this supported staff who felt they needed to talk.

We saw evidence that risks and incidents were identified and recorded on the electronic incident reporting system. The system allowed staff to escalate risks and incidents as needed. We were told that senior staff aimed to close the feedback loop by reporting back to staff who completed these forms. However, the comment regarding an area for improvement at the Environment section above, relating to evidencing this feedback also applies here. Incidents were investigated at different levels dependent on the nature and severity of the incident. This will be added to the full improvement plan below.

[7] The All Wales COVID-19 Workforce Risk Assessment Tool is a two-stage risk assessment, which is suitable for use for all staff who are vulnerable or at risk of contracting coronavirus, including people from BAME backgrounds. It has been designed to be a sensitive and supportive process.

[8] Undertaken to ensure that staff development was enhanced and opportunities created in relation to professional development, leadership and clinical skills.

[9] A values-based approach to nursing involves taking into account values as well as the evidence base when making decisions about care.

We were told that the unit ensured safeguarding protection and maintaining deprivation of liberty safeguards (DOLS)[10] were completed on patients as necessary to ensure that vulnerable patients are protected from harm, abuse or neglect. There were quiet areas in the unit that could be used by patients with certain needs such as learning disabilities and dementia. Carers could also accompany these patients. Specialist nurses were also available and a flag was entered on the patient notes system as a prompt. The unit also ensured that cubicles were used for any children attending the unit.

We saw evidence of the COVID-19 Prevention and Response Plan that covered the Cardiff and Vale University Health Board (CVUHB) area. This included all the component parts that the health board had developed as a region to deliver an effective regional Test, Trace, Protect response. It had been prepared on a collaborative basis and signed off by the CVUHB and both Cardiff and Vale of Glamorgan local authorities. We also saw the recent submission to the Senedd, Health, Social Care and Sports Committee.

Additionally, we saw evidence of regular team meetings that took place on a monthly basis where various issues were discussed and made known to staff.

Patient feedback was organised by the patient experience team of the health board. Due to the pandemic, surveys had not been carried out with patients since February 2020. The last survey carried out had positive feedback and comments about the unit.

No improvements were identified.

Patient Flow

For Assessment Units, HIW felt it was important to explore the flow of patients through the department. The aim of this is to make sure patients are being assessed, admitted and discharged in a timely way.

The following positive evidence was received:

The patient flow was described. Initially, patients would be referred by their General Practitioner, through the bed booking system at the health board headquarters. This meant that only GP admissions who were appropriate for the level of care at MEAU were routed there. Additionally, the WAST emergency ambulances would be called through by the unit depending on location and the limited treatment required by the patient based on agreed protocols. If patients were too unwell or required a higher level of care, they would be redirected to the University Hospital of Wales.

[10] The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They apply to adults who are in hospital or who live in a care home or in supported living and who lack the mental capacity to consent to treatment or care. People need to be cared for in a way that ensures they are safe, but as far as is possible they should also be free to do the things they want to do.

We were told that patients stayed on the unit up to a maximum of 48 hours, although on the rare occasion this would only be exceeded by a day. The unit had recently purchased new trolleys which had pressure relieving mattresses with a maximum use of 48 hours. Patients who stayed on the unit in excess of this time would be transferred onto a low rise hospital bed. Staff would determine whether a patient required a trolley or bed on an individual basis, based on the patients' individual needs. This was risk assessed prior to admission. The time patients were in the unit was monitored using the computer system. This was actively monitored by the unit staff and bed managers. Should demand outstrip capacity at the site, we were told that GP referrals would be redirected to the Assessment Unit at UHW. Conversely UHW were able to redirect GP admissions to the MEAU as required.

The senior nurse stated that the unit had access to specialist multi-disciplinary teams and professionals as required. These included occupational therapists, physiotherapists and speech and language therapists. Acute consultant physicians were always present in the MEAU. This all ensured that patients received a senior review and input as needed.

We were told that two hourly unit meetings were held to ensure that patient flow was considered regularly. Additionally, there were four bed meetings held at different intervals throughout the day. At these meetings staff across the hospital site would assess and review the patients waiting to come in and also patients waiting for a bed. We saw evidence of the MEAU Escalation Card Triggers and actions to be taken; and the MEAU social distancing escalation plan which described the process to be used to escalate to senior management. Patients would be allocated a bed, if required, in a relevant purple or amber ward depending on whether they were COVID-19 positive or not, when one became available.

The following areas for improvement were identified:

Whilst we were told that patients would not normally stay on the unit for longer than 48 hours, there were occasions when patients were on the unit for longer than this. However, there was no data collected which would identify how often this happens. Additionally, we were told that there was no data collected which recorded how long patients were on the unit or waiting to be seen by a healthcare professional. Whilst staff may well be aware of individual patient stays at the unit, the opportunity to identify themes and trends is missed by not gathering this information together.

The health board should consider introducing targets and measures, including waiting times, time between treatments and time spent on the unit.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.

