Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Emergency Department (Adults), Morriston Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Emergency Department in Morriston Hospital as part of its programme of assurance work.

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.

Morriston hospital is one of the largest hospitals in Wales, with around 720 beds. It is the regional acute tertiary hospital for South west Wales, offering a range of specialist services, including trauma and orthopaedics, renal medicine, neurology, oral and maxillofacial surgery and hosts the Welsh Centre for Cleft Lip and Palate.

Morriston hospital has a large emergency department. The department saw a fall in attendances during the early phase of the Covid-19 epidemic, although attendances have increased to those similar to pre-pandemic 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 Emergency Department Sister, Matron and Consultant in Paediatric Emergency Medicine on 17 March 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

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 setting 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:

We were informed that in response to the pandemic, changes were made to the environment within the emergency department. A one way system and high risk red zones were introduced to reduce infection and cross contamination. Management told us this was supported with a robust plan to provide and train staff to use personal protective equipment (PPE). We were informed staff were able to access prepared bundles of PPE known as grab boxes. These boxes provided staff with the correct PPE to protect their health and safety. Pictorial aids outlining PPE guidance and infection prevention were provided to staff and placed around the department at the start of the pandemic to enable learning. The negative pressure room was designated as an area for confirmed cases of Covid-19 and the Rapid Evaluation and Commencement of Treatment (REACT) area accommodated suspected and confirmed Covid-19 cases on socially distanced trollies. To further reduce the risk of cross contamination the department were provided with additional observation machines to reduce the movement of appliances between patients.

We were informed additional nursing resources had been allocated to the triage area in response to the pandemic, to ensure all patients attending the department are swabbed on arrival and receive appropriate checks to establish their Covid-19 status. Management informed us the number of seats in the waiting room had been reduced to enable social distancing and quieter conversations. Healthcare assistants provide the fundamentals of care to patients by responding to and attending to their needs. This includes the provision of bottled water and food if patients are hungry. Management told us the health board has commissioned the services of the British Red Cross to provide patients in the waiting areas with refreshments and snacks in assessment areas. The department has also benefitted from an integrated clerk who has enabled improved communication between nursing and medical departments.

Management informed us they have recently created two additional roles to act as flow co-ordinators between the emergency department and ambulance service. Flow co-ordinators are responsible for the monitoring and development of practices for safe and effective offloading of patients from ambulances into the emergency department. We were informed the effectiveness and success of the introduction of the new roles will be measured by the quality of patient experience.

Wherever possible family, relatives and friends are asked not to enter the department to protect patient safety. However management confirmed that a designated member of the family is permitted to accompany the patient under special circumstances and when it is appropriate to do so. On these occasions family members are required to wear appropriate PPE and are reminded of the need for hand hygiene and social distancing. We were informed that unaccompanied patients are able to request support from a waiting room nurse should they wish to contact family and friends.

We were told that the footfall had been reduced both in the emergency department and the hospital as a whole at the start of the pandemic. Management confirmed this had reduced delays in patient care, improved patient experience and enabled more efficient patient flow out of the department to the appropriate ward or via discharge.

We were informed that incidents, complaints and patient feedback are reviewed by clinical governance groups, at board meetings and quality and safety meetings. Patient safety incidents are scrutinised and investigated by the clinical director and head of nursing.

We were informed that the hospital has provided a decontamination area on the hospital grounds for ambulances. This enables ambulance staff to clean ambulances and appliances before leaving the hospital with a view to preventing infection and reducing the risk of cross contamination.

We were informed the department has a safeguarding hub that allows staff to access specialist advice and support for vulnerable people. Management informed us that there is a multi-faith room on the hospital site. Social distancing measures are in place. In addition a chaplain can be contacted by telephone.

We were informed the department can access support from onsite security and the local police. The hospital site also has a dedicated police liaison officer. If required, the emergency department is able to lockdown all main access points in order to protect the safety and security of patients and staff.

No improvements were identified.

