Hospital Inspection (Unannounced) Prince Charles Hospital, Emergency Department and Clinical Decisions Unit

Inspection date: 13, 14 and 15 September 2021

Publication date: 15 December 2021

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Digital ISBN 978-1-80391-483-1

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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 Prince Charles Hospital within Cwm Taf Morgannwg University Health Board on 13, 14 and 15 September 2021. The following hospital sites and wards were visited during this inspection:

- Emergency Department (ED)
- Clinical Decisions Unit (CDU).

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors, HIW Assistant Director of Quality and Clinical Advice, two clinical peer reviewers and one lay reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

The inspection was initially planned to focus on the CDU due to significant concerns received by HIW relating to staffing. However, on arrival at the unit, we were informed that there was an outbreak of COVID-19 in the hospital and that there were COVID-19 positive patients accommodated on the CDU. Consequently, a decision was made to focus on the services provided within the ED, with limited focus on the CDU. In addition, based on the risk to members of the inspection team and to reduce the footfall within the hospital, it was decided that half of the inspection team would locate themselves offsite at the Welsh Government offices in Merthyr Tydfil, to conduct aspects of the inspection remotely. This then left one HIW Senior Healthcare Inspector, HIW Assistant Director of Quality and Clinical Advice and one clinical peer reviewer to conduct the on-site elements of the inspection.

The Community Health Council had also escalated concerns with HIW about the experience of patients using the ED at Prince Charles Hospital, which helped to inform our inspection.

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

At the time of our inspection we found that the ED, as the front door to a wider system, was experiencing a period of heightened pressure due to an unrelenting demand on services as a result of the COVID-19 pandemic. There were significant issues with bed availability and patient flow throughout the hospital. We acknowledged that this was a very challenging and stressful environment for some staff, who were working above and beyond in exceptional and challenging conditions.

We found that the health board was not fully compliant with many of the Health and Care Standards and we highlighted significant areas of concern which could present an immediate risk to the safety of patients.

Our main concerns included poor patient experience across both the ED and CDU, where patient dignity was not always maintained.

We saw significant overcrowding in the ED and risks to health and safety were not managed appropriately, with poor infection prevention and control arrangements.

We highlighted significant concerns regarding many aspects of the delivery of safe and effective care. We were not assured that all the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of safe and effective care. However, we saw that staff were working hard to deliver care under very difficult and highly pressurised circumstances.

We found that the quality of management and leadership was not sufficiently focused and robust. We also found that the wider leadership and governance arrangements, beyond direct management of the ED, were not having an effective or supportive impact on the ED.

This is what we found the service did well:

- Committed and hardworking staff with clear focus on patients
- Triage generally very thorough
- Communication between doctors and nurses
- ED staffing had recently been increased
- Committed, competent and hardworking reception staff
- Effective medicines management including the management of controlled drugs
- Dedicated cleaning team in the CDU
- Passionate and committed IPC team

During the inspection, we found significant areas of concern which could present an immediate risk to the safety of patients. These included:

- Arrangements for the prevention and control of infection
- Arrangements for oversight and access to the waiting room in the ED
- Insufficient facilities to undertake essential clinical interventions
- The use of the GP assessment area to assess COVID-19 positive patients
- General environmental safety and security
- Provision of toilets within the ED
- Staffing of the paediatric area within the ED
- Environment of the paediatric area
- Screening and monitoring of patients
- Staff were unhappy and struggling with their workload
- Wider leadership and governance beyond direct management of the ED.

The above issues were discussed with managers from the health board during our inspection feedback meeting, which was held immediately following the inspection, and were subsequently dealt with under HIW's immediate assurance process. This involved us writing to the health board, within two days of completion of the inspection, outlining the issues and requiring a written response within seven days. The immediate assurance issues, and the health board's response, are referred to in detail within Appendix B of this report.

On Thursday 16 September 2021, we met with senior managers from the health board, and colleagues from relevant departments within Welsh Government, to discuss our concerns and seek assurances from the health board that the issues of concerns would be addressed as a matter of urgency.

We held further meetings, and continue to engage with senior managers from the health board, to monitor the progress made in addressing the issues highlighted.

In addition to the immediate assurance issues, we also found that the health board needs to make improvements in the following areas:

- Review the layout of the proposed triage room
- Review the medication management policy
- Provide lockable cabinets within the ED for patients to store their medication
- Review the intentional rounding arrangements to ensure that the care needs of patients who have been assessed as requiring one to one care, support and supervision are fully met at all times
- Staff training
- Staff support and well-being
- Ensure that the patient use i-pad is working

3. What we found

Background of the service

Prince Charles Hospital is a district general hospital located in Merthyr Tydfil. It is managed by the Cwm Taf Morgannwg University Health Board. It was officially opened in 1978. A new Emergency Care Centre opened in 2012, and the complete refurbishment of the whole hospital was approved by the Welsh Government in October 2013. The refurbishment work was on-going at the time of the inspection.

The hospital provides acute emergency and elective medical and surgical services, Intensive Care and Coronary Care, consultant-led obstetrics services with Special Care Baby Unit and inpatient consultant-led paediatric medicine. There are seven operating theatres. The hospital also provides sub-regional oral and maxillo facial services, a full range of locally provided and visiting specialist outpatient services and has an extensive range of diagnostic.

The Emergency Department consisted of:

- Reception area and waiting room
- Triage rooms – where patients are assessed in order to decide which are the most seriously ill and must be treated first
- Ambulatory area (referred to in this report as minors area) – where patients with minor injuries or ailments are treated

- Majors area – where patients with more serious injuries or ailments are treated
- Resuscitation area – where the most seriously ill or injured patients are treated
- Separate paediatric treatment and waiting room
- COVID-19 positive waiting area
- GP assessment area.

The Clinical Decisions Unit (CDU) is located adjacent to the ED. Patients are admitted on to the unit directly from the ED and through direct GP referrals. Patients who are admitted on to the CDU may require further investigations, procedures and stabilisation before being transferred to the most appropriate ward, other hospital or being discharged home.

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.

We found evidence of poor patient experience across both the ED and CDU.

We found evidence that patient dignity was not always maintained in the ED.

We found that the ED was significantly overcrowded. This included patients being held in corridors, on trolleys within the majors area and in chairs within the minors area, for up to and over 24 hours.

Due to the COVID-19 status of the CDU, we were unable to hold discussions with patients face to face. The team on site were able to hold brief discussions with some patients within the ED. Their comments are noted further on in this report.

Dignified care

We found evidence that the dignity of patients was not always maintained in the ED.

This included:

- patients being held in corridors, on trolleys within the majors area and in chairs within the minors area, for up to and over 24 hours, with some patients resorting to sleeping on the floor
- a patient experiencing a miscarriage, in full view of another patient
- only one toilet available for all COVID-19 negative patients within the ED, GP assessment unit, fracture clinic and gynaecology assessment area. This included patients with vomiting and diarrhoea and patients experiencing miscarriages.

These issues are referred to in more detail further on in this report.

Two patients told us that they were unhappy with being cared for in the corridor. One told us they felt it was undignified and everyone knew their business and another patient said they would have been more comfortable in a police cell. Both these patients were actively receiving intravenous therapy[1] in the area.