Improvement plan

Setting: University Hospital Llandough

Ward: Medical Emergency Assessment Unit

Date of activity: 8 December 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	We were provided with evidence of pressure damage and falls audits. Additionally, we saw the incidents reported by the unit. Whilst any learning would be shared in safety briefings and staff meetings, there was no mechanism in place to monitor which staff had received reminders and lessons learned. The health board must put a	Standard 3.3 Quality Improvement, Research and Innovation	All HIW quality checks will be shared with staff via email, safety briefings and hard copies in staffrooms. To ensure that all staff have received updates and service reminders there will be a register taken for staff to sign once they have received the update. This will be completed over a two week period. Any staff who have not signed will be updated	Unit Manager	Immediate.

	mechanism is put in place to ensure that all staff receive reminders and lessons learned from any incidents and HIW quality checks. This must be documented to ensure that there is written evidence that all staff receive the relevant information. Additionally, to ensure future compliance with the required standards such as completing patients notes in full.		separately. These reminders will also be sent via email with read receipts. The UHB has developed a process whereby a self -assessment checklist is developed following HIW inspections/visits/quality checks. This picks up issues for wider learning and can be circulated across the UHB via Clinical Board structures. HIW updates and learning are also included in regular Patient Safety and Quality Newsletters. The UHB will introduce a twice yearly audit based on the findings of HIW inspections to ensure that lesson have been learned and implemented and remain embedded. In doing so we will explore whether this can be achieved through the Perfect Ward accreditation scheme.	Head of Patient Safety and Quality Assurance Head of Patient Safety and Quality Assurance Head of Patient Safety and Quality Assurance	In place In place Introduce by June 2021.
2	The unit were unable to provide evidence of an environmental risk assessment. The health board must ensure that	Standard 2.1 Managing Risk and Promoting Health and	The Health and Safety department have been requested to undertake an environmental audit as a matter of urgency.	Health and Safety officer	Complete by end February 2021

	an environmental risk assessment is carried out, with a regularly updated action plan. The risk assessment must be updated regularly, at a frequency which ensures that risks are identified and mitigating actions put in place. The environmental risk assessment must be sent to HIW, once complete.	Safety			
3	One of the two IPC documents selected was overdue a review to ensure that it still reflected current practice. The health board is to ensure that out of date documents are reviewed, amended and re-issued as necessary. The health board must inform HIW: • Why these were not reviewed on time	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The '*INFECTION CONTROL PROCEDURE FOR INFECTIOUS INCIDENTS AND OUTBREAKS IN UNIVERSITY HEALTH BOARD HOSPITALS'* was reviewed at the time renewal was due, as no national changes had been made the procedure remained the same and did	Lead Nurse for Infection, Prevention and Control	

			not go through the formal review process as other more urgent procedures required revision at the time. There is a covering statement on the IP&C clinical portal page that states 'Some policies are due for review. Please refer to existing policies in the meantime'.		
	• When this will be completed by and		The guidance was formally reviewed in June 2020 and shared for comment in line with the Health board guideline/ratification process, the procedure was ratified in November 2020 and will be updated on the clinical portal imminently.	Lead Nurse for Infection, Prevention and Control	January 2021
	• What process they will put in place to ensure that these important documents are reviewed as required in the future.		The Health Board has a process in place to review IP&C Procedures to ensure that IP&C procedures are up to date, an Infection Prevention and Control Group is in place which is chaired by the Executive Nurse Director and meets every 2 months. All IP&C procedures that require revision are discussed, including any new national guidance that has been published.	Lead Nurse for Infection, Prevention and Control	Review June 2021; December 2021.

			To ensure the timely review and update of all IP&C guidance a separate forum has been set up specifically for COVID guidance/procedures which is led by the IP&C team. This ensures that the Health Board can keep up with the demand of the frequent changes relating to COVID guidance/procedures whilst minimising the impact on other IP&C guidance/procedures.		
4	Whilst we were told that patients would not normally stay on the unit for longer than 48 hours, there were occasions when patients were on the unit for longer than this. However, there was no data collected which would identify how often this happens. Additionally, we were told that there was no data collected which recorded how long patients were on the unit or waiting to be seen by a healthcare professional. Whilst staff may well be aware of individual patient stays at the unit, the opportunity to identify themes and trends is missed by not gathering this	Standard 2.1 Managing Risk and Promoting Health and Safety	Length of stay can be recorded on Ward Clinical Work Station. A report will be made. This report will be used to escalate and prioritise patients via the patient access teams and senior nurse team. The length of stay will then be discussed at the Q&S directorate meetings. Recording and defining length of stay per area will be reviewed and incorporated into transformation work being undertaken.	Service manager	March 2021.

	information together. The health board should consider introducing targets and measures on waiting times at the unit to include: • Length of stay in the various areas of the MEAU • Length of stay in in the MEAU • Length of stay on beds, trolleys and ambulatory chairs. Together with any other measures that could be used to inform the health board for the benefit of the patients.		Medicine Clinical Board will consider the introduction of targets and measures on waiting times at the unit in their next Quality and Safety Meeting	Director of Operations/ Director of Nursing	January 2021.

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.

Name: Rebecca Aylward

Date: 6/01/21