Infection prevention and control

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 personal protective equipment (PPE).

The following positive evidence was received:

We were informed that handwashing and sanitising stations are available in all areas of the

department and signage is clear and bilingual.

We saw evidence of hand hygiene audits that indicated staff were washing their hands and using alcoholic hand gel correctly. We were informed that face to face training had been given to staff in relation to hand hygiene and use of PPE. Records identified staff had been fit tested for masks. We were informed that all staff on substantive contracts and most regular agency and bank staff have been fit tested for FFP3[1] masks. Some staff have been allocated their own mask. They are responsible for cleaning the mask and changing filters at the appropriate time. We were informed that staff are required to adhere to social distancing rules in staff rooms and adjustments have been made to avoid overcrowding.

We were told that the level of cleaning had increased since the beginning of pandemic with service provision increased to 24 hours a day. All bays are cleaned between each patient and more if required.

The following areas for improvement were identified:

The Infection Control (IC) performance statement for a Fundamentals of Care[2] spot check audit dated January 20 to January 21 noted the overall level of compliance and health board tolerance level as follows:

- IC compliance as 90% (HB tolerance level 95%)
- World Health Organisation (WHO) 5 moments of hand hygiene[3] - 91% (HB tolerance level 100%)

This information was contradicted by additional piece of evidence entitled IC Hospital Service Group Service statement dated January 2021 that identified different levels of compliance, national targets and in-month tolerance. The health board must ensure it accurately and consistently reports levels of tolerance and outlines the action it has taken or any progress made to achieve health board tolerance levels and national targets.

We reviewed audits completed by ward staff outlining the level of staff compliance with the requirements to be bare below the elbow (BBE) and the need for thorough and appropriate hand hygiene. The audits indicated a high level of staff compliance, however, one audit dated 5 February 2021 noted that a doctor and nurse were not compliant with the requirement to be BBE. The audit report did not indicate a management response to this or what action was taken to address the issue and provide necessary training or learning. The health board must ensure action is taken to ensure staff are reminded of the need to be BBE and to provide training or learning as deemed appropriate.

The Standard Infection Control Precautions (SICPs)[4] audit tool was completed by the Infection Prevention and Control Nurses on 5 February 2021 for the emergency department. Whilst the

[1] FFp3 masks provide protection against air borne viral and bacterial infections.
[2] Fundamentals of Care http://www.wales.nhs.uk/documents/booklet-e.pdf
[3] WHO 5 Moments of hand hygiene https://www.who.int/gpsc/tools/Five_moments/en/
[4] SICPs https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/chapter-1-standard-infection-control-precautions-sicps/

outcome identified a high level of compliance, there was no context, detail or comments provided other than one issue that was referred to the Estates department. The health board must ensure that details are provided to confirm the time the audit is completed, the areas and equipment that were reviewed, number of staff observed, good practice, any issues arising and the action taken to address those issues.

We were provided with an IC spreadsheet dated January and February 2021. The information provided indicated the department were 100% compliant with IC requirements in January 2021. However compliance dropped to 81% in February 2021 owing to issues highlighted within the environment. There was no further information provided to indicate what issues had been raised and if indeed any remedial action was taken. The health board should ensure all outcomes are supported with evidence and the action it plans to take to address the issues arising.

An additional IC environmental audit dated 12 February 2021 identified a series of issues arising where the emergency department was either not or only partially compliant with infection control requirements. The audit did not provide the overall compliance score and did not document any action taken to address the areas of non-compliance. The health board must ensure the outcome of audits and any actions required are documented accurately and in full.

We were provided with evidence dated 15 January 2021 and the 12, 15 and 21 February 2021 that documented the review of patients for pressure and tissue damage. Whilst the evidence on the 15 January and 15 and 21 February confirmed staff were completing Waterlow assessments[5] the evidence provided dated 12 February indicated that staff were not completing the assessments in full. The health board must ensure staff are aware of the requirement to assess patients for pressure and tissue damage and to document the outcome of the assessment.