We saw doctors and nurses attending to the needs of patients in the corridor. This included assessment and in some cases venepuncture. However, no intimate examinations were seen to take place and all patients were appropriately covered by blankets.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

Visiting was restricted at the time of the inspection due to a rise in COVID-19 cases. However, terminally ill patients could receive visitors if their condition warranted this and only following a risk assessment.

[1] Intravenous therapy (abbreviated as IV therapy) is a medical technique that delivers fluids, medications and nutrition directly into a person's vein.

Timely care

We found that the ED was significantly overcrowded. This included patients being held in corridors, on trolleys within the majors area and in chairs within the minors area, for up to and over 24 hours. Staff told us that the situation had been made worse by the downgrading of emergency services at the nearby Nevill Hall and Ysbyty Ystrad Fawr hospitals which has resulted in more patients attending the ED at Prince Charles Hospital.

Staff described how patients in minors, who were waiting for a bed to become available elsewhere in the hospital, would often be sitting in a chair for long periods and, in some cases, overnight. The waiting room chairs were very hard and uncomfortable and presented a risk of pressure and tissue damage to some patients.

We were told that some patients resorted to lying and sleeping on the floor. We also saw photographic evidence of this. Some staff told us they had been told by senior managers not to accommodate patients on trolleys in the minors area and that staff often overruled this direction if patients were there for long periods. Having patients lying and sleeping on the floor is not only undignified, but presents a risk of cross infection, tissue damage and a risk of trips and falls.

Some staff described the treatment of patients who were waiting for long periods of time on the chairs in the minors area as ‘torture’ as they were often deprived of sleep and comfort.

The above issues were dealt with under HIW’s immediate assurance process and are referred to Appendix B of this report.

Communicating Effectively

We were told that there were two bilingual (Welsh/English) speaking staff in ED, one nurse and one healthcare assistant.

We attempted to use the CDU patient i-pad to speak with patients during the inspection. However, we encountered issues with this and were unable to connect. This is concerning as it could mean that patients are unable to contact their relatives using this device.

Improvement needed

The health board must ensure that the i-pad provided for patients’ use is working and that patients are able to make use of it to maintain contact with their relatives and friends.

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 were not assured that all risks to health and safety within the ED and CDU at Prince Charles Hospital are managed appropriately.

We found that the arrangements for the prevention and control of infection within the ED and CDU did not protect patients, members of the public and staff.

We also found that not all aspects of care were being delivered in a safe and effective manner.

Safe care

Managing risk and promoting health and safety

We found that risks to health and safety were not appropriately managed with the ED. This presented a significant risk of harm to patients and members of the public.

There were no clinical staff based in the waiting room and no on-going checks were undertaken on any of the patients within this area.

Reception staff were relied on to alert staff to any patients who presented as being significantly unwell. In addition, reception staff do not have sight of the whole waiting room due to the layout and blind spots. Staff provided several examples where patients had deteriorated and collapsed unnoticed in the waiting room.

Reception staff had no means of quickly calling for emergency help. They had a phone line but this was not always a quick contact to the staff in ED. There was no emergency bell for emergencies such as collapse or security issues. We were told that, on one occasion, the receptionist had to rely on a member of the public to help them support a patient who had collapsed in the waiting room.

We were told that the reception staff often prioritised and directed patients to the various treatment areas within the ED, known as streaming. This practice is not reflective of nationally accepted guidelines which are clear that streaming should be undertaken by clinical staff.

The reception staff have not been provided with training on triage or information on which conditions and symptoms they would need to highlight and escalate to the

nursing staff. Reception staff told us that they would use their personal judgement in this respect. However, we observed two cases where patients attended with symptoms which required escalating. However, the reception staff did not recognise this as the symptoms were not obvious to someone not appropriately trained.

The COVID-19 waiting area was not staffed. Consequently, patients waiting in this area were unsupervised. On one occasion during our inspection a patient's deteriorating condition went unnoticed and they subsequently had to be moved to the resuscitation area.

We were told that the nurse in charge never has time to attend the ED waiting room as they are covering the whole of the department, which was very busy, covered a large area and was complex in layout.

Staff described the department as 'chaos' and a 'war zone'. Staff were highly distressed about the overcrowding and told us that they felt this was putting lives at risk.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

We found that the triage room was located away from the main ED waiting room. Consequently, the triage nurses had no oversight of patients waiting to be seen. We were told that the triage room was to be moved to another location. On viewing the proposed area, we found it to be very confined with poor access for patients who have mobility problems or who are wheelchair users. We also noted that there was only one door into the proposed triage room which could compromise staff safety in the event of patients becoming aggressive or intimidating whilst being triaged. We recommend that the health board re-consider the use of this location as the proposed triage area and consider utilising an area that is more accessible and spacious.

Triage is carried out using the Manchester Triage System[2] and the triage nurse is supported by a healthcare assistant. This allows for observations to be recorded, wounds cleaned, blood tests and electrocardiogram (ECG) to be performed. Skin condition assessment is also carried out as part of the triage process if needed. This

[2] The Manchester Triage System is one of the most commonly used triage systems in Europe. It enables nurses to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis.

is seen as good practice, as it allows staff to document the condition of a patient's skin at an early stage to monitor for potential deterioration. However, carrying out all these procedures can potentially slow down the triage process.

Improvement needed

The health board must review the proposed triage room layout to ensure that it is fit for purpose, accessible to people with poor mobility and that it does not compromise staff safety.

Infection prevention and control

We found that the arrangements for the prevention and control of infection within the ED and CDU at Prince Charles Hospital, in general, did not protect patients, members of the public and staff.

We found that the layout of the ED was complex in its design. Patients were accommodated in many different areas separated by busy corridors. This meant that staff have to walk through different areas of the department to get to where they needed to be. There was no one way system in place which meant that the footfall was significantly increased throughout all areas of the department. We were told that a review of the ED layout was in progress and that improvement work is scheduled. However, the current layout of the ED presents a significant risk of cross-infection.

We found that arrangements for cleaning following COVID-19 exposure were unclear. Some areas would undergo enhanced cleaning with a specific cleaning fluid and double wiping. Some areas would be cleaned using the hydrogen peroxide vapour (HPV) system. Staff told us that, often, only the enhanced cleaning would be utilised as this took less time and thus improved flow.

We saw multiple examples of staff members not adhering to local and national guidelines for the correct use of personal protective equipment (PPE). This included staff wearing the wrong level and types of PPE and masks either not being worn correctly or, in some cases, not at all. Staff were also seen moving between areas within the ED without changing PPE. This included areas with suspected and confirmed cases of COVID-19. However, we saw good use of PPE and hand hygiene by staff in the triage area and noted that equipment was being cleaned between patients.

We saw that there were inadequate, designated donning and doffing areas in the ED with staff unable to don and doff PPE safely in specific areas increasing the risk of cross infection. In addition, some staff were unclear as to what level of PPE was required in each area and when they should change their PPE.

We saw some staff, external to the ED, wearing fabric masks and not the required fluid resistant face masks (FRSM), despite COVID-19 positive cases being accommodated in the department.

We saw that some staff did not properly clean their hands when leaving and entering areas of the ED and CDU, despite COVID-19 cases being present in both areas. In addition, we saw that patients and visitors were not challenged or asked to clean their hands when entering these areas.