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:

We saw evidence of the following policies, procedures and standing operating procedures that

[5] Waterlow assessments are a simple risk assessment tool that determines whether a patient is at risk of developing a pressure sore.

reflected the changes made in response to Covid-19 and the pandemic:

- Infection outbreak and incident management
- Public Health Wales (PHW) manual for National IPC
- Communicable Disease outbreak plan
- Covid-19 resource pack
- Infection, Prevention and Control (IPC) policy
- Covid-19 Guidance for IPC in healthcare settings
- Pandemic framework and tactical plan
- Exercise Corvus emergency preparedness
- How to swab for Covid-19
- Clinical guide for management of emergency department patients
- Emergency department 4 hour escalation protocol

Management told us they can access wider hospital group systems to support service delivery and engage in daily site staff meetings. The department can request support if staffing levels do not meet the minimum standards required to deliver safe services. We were informed that recently during the last roster period a total of 45 hours of redeployed nursing time was utilised by the emergency department.

We were informed the rota co-ordinator actively manages gaps in the rota and escalates concerns. Gaps in medical staffing shifts are filled with reliable locums and the department has a succession plan for tracking retirements and upcoming junior medical staff in future substantive posts. Management confirmed medical staff are allocated a supervisor and are able to attend virtual one to one meetings. We were told that consultants meet on a weekly basis and a number of consultants operate an open door policy to enable ease of communication and offers of support between themselves and medical staff. Arrangements have been made for staff to attend on line social events and a departmental awards night. The Sister informed us that nursing staff have well-being checks at each staff handover and they are encouraged to speak to a senior nurse if they need advice or support. All staff are also aware they must inform management if they are unwell and must go home immediately. They are required to take a PCR Covid-19 test and contact the Occupational Health Department.

We were informed that nursing staff employed within the department are allocated into Teams led and managed by a Band 7 Nurse and supported by two Band 6 nurses. The sister confirmed she is supported by and regularly meets with the matron. In response to the pandemic the number of qualified nurses and healthcare assistants required on all shifts had increased to 21:9 respectively. We were informed by the Consultant Paediatrician that there is an improved junior doctor presence in the department. This is supported by a consultant rota escalation back up plan that provides consultant presence during absence.

We were also informed that the Wales Deanery[6] has agreed to increase the number of middle

[6] Wales Deanery is an academic unit offering doctors and dentists post graduate facilities and educational

grade doctors in the emergency department, however, these positions have not been filled. The medical team were successful in recruiting four consultants since the last HIW inspection in January 2020.

We were informed staff absences are managed in accordance with Health Board policy and management work closely with staff to support them back to work. We saw evidence of sickness reports indicating a current sickness rate of 7.9% within the nursing workforce during the course of the pandemic. Management confirmed that the adjustments made within the department along with the co-operation of staff had helped reduce transmission of the Covi-19 virus within the department.

The matron informed us that arrangements were in place to ensure that those staff deemed to be clinically vulnerable were allowed to work from home. They had been provided with laptops and were assigned duties that incorporated staff well-being and training in Trauma and Risk Management (TRiM)[7] and REACT[8].

The following areas for improvement were identified:

As part of the NHS Knowledge and Skills Framework (KSF)[9], administrative, clerical and nursing staff should receive an annual personal appraisal development review (PADR). This process reviews staff learning, development needs and pay progression. Records indicated poor compliance with the requirement for an annual review for the following Bands of staff:

- Band 7 - 50%
- Band 6 - 53%
- Band 5 - 68%
- Band 6/7 (Emergency Nurse Practitioners) - 33%.

84% of Band 2 and 3 staff had received their annual reviews. We were informed annual appraisals had fallen behind as a result of the pandemic. However, management confirmed there was a plan to arrange PADR appointments with staff plus an offer of time in lieu if they attended out of contracted hours. The health board must ensure staff receive a timely appraisal and confirm how the emergency department plans to improve compliance.