We found that the arrangements for segregating suspected or confirmed COVID-19 positive patients were inadequate and presented a significant risk of cross infection to patients, members of the public and staff. In addition, we found that staff delegation did not ensure that only specific staff cared for suspected and COVID-19 positive patients on both the CDU and ED majors, triage and resuscitation areas. This meant that the same staff provided care for both COVID-19 positive and negative patients. This significantly increases the risk of cross infection and harm to patients.

Staff told us that the measures for segregating patients were insufficient and 'chaotic'. They described being under pressure from senior managers, from outside the ED, to compromise IPC standards and best practice in order to increase patient flow through the department. Staff also told us that they felt worried about contracting COVID-19 and that they were concerned for the patients. Only one member of staff we spoke with said they would have been happy for their relative to be treated in the areas where cases were mixed.

The process for assessing patients' COVID-19 status on arrival at the department resulted in COVID-19 positive patients entering the main waiting area and coming into contact with patients who had tested negative for COVID-19 and clinically vulnerable patients. The only visible guidance to patients with COVID-19 symptoms, or confirmed positive status, was a sign on the front door advising them to attend the designated COVID-19 waiting area through another entrance. This alternative entrance was not clearly signposted and was not visible from the main ED entrance. Consequently, COVID-19 positive and COVID-19 suspected patients were seen entering the main ED waiting area unchallenged. In addition, we saw that in order to access the suspected or COVID-19 positive waiting area, patients had to walk unescorted and un-assisted, from the main ED entrance, along a path outside of the hospital building. This area was not staffed by nursing or medical staff and was not easily visible to reception staff. The signage within this area was inadequate and did not clearly indicate that this was a COVID-19 high risk area. This presented a risk of cross-infection.

We saw a very unwell patient attend the main ED waiting area to book in. The patient advised staff that they were COVID-19 positive. The patient was directed out of the department by reception staff. The patient walked to the designated COVID-19 waiting area un-escorted. There were no staff to meet them in the COVID-19 waiting area and

the triage nurse from the main ED then had to go to the COVID-19 waiting area to assess the patient. This presents a risk of cross infection and harm to patients.

We saw that, at times of peak demand, when there were delays in booking in at the ED reception, patients were queuing without social distancing. This placed them in close proximity of each other and increased the risk of cross-infection.

We were told that COVID-19 positive patients, who needed to be cared for on a trolley, would be accommodated in the adjacent CDU. However, we saw that this was not always the case and that some COVID-19 positive patients were accommodated in the majors area within the ED. ED staff informed us that this was routine practice and they frequently accommodated symptomatic and confirmed COVID-19 cases in the majors area alongside patients who had tested negative for COVID-19 and those classed as clinically vulnerable.

We saw up to eight patients waiting on trolleys in the corridor within the majors area of the ED and were told by staff that this was a regular occurrence.

We saw staff working in this corridor area only wearing face masks as protection whilst moving around and interacting with each other and patients. We were told that staff would only wear aprons, gloves and eye protection if they were delivering care to a patient at a distance of less than two metres. This was despite there being little air flow within the corridor area and COVID-19 symptomatic patients being present**.**

We were presented with conflicting information by senior managers in relation to the management of COVID-19 positive or suspected patients in the ED. We were informed that, if such patients required resuscitation level treatment that they would only be treated in a cubicle on the CDU which was designated for this specific purpose. The Infection Prevention and Control (IPC) lead nurse also told us that the cubicle on the CDU was used for all COVID-19 positive or suspected patients, and that no such patients were cared for in the resuscitation area. However, staff told us that this was not always the case and that such patients were routinely accommodated in the majors area, where only one room had a door, or the resuscitation area, including at times when COVID-19 negative patients were present. All other cubicles were fitted with curtains instead of a door, which makes the isolation of patients less effective. We spoke with six nurses about this issue. Out of the six nurses, five told us that they had never seen the CDU cubicle used and that the resuscitation area was always used to accommodate these patients. One staff member told us that they had seen the CDU room only used once for this purpose.

Members of the senior management team also told us that they did not regard cardiopulmonary resuscitation (CPR) as an aerosol generating procedure (AGP)[3], and that they would undertake AGPs on patients in the resuscitation area when their COVID-19 status was unconfirmed, as they would regard these patients as COVID-19 negative until tests had confirmed otherwise. We questioned the appropriateness of this practice as CPR is likely to generate aerosols which could present a risk to staff, particularly when the COVID-19 status of the patient is unknown.

We found that the resuscitation area was not clearly signposted as a high risk COVID-19 'red' area. There were two entrances to this area where the members of the public or other staff, not delegated to work within this area, could enter.

The resuscitation area also shared a clean utility and drug storage room with the majors area. This presented a risk of cross infection, as staff from the two areas were regularly coming into direct contact with each other.

We looked at the GP assessment unit located within the ED. This area is used to assess and treat patients who have been referred directly by their GP. Within this area, there was also a room which is used by the GP out of hours service (OOH), from 5.00pm until 8.00am, to accommodate and assess suspected COVID-19 patients. We were told that patients from the ED are routinely held in the GP assessment unit overnight as additional surge capacity. This included some patients accommodated on trolleys in the corridor area outside this room. Patients attending the GP out of hours service had to first book in at the ED reception, then walk through the ED waiting area and pass through part of the minors area and triage. This provides multiple opportunities for these patients to come into contact with staff and patients who are COVID-19 negative thus increasing the risk of cross-infection.

Some staff told us that they never saw members of the IPC specialist team within the ED and that this was possibly due to the high infection risk due to the mixing COVID-19 positive and negative patients within the same areas. However, the lead IPC nurse told us that the members of the IPC team would visit the ED daily.

During the tour of the ED we found numerous, more general infection prevention and control issues. These included:

[3] An Aerosol Generating Procedure (AGP) describes an activity that can result in the release of small airborne particles (aerosols) or droplets. Under certain conditions, the aerosols might contain potentially transmissible quantities of virial material.

- Eye level dust present in several areas presenting a potential infection reservoir
- Overflowing linen bins with soiled linen
- Broken chairs with rips or tears in the fabric
- A plug on a piece of medical equipment held together with a disposable tourniquet and micropore tape which was soiled
- Overflowing sharps bins
- Discarded bottles of water and drinks cans.

We saw that social distancing guidance was not being adhered to due to extreme overcrowding within in multiple areas of the ED. This included patients sitting directly next to each other. We were provided with photographic evidence of this and of patients sleeping on trolleys directly next to each other with less than half a metre space between them. The photographs also showed scenes of extreme overcrowding with patients sharing equipment such as drip stands and blankets. These practices significantly increase the risk of cross-infection.

We saw that clinical areas were not always cleaned and tidied between patient uses. We also saw that trolleys were not tidied and cleaned in a timely fashion after use. We saw soiled linen on one empty trolley and a mattress from another trolley was seen on the floor of the corridor.

We saw that a partition had been erected in an attempt to segregate COVID-19 positive and negative patients within the ED waiting area. However, this has resulted in patients accommodated on the COVID-19 negative side of the waiting room being unable to make use of the toilets which are located on the COVID-19 positive side of the partition. This meant that COVID-19 negative patients were having to use the toilet located by the triage room. This toilet also served all patients in minors, GP assessment unit, fracture clinic and gynaecology assessment area. This often resulted in queues forming outside the triage area. We were told by staff of an occasion when a patient had been incontinent of faeces as the wait for the toilet was too long. Staff were also concerned that this one toilet was used for all patients, including those with vomiting and diarrhoea and patients experiencing miscarriages. Staff talked of their uneasiness of having to direct very distressed women who were experiencing miscarriage to this toilet to be confronted with long queues. Some were in severe discomfort and distress. Not only does this present a risk of cross infection but it is also highly distressing and undignified for the patients.

We saw that, due to extremely limited space within the ED, clean trolleys were often stored next to waste receptacles such as clinical waste bins. This included aseptic procedure trolleys used for procedures such as venepuncture and cannulation. Patients were also seated within these areas.

We found that there was only one sink available for handwashing within the minors area.

A member of the IPC team told us that, although the Integrated Locality Group (ILG)[4], which is part of the health board management team, accepted some of the advice they gave, there were other times when they did not follow advice. For example, senior managers had overruled the IPC team's advice and had instructed that staff working in COVID-19 positive areas to only wear fluid resistant surgical face masks when in the main ward area, unless they were delivering care at less than two metres, and the advice regarding the mixed Covid-19 positive and negative status areas in the ED and CDU.

Another example given was that the IPC team recommended that a ward should be closed due to a new COVID-19 outbreak. We were told this was overruled by the ILG on the basis of flow. This meant that patients continued to be admitted to that area.

We were told that, up until recently, security staff had been deployed on all entrances to the hospital to guard against any unauthorised entry and to ensure that everyone entering wore face masks. We were told that this had been discontinued by the ILG management without wider consultation. Staff told us that, as a result of this, they frequently had unauthorised visitors make their way into the department. We saw this to be the case during the inspection.

We were told that the IPC team have repeatedly raised the issue of PPE and segregation of patients in the ED and CDU with senior management but no action had been taken to remedy the situation.

A member of the IPC team felt that this current COVID-19 wave was being treated less seriously by staff and the health board and that some staff members had 'forgotten' their training and were no longer adhering to IPC policies and procedures.

They also told us that the policies and procedures for the segregation of COVID-19 positive and negative patients had not been reviewed as the pandemic evolved. For example, policies and procedures remain heavily focussed on patients displaying symptoms when some patients with COVID-19 were presenting with no symptoms.

[4] The Merthyr and Cynon Integrated Locality Group is a new operating model adopted by the health board on the 1 April 2020.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

Medicines management

We were presented with a copy of the health board's medication management policy. This was dated October 2014, and there was no evidence that this had recently been reviewed. The health board must ensure the policy is regularly reviewed and updated. Governance systems must ensure all policies are kept in date.

We were told that there was dedicated pharmacy support for the CDU. However, this was not the case in the ED. Medication within the ED was dispensed electronically by means of an automated dispensing cabinet.

We were told that, if medication is required out of hours, there is an emergency drug cupboard which can be accessed through the automated controlled substance management system, and if anything else is needed then the on call pharmacist is called who can also dispense medication remotely.

There was also a locked fridge for the storage of temperature sensitive medication. We saw that daily temp checks were being undertaken and recorded.

We saw that medication administration record (MAR) charts were being completed appropriately and that the correct codes were being entered if patients refused their medication.

We found that controlled drugs were being appropriately managed with regular checks undertaken and signatures entered as required. The controlled drugs were stored in a locked cupboard, with the keys held by a designated nurse.

We saw that oxygen was being prescribed, monitored and recorded appropriately.

We saw that there were lockable cabinets next to each bed in the CDU for patients to store medication safely. However, there were no such facilities in the ED. We saw that medication was being placed on lockers in one of the cubicles in ED and suggested that consideration be given to the provision of individual wall lockers, with keypads, adjacent to each patient trolley space in order to store medication safely within the ED.

We saw that patient identification wristbands were being used appropriately within the ED, with red wristbands used to identify patients with known allergies.

Improvement needed

The health board must:

- Review the medication management policy.

- Ensure that there is a system in place to keep all policies in date
- Consider providing lockable cabinets or lockers within the ED for patients to store their medication.

Effective care

Safe and clinically effective care

We were told that the facilities within the ED were used by a number of other departments. This included rooms used for gynaecological examination and pregnancy loss, maxillo facial and orthopaedics. None of these specialities used nursing staff from their respective divisions to support patients. Consequently, ED staff were expected to assist medical staff with examinations and investigations. This took up valuable time, resource and physical capacity from the ED. This hindered the flow of patients and had a detrimental effect on the department's capacity to accommodate patients.

The gynaecology room was used regularly to treat patients who were experiencing miscarriage. The doctor would be assisted by an ED healthcare assistant (HCA), who had no training in this area. The room was not considered a sterile environment and several IPC risks were present, including an electric plug which was held together by tape and a disposable tourniquet. The lamp used during the procedures was also broken and so required the HCA to physically hold the lamp for the doctor.

This room was within the minors and next to patients being accommodated there. An example was given by staff of a patient experiencing a miscarriage in this room and there was an elderly patient on a seat outside the door.

The products of pregnancy had to be managed by the ED staff and this included transfer of products and foetuses to the mortuary. This would take two ED nurses away from the ED.

The patients who experienced miscarriages did not have access to any counselling or support from the maternity services. ED staff were doing all they could to support the patients but had very little experience or formal training in this area.

We found that the paediatric area within the ED was not approriately staffed, with often only one qualified nurse and one HCA working in the area. This resulted in the area regularly being left without a qualified nurse as they had to escort patients to x-ray or when they were required in the resuscitation area.

The nurses working within the paediatric area were very stressed and upset by this situation. The COVID-19 positive treatment room was in the same area as the waiting room and other patients who were COVID-19 negative. In addition, the waiting area was very small and did not facilitate social distancing.

The area is access controlled by means of a swipe card system. However, it is located immediately adjacent to the ED reception and was seen to be used as a thoroughfare by a number of staff members from the department. This meant the doors were unlocked and opened numerous times.

There was inadequate space for donning and doffing of PPE, with this being undertaken in the corridor.

We were told that children often waited in the department for up to 10 hours, even when there was space on the children's ward, as there were times when the ward would not accept admissions from the ED.

Patient Group Directions (PGD)[5] were not up to date. Therefore staff were unable to administer simple analgesia to children at triage.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

Staff told us that intentional rounding[6] had recently been introduced within the CDU.

Staff were concerned that this process had been implemented due to insufficient staff to provide one to one care for some patients. Under this process staff carry out more frequent checks on a group of patients. This could lead to elements of care and support not being provided in a timely way and increases the risk of harm to patients.

[5] Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. NHS PGDs must only be used as part of a commissioned NHS service.

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

Improvement needed

The health board must review the intentional rounding arrangements to ensure that the care needs of patients who have been assessed as requiring one to one care, support and supervision are fully met at all times.

Record keeping

We were told that regular documentation audits are conducted and findings shared with staff in order to improve practice.

We looked at a sample of patients' care notes and risk assessments and found that, on the whole, these had been accurately completed within the CDU. However, we found record keeping to be generally poor in the ED.

We found that 10 out of 12 required observations were not performed at a frequency necessary to identify deterioration. This included patients with increased National Early Warning Score[7] (NEWS). NEWS scores were frequently miscalculated or missing. On all charts reviewed the frequency specified at the top of the chart was not adhered to.

Staff were unaware of the Royal College of Emergency Medicine (RCEM) guidelines on monitoring patients' vital signs which require an increased frequency of observations.