We were informed the department has 17 registered nurse Band 5 vacancies and one Band 3 and as a result the department is using significant numbers of agency and bank nursing staff equating to approximately 49% of the workforce (30% agency and 19% bank). Management confirmed they endeavour to engage the same agency and bank nurses to ensure continuity of care and provide them with necessary point of care and PPE training. Management told us

support.

[7] TRiM training is a peer delivered risk assessment and on-going support system to help staff manage traumatic events.

[8] REACT is a training mechanism and technique designed to support the mental health and well-being of staff, their teams and communities.

[9] KSF is a useful tool used to identify the knowledge, skills, learning and development that staff need to do their job.

there has been some successful recruitment since the last HIW inspection that took place in January 2020 however there are still a high level of vacancies prompting the department to run a recurring recruitment advert approximately every two months for four qualified nurses. Given the high level of registered nurse vacancies HIW require assurance that the Health Board has a robust workforce plan in place acknowledging the need for recruitment and retention of nurses in the Emergency department.

Immediate assurance was required in relation to the following:

In advance of the Quality Check, HIW requested details of up to date mandatory and departmental training and associated compliance.

During the quality check we highlighted a number of concerns raised as part the review of training compliance. HIW considered this evidence in conjunction with the verbal responses made in the Quality Check meeting and further evidence provided following the call. The evidence showed mandatory and departmental training compliance for the Emergency Department was poor and did not provide HIW with assurance that staff were adequately trained to provide safe and effective services.

We were provided with evidence that reported the following mandatory training compliance:

- IPC (mandatory training) - 9%
- Safeguarding Adults - 12%
- Safeguarding children - 32%
- Fire safety - 19%
- Moving and Handling - 20%
- Resuscitation between 0% and 25% (several levels of compliance provided in evidence pack)

In addition we were provided with evidence that reported the following departmental training compliance in the following areas:

- Sepsis - 12%
- IV Medication - 47%
- Hand washing - 16%
- Deprivation of Liberty Safeguards - (DoLs) 9%
- Mental Capacity Act - 13%

It should be noted that HIW requested assurance from the Health Board to improve training compliance as part of the inspection carried out in January 2020. The Health Board provided assurances in the improvement plan that measures would be taken to improve compliance.

HIW cannot be assured that the health board's governance mechanisms provide sufficient oversight of this matter and would request measures are taken to improve compliance without delay.

We were informed that management has provided some face to face training and some bespoke training and the Clinical Educator was organising additional training.

We noted that staff compliance with the training for Equality and diversity was 75% and Information governance was 73%.

In response to the letter requesting immediate assurance, the health board provided us with a new set of training figures. We were informed that the new training figures had been sourced directly from the department of Workforce and Information and identified an improved level of compliance. We were provided with assurance that training compliance would be subject to high level review on a quarterly basis by the Quality, Safety and Governance Group. In addition the Interim Director of Nursing and Patient Experience confirmed a review had been conducted to establish why incomplete and inaccurate information had been provided.

HIW require an explanation as to why we were provided with incorrect mandatory and departmental training compliance during the inspection.

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: Adult Services in the Emergency Department in Morriston Hospital

Date of activity: 17 March 2021

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	The Infection Control (IC) performance statement for a Fundamentals of Care spot check audit dated January 20 to January 21 noted the overall level of compliance and health board tolerance level as follows: • IC compliance as 90% (HB tolerance level 95%) • World Health Organisation (WHO) 5 moments of hand hygiene - 91% (HB tolerance level 100%)	Standard 2.4 IPC and Decontamination	Current performance parameters for Infection Control measured within the Health Board Performance Card are: • Compliance with Infection Control Spot Audit (National Target 95%) • Hand Hygiene Audits – compliance with WHO 5 Moments (National Target 100%) **Action:** 1. Quality & Safety Reporting Template to be reviewed and	Service Group Head of Q&S	1st June 2021