Staff we spoke with told us that they were aware of the health board's sepsis protocol and that they knew how to access relevant clinical guidelines via the intranet. However, in all three patient cases tracked, where signs of sepsis were present, a screening tool was not completed. This meant that patients were not always monitored at a frequency which would identify deterioration and changes in their condition.

[7] National Early Warning **Score** (NEWS) is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

The ED did not have their own schedule detailing what observations are required and how often these should be completed and recorded.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

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 that management and leadership was not sufficiently focused and robust. We highlighted serious issues, which require immediate action by the health board in order to prevent significant harm to patients, members of the public and staff.

We found that the wider leadership and governance arrangements, beyond direct management of the ED, were not having an effective or supportive impact on the ED. This meant that staff felt unsupported and not listened to. This had led to a culture of front line staff feeling abandoned.

We highlighted a number of significant issues, that presented a significant risk of harm to patient and staff, which the management team were unaware of.

Governance, leadership and accountability

We spoke with a cross-section of staff working in the ED and CDU, both face to face, and remotely through Microsoft Teams.

Many of the staff members we spoke with were very unhappy, stressed and struggling to cope with their workload. Some staff were visibly upset and cried while speaking to the inspection team. Some staff told us they were ashamed of working in the hospital and felt that they were not invested in it.

Staff told us that they did not feel supported by the senior managers within the hospital, and that they did not listen to their concerns about IPC and staffing levels. Staff also told us that they had repeatedly raised concerns about patient and staff safety to senior managers, outside of the ED and CDU, and that these had not been addressed.

Staff working in the paediatric area within the ED told us that the senior nurses were disconnected and did not understand the specific issues and challenges faced by staff working in that area.

We were concerned that senior managers were unaware of some of the very serious issues that we found during the inspection and that there was disconnect between what they told us was happening, what staff told us and what we observed during the inspection.

Staff were unclear on the complex layers of management outside of ED and CDU and in particular the Integrated Locality Group structure. Staff felt that this was an additional layer which did not bring about meaningful support or change. Staff told us that the site management team were not proactive which, in turn, placed additional pressure on the head of nursing.

Staff told us that they were not consulted on changes made to the areas that they worked in which resulted in the clinical impact of change not being taken into consideration.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

In addition to holding face to face discussions with staff, we issued posters with Quick Response (QR) codes and sent staff links to access an online survey in order to gain their views on the service offered at the ED and CDU.

In total, we received 30 responses from a cross-section of staff who had worked at the hospital for durations ranging from less than a year to more than 10 years. Eleven of the respondents said they worked in the ED, thirteen said that they worked in the CDU, and four said that they worked in other areas.

The following information is a summary of responses received from staff through the online survey:

- Less than a quarter of staff who completed the online survey agreed that care of patients is the organisation's top priority and that the organisation acts on concerns raised by patients.
- Only four out of 27 respondents said that they would recommend the organisation as a good place to work, with only three stating that they would be happy with the standard of care provided by the organisation if it was for themselves or for friends or family.
- Less than a quarter of respondents said that patient feedback was collected within their directorate/department and that they receive regular updates on patient experience feedback.

- Less than a quarter of respondents said that feedback from patients is used to make informed decisions within their directorate/department.

We asked staff, through the online survey, to give us their views on their immediate manager:

- Half of the staff who completed the online survey said that their immediate manager encourages them to work as a team.
- One third of the respondents said their immediate manager can be counted on to help with a difficult task at work.
- A quarter of respondents said their immediate manager gives clear feedback on their work and that they asked for their opinion before making decisions that affect work.
- One third of respondents said their immediate manager is supportive in a personal crisis.

These are some of the comments that we received from staff about their immediate manager:

> *"Have amazing support from my line manager and deputy manager. However can't help but feel sorry for them when we are so short and end up being pulled about the place"*
>
> *"These answers are based on my band seven managers. I feel there is no rapport with the managers above this role"*
>
> *"I feel that my opinion is not valued or listened to, which is a sentiment shared by most staff in the department and we are never asked our opinion or consulted on any changes/improvements"*
>
> *"They make me take charge when I haven't been qualified long because so many senior staff have left and they haven't been able to fill the posts."*

We asked staff, through the online survey, to give us their views on the senior management:

- Just over half the respondents said they knew who senior managers were.
- Only three respondents said communication between senior management and staff is effective and that senior managers try to involve staff in important decisions.

- Only two respondents said that senior managers act on staff feedback and that they are committed to patient care.

These are some of the comments that we received from staff about senior managers:

> *"We have changed senior management many times over the past few years due to the pressures that CDU attracts. We have many complaints about patient care due to staffing problems but they still leave us short staffed. Managers would rather sit in the office than be hands on and help with patient care and wash or give medications"*
>
> *"Don't see them. Don't ever come and help"*
>
> *"I feel senior managers are committed to meeting targets more than committed to the quality of care the patients receive. This pressure is placed up on lower grade staff affecting the quality of care"*
>
> *"We work short regularly on days the manager never comes out of [the] office to help … just sits there and tells us to have more patients each when we can't cope with the workload we already have"*

We asked staff about their well-being and work patterns:

- Half of the staff who completed the online survey said that they regularly have sight of new guidance, patient safety alerts and medical device alerts.
- A quarter of respondents said they are supported to ensure implementation and adherence to patient safety alerts and medical device alerts whilst a third said that they had been made aware of the revised Health and Care Standards.
- More than half of the staff felt that their job is detrimental to their health.
- Only one third of respondents agreed their immediate manager takes a positive interest in their health and well-being with one fifth telling us that the organisation takes positive action on health and well-being.
- Just under a third said they are offered full support when dealing with challenging situations.
- Over half of the respondents said that they were aware of the Occupational Health support available.

- One third of the respondents agreed that their current working pattern/off duty allows for a good work life balance.

These are some of the comments that we received from staff about their wellbeing and work patterns:

> *"I have child care problems I was told come to work or find another job"*

> *"They make me work on off shifts all the time so I don't get much down time. Then they say I have to try and do online learning at home when I should be relaxing"*

We asked staff about what happens when incidents and errors occur:

- Two thirds of respondents said they had seen errors, near misses or incidents affecting staff in the last month and a third said they had not. Three quarters of staff told us that they had seen errors, near misses or incidents affecting patients in the last month.

- Most of the respondents said that, the last time they saw errors, near misses or incidents, they reported it.

- Just under a third of respondents said that the organisation treats staff who are involved in an error, near miss or incident fairly with just over half telling us that the organisation encourages them to report errors, near misses or incidents.

- A third of respondents agreed that the organisation treats reports of errors, near misses or incidents confidentially.

- Just over a third of respondents said that the organisation does not blame or punish people who are involved in errors, near misses or incident.

- Under a third of respondents agreed that, when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again and the same number of respondents said that they are informed about errors, near misses and incidents that happen in the organisation.

- Under a quarter of respondents said that they are given feedback about changes made in response to reported errors, near misses and incidents.

- The majority of respondents said that, if they were concerned about unsafe clinical practice, they would know how to report it with less than half telling us that they would feel secure raising concerns about unsafe clinical practice.

- Most respondents said that they were not confident that their organisation would address their concerns.