	This information was contradicted by additional piece of evidence entitled IC Hospital Service Group Service statement dated January 2021 that identified different levels of compliance, national targets and in-month tolerance. The health board must ensure it accurately and consistently reports levels of tolerance and outlines the action it has taken or any progress made to achieve health board levels of tolerance and national targets.		to include explicit targets and definitions for performance monitoring & reporting. Completed reports will be used at Service based Q&S meeting and will be reported to the Morriston Q&S Group in line with the Q&S Work Programme. Template report to be shared with HIW following Service group sign-off at Morriston Q&S Group	Service Group Head of Q&S	1st July 2021
2	We reviewed audits completed by ward staff outlining the level of staff compliance with the requirements to be Bare below the elbow (BBE) and the need for thorough and appropriate hand hygiene. The audits indicated a high level of staff compliance however one audit dated 5 February 2021 noted that a doctor and nurse were not compliant with the requirement to be BBE. The audit report did not indicate a management response to this or	Standard 2.4 IPC and Decontamination	**Immediate Action** 1. Staff members identified as non-compliant have been spoken to by Emergency Department Matron to remind them of and reflect on infection control requirements **Further Actions:** 2. Group Medical and Nurse Director to issue a reminder to all staff at Morriston in relation to the requirements of infection control including Bare Below Elbow and	Matron Emergency Department. Group Medical & Nurse Directors	Completed March 2021 By 1st May 2021

	what action was taken to address the issue and provide necessary training or learning. The health board must ensure action is taken to ensure staff are reminded of the need to be BBE and to provide training or learning as deemed appropriate.		Hand Washing 3. Ensure local training records are matched and aligned to HB ESR Mandatory Training records in order to ensure consistency	Head of Nursing, Emergency Care/ Deputy Head of Nursing Emergency Care/Directorate Manager Emergency Care	By 1st June 2021
			4. Escalate concerns in relation of ESR and the provision of and access to current up to date performance data	Group Human Resource Partner	Completed April 2021
			5. Protected training time rostered for staff in *Allocate* to support tracking and overview of progress	Head of Nursing, Emergency Care/ Deputy Head of Nursing Emergency Care/Directorate Manager Emergency Care	Completed March 2021 and ongoing
			6. Monthly IPC peer review visits in the diary undertaken by Morriston Site Lead for IPC. Latest Report available below	Infection control leads within Emergency Department	Completed April 2021
			7. Establish Weekly hand hygiene audits– *Example embedded below*	Head of Nursing, Emergency Care/ Deputy Head of	Completed April 2021

			8. Identify Departmental Lead for Hand Hygiene (all Clinical Lead Roles are held on Safety Improvement Progress made by the Emergency Department providing current performance % Compliance with Infection Control Spot Audit = Hand Hygiene Audits – compliance with WHO 5 Moments = **100%** Progress taken to date: - 4 new hand hygiene trainers identified and training plan developed	Nursing Emergency Care Head of Nursing, Emergency Care/ Deputy Head of Nursing Emergency Care	Completed April 2021
3	The Standard Infection Control Precautions (SICPs) audit tool was completed by the Infection Prevention and Control Nurses on 5 February 2021 for the emergency department. Whilst the outcome identified a high level of compliance, there was no context, detail or comments provided other	Standard 2.4 IPC and Decontamination	**Action:** 1. Infection control team to review SICPs audit tool to ensure detail context provided. 2. Morriston SOP to be developed in order to support routine audit completion and submission to ensure outcomes	Assistant Director Nursing -IPC Group Head of Q&S	By 1st June 2021 By 1st June 2021