These are some of the comments that we received from staff about incident reporting:

> *"Datix put in at every near miss or incident always comes back as low risk nothing ever changes"*
>
> *"Reported to manager and put on the system never get feedback from anything and nothing ever changes"*
>
> *"Never get feedback. Just shouted at and bullied"*
>
> *"Although it is promoted that there is no blame culture in the department, I believe that to be fictional. I have seen on many occasions that people will be punished by being stopped working in certain areas or sent to different wards to work for periods of time, serving no other purpose than to punish an individual. Staff are treated as children and have witnessed other staff members being spoken down to by senior management in a degrading manner"*
>
> *"Never get feedback, don't get any help. Haven't had supervision when I first qualified. Was told sink or swim"*

We asked staff about infection prevention and control and COVID-19 compliance:

- Only half of the respondents said that infection prevention and control procedures are followed.

- Only one third of respondents agreed that the organisation has implemented the necessary environmental changes and that the necessary practice changes had been implemented.

- More than half of the respondents told us that the supply of PPE was insufficient with three quarters telling us that arrangements for decontaminating equipment and affected areas was not sufficient.

These are some of the comments that we received from staff about infection prevention and control and COVID-19 compliance:

“Sometimes we don't have gowns or aprons available. No visors available for COVID patients and hand sanitizer is hard to find”

“Having to nurse both ‘clean’ patients and ‘COVID-19 positive’ patients during the same shift, within a short space of time is ridiculous. Having a minor COVID room that is so far away from our main areas is also a great concern that has been raised many times by many staff but has not changed.”

“The COVID waiting room for patients walking into the department with COVID symptoms is located away from both minors and majors with no quick access to either area. Many patients have rapidly became unwell there as they are unable to be monitored. We usually only have one or two rooms available for COVID patients to go for assessment by a and e. This usually leads to the ending up in either majors or resuscitation areas. We are also expected to look after COVID and non COVID patients simultaneously. The green waiting room is also very small and is always busy with social distancing near impossible. All minors patients, which usually totals over 40 to 50 patients alone, only share a single toilet”

We asked whether staff had faced discrimination at work within the last 12 months:

- Three staff members reported discrimination on grounds of age, two on grounds of sex, five on “other” grounds, and six answered “prefer not to say”. Some respondents reported they had been discriminated against in multiple categories.

- Less than half of the respondents agreed that they have fair and equal access to workplace opportunities (Regardless of Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation).

- Half of the respondents agreed their workplace is supportive of equality and diversity.

These are some of the comments that we received from staff relating to discrimination in the workplace and workplace opportunities:

“I'm a single parent they don't care about my child”

"There are no work place opportunities as there are not enough staff. We are worked to the bone and covered by agency on most shift as we can't get staff"

Staff and resources

Workforce

We looked at staffing rotas for both the ED and CDU and spoke with staff to gain their views on the current staffing levels.

We were told that staff recruitment and retention was challenging and that the service was heavily reliant on agency and bank staff to meet the level of staffing. We were also told that the situation is made worse by the number of staff on sick leave. Efforts were being made to secure the same agency staff where possible in order to maintain continuity of care and ensure that the staff members were familiar with the environment. However, this was not always possible and the use of agency staff often added to the pressure on the established staff as they had to spend time inducting, directing and supporting agency staff that had not worked on the ED and CDU before.

We were also told that the workforce, in general, across the ED and CDU was very inexperienced with junior staff expected to take on responsibilities normally allocated to more experienced staff members.

We were told that there had been changes in senior nurses' roles over the last few years which had been difficult for staff to adjust to.

We were told that staffing levels have been recently increased on the ED with the aim of having up to 13 trained nurses covering each shift supported by up to five HCAs. This was reflected in the staffing rotas provided. We were told that, within the CDU, there are normally five trained nurses on duty during the day, with four at night. There are usually four HCAs working on CDU and that this can go up to six depending on patient dependency levels and to meet the needs of any bariatric patients who may be accommodated.

The above issues were dealt with under HIW's immediate assurance process and are referred to Appendix B of this report.

The following is a summary of responses received through the online survey relating specifically to the provision of care:

- Only one third of staff who completed the online survey told us that they were able to meet all the conflicting demands on their time at work and that they have adequate materials, supplies and equipment to do their work with just over half of the respondents said there were never enough staff on duty.

- Only nine staff said they were able to make suggestions to improve the work of their team / department and that they were involved in deciding on changes introduced that affect their work area.

- Only half of the staff who completed the online survey said that patients' privacy and dignity is maintained, with less than half telling us that they were satisfied with the quality of care they give to patients.

- Only half of the staff who completed the online survey said that patients and/or their relatives are always or usually involved in decisions about their care, with just over a half saying that patient independence is always promoted.

- One third of respondents said the organisation encourages teamwork with less than a quarter saying that the organisation is supportive.

- Under a third of respondents said that front-line professionals, who deal directly with patients, are sufficiently empowered to speak up and take action if they identify issues in line with the requirements of their own professional conduct and competence.

- Only four out of 27 respondents said there is a culture of openness and learning within the organisation that supports staff to identify and solve problems, and that the organisation has the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings.

- Only four respondents said they were content with the efforts of their organisation to keep them and patients safe.

These are some of the comments that we received from staff through the online survey:

> *"We work short both days and nights. We have very few study days as there are not enough staff available to be released to go on courses. Over the years many staff have left due to managers bullying them. And recently one [grade] nurse was forced to retire as they were making her work days she was unable to work… We work most shifts covered by agency or nurses that just don't turn up. Everyone is applying for new jobs as there is no chance for progression as the [grade] nurses we used to have have not been replaced and the [grade] nurses that have left still have not been replaced. The shielding staff have been redeployed to green areas meaning again we have lost more staff but they still come out of our*

budget so we can't replace then. I'm scared every time I work and everyone feels the same"

"I would go somewhere else than go to Prince Charles Hospital we have no staff they have all left and haven't been replaced"

"Care of patients very difficult in current climate caring for patients in corridors and on back of ambulance difficult to maintain respect and dignity for patient. Stressful job made harder by management who have no experience in A&E so unable to identify issues and act upon them. Blame culture clearly evident within our dept with bullying and harassment ongoing, poor skill mix high turnover of staff"

"The demands of our department affect the quality of our care. As individuals, we strive always to deliver the best care. Working in such a busy department and getting pulled from pillar to post is definitely affecting the quality"

"I would not wish my relatives to stay at hospital at present due to the pandemic and winter pressures soon to come and also staff shortages and some agency nurses I feel are quite dangerous to work with"

We were told that a staff well-being service is available and relevant information is shared with staff by e-mail. Staff also told us that a staff Wellness room was available for break. However, this is no longer the case.

Staff Training

We were provided with staff training information and found that there was a huge variance in individual staff training completion rates from 7.7% to 92.3% of training topics completed. In general, training compliance was found to be low and we were told that this was due to the pandemic and staffing pressures. Staff confirmed that they find it difficult to complete on-line training due to the department being so busy.

Staff also told us that when training opportunities arise they are usually allocated on a first come first serve basis which means that some staff miss out.

We were told that a Practice Development Nurse (PDN) post was being advertised and that it was envisaged that the appointment of a PDN would greatly aid staff training and development.

We were told that new staff were required to undertake induction training. However, this training is not specific to the ED or CDU.

We were told that, up until last year, training and access to courses including Advanced Life Support (ALS), Paediatric Advanced Life Support (PALS) and Advanced Trauma Life Support (ATLS) had been good. However, due to the COVID-19 pandemic, access to training had been difficult. However, Intermediate Life Support (ILS) training had recently been provided.

The following is a summary of responses received through the online survey relating specifically to staff training:

- Only six staff said that their learning or development needs were identified, with 24 stating they were not. Just over a quarter of staff said that their manager supported them to undertake training or development.

- Approximately half of the respondents told us that training helped them to do their job more effectively, helped them stay up-to-date with professional requirements and helped them deliver a better patient experience.

- Approximately half of the respondents said that they had received training in Health and Safety, Fire Safety and Awareness, ALS, Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS), infection control, safeguarding, dementia/delirium and older persons care (privacy and dignity).

- Just over half of the respondents told us that they had received other training relating to specialist care.

- Staff told us that they would benefit from further training in subjects such as ILS, venepuncture, IV cannulation, manual handling, Datix, dementia, infection control, mental health, de-escalation, autism, fire safety, management of violence and aggression, male catheterisation, ECG analysis, critical care, swallowing assessments and plastering.

- Only six respondents told us that they had an annual review or appraisal within the last 12 months with 22 staff stating that they had not. Three said they have had clinical supervision in the last 12 months, and 27 said they have not.

- Half of the staff said that they received an appropriate mentorship / preceptorship on commencement of their role, adding that it was not for a long enough period of time.

Improvement needed

The health board must:

- Ensure that staff have access to training opportunities, and designated time to undertake training, in order to develop their knowledge and competency base. This training should cover service specific as well as mandatory subjects.

- Reflect on the less favourable staff responses to some of the questions in the HIW online 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 summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No concerns identified on this inspection were able to be resolved on the day.			