	than one issue that was referred to the Estates department. The health board must ensure that details are provided to confirm the time the audit is completed, the areas and equipment that were reviewed, number of staff observed, good practice, any issues arising and the action taken to address those issues.		are fully recorded and actions are documented through to completion		
4	We were provided with an IC spreadsheet dated January and February 2021. The information provided indicated the department were 100% compliant with IC requirements in January 2021. However compliance dropped to 81% in February 2021 owing to issues highlighted within the environment. There was no further information provided to indicate what issues had been raised and if indeed any remedial action was taken. The health board must ensure all outcomes are supported with evidence and the action it plans to take to address the issues arising.	Standard 2.4 IPC and Decontamination	Issue highlighted in the report reflects a temporary issue and is not consistent with previous performance (please trends embedded above) **Immediate Action:** 1. Immediate action to improve cleanliness of the environment 2. Dedicated Estates link for Emergency Department identified 3. Weekly Estates walk-about reinstated and action log established to support remedial actions 4. Enhanced cleaning in place from Domestic Service – with 2 staff available 24/7 to support	Deputy Head of Nursing – Emergency Services As Above As Above As Above	Completed March 2021 Completed April 2021 Completed April 2021 Completed April 2021

			issues in both clinical and non-clinical areas established		
			5. Nominated Clinical Lead for domestic services to address any issues identified	As Above	Completed April 2021
			6. To establish weekly environmental audits undertaken by Dept Matron	As Above	Completed April 2021
			7. To establish weekly walk-about with IPC Team and Dept Matron	As Above	Completed April 2021
			Compliance with the National standards of cleanliness are now reported and ECHO Board/ECHO Q&S Group.		
			There is a clear expectation that where standards are not achieved an overarching Action Log detailing outcomes, risks and any remedial work required is provided routinely on a monthly basis for assurance and sign-off.	Deputy Head of Nursing – Emergency Services	By 1st July 2021
5	An additional IC environmental audit dated 12 February 2021 identified a series of issues arising where the emergency department was either not or only partially	Standard 2.4 IPC and Decontamination	Please see actions in Improvement Need; 1, 3 and 4 above		

	compliant with infection control requirements. The audit did not provide the overall compliance score and did not document any action taken to address the areas of non-compliance. The health board must ensure the outcome of audits are documented accurately and in full.				
6	We were provided with evidence dated 15 January 2021 and the 12, 15 and 21 February 2021 that documented the review of patients for pressure and tissue damage. Whilst the evidence on the 15 January and 15 and 21 February confirmed staff were completing Waterlow assessments the evidence provided dated 12 February indicated that staff were not completing the assessments in full. The health board must ensure staff are aware of the requirement to assess patients for pressure and tissue damage and to document the outcome of the assessment.	Standard 2.2 Preventing pressure and tissue damage	**Immediate Action:** 1. A Knowledge Gap Analysis Tool has been undertaken within the Emergency Department The aim of this tool was to assess staff's knowledge and training needs and to develop a training programme specifically tailored to the needs of the Emergency Department **Further Action:** 2. 2-week training programme to be developed and implemented 3. Additional Interim TVN specialist nurse support 7.5 hours a week now supporting	Emergency Care Matron/Nominated Band 7 – ED Clinical Lead for TVN Emergency Care Matron/Nominated Band 7 – ED Clinical Lead for TVN Head of Nursing Emergency	Completed February 2021 Commenced March 2021 Commenced March 2021

			staff. 4. New flow chart devised on correct process for reporting pressure ulcers on DATIX. 5. Nominated Clinical Lead for Pressure Ulcer Scrutiny in place 6. Bi-monthly PU scrutiny panel in place addressing historical and current cases 7. To fully adopt of PURPOSE-T and change from use of Waterlow Score, as a tool for the assessment and management of pressure damage.	Head of Nursing Emergency Care Group Nurse Director Head of Nursing Emergency Head of Nursing Emergency	Completed March 2021 Completed January 2021 Commenced February 2021 By 1st August 2021
7	As part of the NHS Knowledge and Skills Framework (KSF), administrative, clerical and nursing staff should receive an annual personal appraisal development review (PADR). This process reviews staff learning, development needs and pay progression. Records indicated poor compliance with the requirement for an annual review	Standard 7.1 Workforce	The Emergency's Department ability to undertake face-to-face training including PADR has been limited during the response to COVID-19 both in relation to operational pressures and social distancing requirements. **Immediate Action:** 1. Recovery plan to be developed and implemented to understand current outstanding PADR and provide a timetable for delivery of a	Head of Nursing Emergency Care/ Deputy Head of Nursing Emergency Care/ Matron for	Completed April 2021

	for the following Bands of staff: • Band 7 - 50% • Band 6 - 53% • Band 5 - 68% • Band 6/7 (Emergency Nurse Practitioners) - 33%. 84% of Band 2 and 3 staff had received their annual reviews. We were informed annual appraisals had fallen behind as a result of the pandemic. However, management confirmed there was a plan to arrange PADR appointments with staff plus an offer of time in lieu if they attended out of contracted hours. The health board must ensure staff receive a timely appraisal and confirm how the emergency department plans to improve compliance.		min. standard of 85% **Further Actions** 2. PADR Dates in place across the Emergency Department – with a planned delivery date 3. Process refresh to ensure that local training updated into ESR to ensure consistency with reporting into HB systems 4. To establish a process for the future scheduling of PADR dates in order to ensure review prospective dates are clearly identified and compliance is maintained in the long-term	Emergency Care/ Directorate manager Emergency Care As Above As Above As Above	 By 1st September 2021 By 1st June 2021 By 1st June 2021
8	We were informed the department has 17 registered nurse Band 5 vacancies and one Band 3 and as a result the department is using significant numbers of agency and bank nursing staff equating to	Standard 7.1 Workforce	Developing a robust workforce plan is a priority to the Service Group **Action:** 1. To develop a robust workforce plan	Head of Nursing Emergency Care/	1st November 2021

	approximately 49% of the workforce (30% agency and 19% bank). Management confirmed they endeavour to engage the same agency and bank nurses to ensure continuity of care and provide them with necessary point of care and PPE training. Management told us there has been some successful recruitment since the last HIW inspection that took place in January 2020 however there are still a high level of vacancies prompting the department to run a recurring recruitment advert approximately every two months for four qualified nurses. Given the high level of registered nurse vacancies HIW require assurance that the Health Board has a robust workforce plan in place acknowledging the need for recruitment and retention of nurses in the Emergency department.		**Progress:** Senior posts have been appointed to in order to support and implement the work needed in progressing the nurse workforce plan within the Emergency Department in terms of both recruitment and retention.	Directorate Manager Emergency Care	
9	Evidence provided in advance of and during the inspection identified mandatory and departmental training compliance for the Emergency Department was poor. The levels of compliance did	Standards 2.1 Managing Risk and promoting	**Immediate Action:** 1. Investigation undertaken to establish source of incorrect data and ensure resubmission of correct information	Group Directors/Group Head of Q&S	Completed March 2021

	not provide HIW with assurance that staff were adequately trained to provide safe and effective services. This was highlighted in a letter to the health board requesting immediate assurance. In response a new improved set of training figures were presented to HIW. However no explanation was provided to explain why incorrect training figures had been submitted before and during the inspection. HIW require an explanation to confirm why incorrect mandatory and departmental training figures had been submitted. In addition HIW require assurance that ward management are adequately trained to maintain, source and review staff mandatory and departmental training compliance.	Health and Safety 2.4 Infection Prevention and Control and Decontamination 2.6 Medicines Management 2.7 Safeguarding Children and Adults at risk 3.1 Safe and Clinically Effective Care 7.1 Workforce	The outcome of the investigation concluded that the submission of incorrect mandatory training data was a result of human error. This has highlighted the need for a single point of contact to ensure flow of data in and out of the organisation **Action:** 2. Service Group Standard Operating Procedure to be developed to support the management of external/internal audit processes including sign-off and submission of evidence **SOP to include:** • Registering of audit locally • Nomination of Group Director Lead • Nomination of Operational Lead - • Process for sign-off • Process for submission • Process for the request of additional evidence	Group Head of Q&S	By 1st July 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: Mark Madams, Group Nurse Director, Morriston Service Group

Date: 29/04/2021