Appendix B – Immediate improvement plan

Hospital: Prince Charles Hospital

Ward/department: Emergency Department and Clinical Decisions Unit

Date of inspection: 13, 14 and 15 September 2021

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
HIW requires details of how the health board will assess and address all risks to health and safety within the ED and CDU.	**Standard 2.1** Managing Risk and Promoting Health and Safety **Standard 2.2** Preventing Pressure and Tissue Damage	This section sets out the way in which we will provide assurance against all the actions we have completed and will continue to progress as a result of the HIW Review and other improvement actions. The detail actions are included in subsequent sections Following on from a number of quality related concerns, a structured PCH improvement programme was launched in July 2021. An initial plan has been		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Standard 2.3 Falls prevention	developed **(Appendix 8)**. Progress is monitored through an executive sponsored Programme Board **(Appendix 6, 7)** and upward reporting through the UHB Governance Structure. A PID has been produced as the basis of the improvement programme of work **(Appendix 9).** In early September 2021, this programme had completed the initial diagnostic of ED quality performance against RCEM standards which identified findings consistent with the HIW review. An improvement director has already been appointed to support delivery the plan (which will now also incorporate the actions being carried forwards from this review) The risk register has been reviewing to align with the risk identified through the improvement	**Merthyr Cynon Head of Quality & Safety**	**30/10/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		programme, with a robust training and awareness strategy in place to ensure the team proactively manage the risks in line with UHB guidance. The PCH acute teams have a scheduled risk awareness session with the Assistant Director of Governance and ILG Head of Quality thus further strengthening the quality governance requirements. Monthly scrutiny panels are in place to review all Falls **(Appendix 58)** and Pressure Damage in line with the All Wales pathway. Whilst reviewing these cases consideration is always given to the potential delays and time spent within the ED on admission to hospital. Further training has been provided by the tissue viability nurse (TVN) across the UHB. These actions are monitored within the ILG Quality and	**Head of Nursing**	**Ongoing monitoring through ILG Assurance meetings and QSE governance structure**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Safety meeting structure **(Appendix 59).** The RCEM standards are directed at improving patient experience. An audit was completed by the Corporate Team to assess compliance in September 2021. Against the 34 Fundamental Standards, Compliance was 50%. Against 16 Development Standards, Compliance was 42%. Full report and recommendations are noted in **Appendix 10.** These findings are in the process of being converted into a detailed action plan which will now be combined with the findings of the HIW review	**Head of Nursing**	**Ongoing monitoring, reassessment February 2022**
HIW requires details of how the health board will ensure that infection prevention and control and	**Standard 2.1** Managing	specific findings outlined in Evidence Section A:		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
decontamination policies and procedures are adhered to within the ED and CDU.	Risk and Promoting Health and Safety **Standard 2.4** Infection prevention and Control (IPC) and Decontamination	• All staff have been briefed through a range of leadership and team briefs that have also been cascaded through the ED and CDU safety huddles. The monitoring of H&S issues related to IPC is described in the IPC section below **(Appendix 28)** • With the cessation of the use of the majors corridor for patient care, there is appropriate safe distance available to allow for donning and doffing of PPE. • A donning and doffing champion/ monitor will be identified, and further training will be provided to the entire team. Assurance to be gained from daily IPC Audits • HoN has communicated with staff with regards to roles and	**ILG Nurse Director and Chief Operating Officer** **Chief Operating Officer** **Head of Nursing** **Head of Nursing**	**Multiple events since 17.9.21 and ongoing** **17/09/21** **30/09/21** **Immediate Completed 16/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		responsibilities in line with the Cleanliness Standards Procedure, team leaders have been identified for the areas to ensure standards are maintained daily **(Appendix 3).** Plan is in place to highlight the responsibilities of the multi-disciplinary team within the ED to maintain high standards. • Adherence to the appropriate PPE guidance has been re-enforced to the clinical teams via several ways; Social Media Email Daily Safety Huddle Staff engagement meetings **(Appendix 33, 34, 35, 36)** The daily morning Nurse in charge review and afternoon senior leadership walk around	**Head of Nursing**	**Commenced on 16/09/21** **In progress**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		also re-enforce the requirement for the appropriate standards of PPE, actively encouraging the team to challenge others should standards not adhere to guidance. • Implementation of appropriate signage and posters to ensure staff and visitors are aware of PPE requirements within the department. The team have commissioned a company to install signage throughout the department and hospital site • A symptom checker has been placed 24/7 at the main entrance to the department to assess likely covid status of patients and segregate suspected or confirmed patients into an alternative waiting room	**Estates Manager** **Head of Nursing**	**08/10/21** **Completed 17/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• The symptom checker monitors the social distancing and PPE adherence for patients within the waiting room area to mitigate the risks as much as is possible • Immediate changes were made to the operational policy within ED that has allowed the majors corridor to no longer care for patients (Appendix 43). There are a specific set of actions being progressed to revise the overall segregation of pathways in conjunction with PHW. Immediate make safes relating to the waiting room and separation of staff have been completed. The more detailed work relating to remodelling the ED is underway in conjunction with IPC and PHW and is described below on page 27.	**ED Lead Nurse** **Chief Operating Officer** **Acute Site General Manager in conjunction with IPC lead nurse**	**Commenced 17.09.21 and Ongoing** **Completed 17/09/21. Risk assessed daily** **17/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		IPC Annual audit was completed in April with compliance of 61% - Immediate actions taken and completed **(Appendix 15)**. A further full audit was completed by the IPC team of the Emergency Department on the 16th September and several actions were identified and compliance was noted to be 53% **(Appendix 1)** immediate measures taken to resolve the concerns **(Appendix 4)**. Ongoing monitoring of the areas continues daily with report submission between 7-9am **(Appendix 16)** by the nurse in charge with a report submission to HoN, Executive Nurse Director & ILG Nurse Director. Senior Leadership walk around of the department each afternoon to review the department acuity, IPC	**Corporate IPC Lead – Deputy Execute Nurse Director** **Head of Nursing & ILG Nurse Director**	**Ongoing monitoring through daily spot check supported by IPC** **Commenced 20/09/21 ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		concerns and meet with staff and ensure strong leadership visibility. **(Appendix 2).** Actions required and taken from the daily monitoring have been captured in **Appendix 42.** Review has been carried out of the Cleaning audit over past 12months with average outcome of 89% **(Appendix 5).** Housekeeping support has been increased to 24/7 commenced 20/09/21 with daily review of standards by the Facilities manager. HoN has communicated with staff with regards to roles and responsibilities in line with the Cleanliness Standards Procedure, team leaders have been identified for the areas to ensure standards are maintained daily **(Appendix 3).** Plan is in place to highlight the	**Head of Nursing** **Facilities manager** **Head of Nursing**	**Commenced 20/09/21** **17/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		responsibilities of the multi-disciplinary team within the ED to maintain high standards.		
HIW requires details of how the health board will ensure that the ED is staffed to a safe level and mitigations are in place to mitigate the risks associated with the area's layout.	**Standard 2.1** Managing Risk and Promoting Health and Safety	Due to the footprint of ED it has been recognised within the improvement plan(June '21) that the medical staffing requirements by night are increased by one middle grade with the recognised benefits; Improved flow, Support for junior staff, Improved safety, Improved patient experience, Improved referral times due to middle grade to middle grade discussion, Improved 4 hour performance Reduce ambulance handover delays **(Appendix 11)**	**Chief Operating Officer**	**Completed June '21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Nursing funded establishment is 10 RN & 4 HCSW; this is currently being reviewed in line with the footprint of the department and the suggested changes to the department template, a staffing paper is in draft currently. Due to these challenges the staffing levels have been agreed over establishment to 13RN and 5 HCSW 24/7, this is inclusive of ensuring that the resus area has 2 Band 6 nurses present each shift- this was not previously a requirement **(Appendix 26)**. Within the review of the staffing establishment there has been consideration to the skill mix required within the staffing portfolio to support the services provided within ED. A training needs analysis	**ILG Director, ILG Director of Operations, ILG Nurse Director** **Head of Nursing**	**Completed November 2020** **Training plan is in place and monitored on a monthly basis**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		has been completed to ensure all staff within the nursing establishment from Band 2-7 have the skills and training opportunities required to fulfil their role **(Appendix 13, 14)** Staffing levels are monitored within a daily staffing proforma report which is shared with HoN, ILG Nurse Director and Executive Nurse Director, when staffing levels are not filled through bank or agency approval is sought for the use of Thornbury **(Appendix 12)**. Lead Nurse for unscheduled care has been meeting monthly with the Senior Nurse for ED to monitor the governance and management requirements of the role, PDR, Sickness and vacancy rates form part of this meeting which informs escalation of concerns to the HoN	**ILG Nurse Director** **Head of Nursing**	**Ongoing** **Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		(Appendix 18, 24). These meetings will now occur weekly. Review of incidents, concerns, complaints and patient experience feedback will provide triangulation of the effectiveness of the actions.	**ILG Head of Quality & Safety**	**ILG Quality & Safety Data review meetings take place every week**
HIW requires details of how the health board will ensure that there are measures in place to ensure patients accommodated in the waiting room are observed and monitored to ensure their safety.	**Standard 2.1** Managing Risk and Promoting Health and Safety **Standard 2.2** Preventing Pressure and Tissue Damage	Implementation of an RN 'symptom checker' role at the main door of the department to ensure that patients are directed to the correct area dependent on their presenting condition. The presence of this RN will always ensure oversight of the waiting area. Security officer is also present at the door to provide additional reassurance and support **(Appendix 41)**. Patients currently within the Covid waiting area that is not within line of sight of the RN have a 30minute rounding process in place to review	**Head of Nursing** **Head of Nursing**	**Commenced 16/09/21** **Ongoing** **Implemented 23/09/21 with ongoing monitoring**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		the patients **(Appendix 44).** The use of a call bell is being considered by the team. A pathway has been implemented to ensure all patients that have been triaged are prioritised and monitored in line with the Manchester Triage guidance **(Appendix 27).** An affray alarm has been installed behind the reception desk of the waiting room. This will allow rapid response in the event of a deteriorating patient being identified in the waiting room between 30 min rounds An emergency nurse call bell is being installed behind the reception desk, which can be pulled to alert the medical/nursing team in the department of a medical emergency. Whilst this is being	**Lead Nurse for Unscheduled Care** **Estates Manager** **Estates Manager**	**Completed 22/09/21** **08/10/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		installed the team will be able to utilise the affray alarm in its place. This will be superceded once the minor works to remodel walls within the waiting area have been completed As part of the ED pathway changes, additional capacity is being provided for minors which will improve waiting times within ED and reduce the number of patients waiting – aiding the reduction of risk in the waiting room	**Chief Operating Officer**	**31.10.21**
HIW requires details of how the health board will ensure that there are measures in place to prevent unauthorised access to all areas of the department not designed for public access and that measures are in place to protect staff and patients.	**Standard 2.1** Managing Risk and Promoting Health and Safety	Doors between areas of the department have had break glass door release covers fitted. Magnetic security contacts have also been installed to ensure that the door system will lock and cannot be overridden. This will be monitored by the Nurse in Charge of	**Facilities Manager**	**Completed**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		the Paediatric and Minor injuries areas, whilst also re-affirming that the area is not to be used as a thoroughfare. The implementation of the Symptom Checker and security on the main door also ensures that the department cannot be used as a thoroughfare as they direct staff/visitors to the main entrance of the hospital to access other areas of the hospital. Additional signage to support the locking of doors is in production	**Head of Nursing** **Facilities Manager**	**Completed 17/09/21** **14.10.21**
HIW requires details of how the health board will review the current layout of the ED to ensure adequate segregation and that non-COVID patients, members of the public, and staff are	**Standard 2.1** Managing Risk and Promoting	In conjunction with colleagues from PHW, Improvement Cymru and CTM IPC, clinical and operational colleagues, a draft revised pathway has been developed (See Appendix	**Acute Site General Manager in conjunction**	**29/10/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
not put at risk by coming into contact with COVID positive patients. HIW requires details of how the health board will review the current arrangements and reflect National guidelines, when re-designing services to meet the differing care needs of COVID positive and non-COVID patients.	Health and Safety **Standard 2.4** Infection prevention and Control (IPC) and Decontamination	28, 29). This pathway will address the issues raised within the visit relating to the overall separation of patient pathways, the use of waiting room areas, the use of the GP assessment space and unauthorised access to clinical areas Two outstanding issues require resolution: • Consistency of the current pathway with anticipated changes in the national IPC guidance (currently out to consultation) • Operational protocols for changes in the Paediatric Pathway to support the overall revised pathway proposal	**with IPC Lead Nurse**	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The pathway of care for paediatric patients is currently being reviewed to ensure the safe movement of children within the department. Due to the absence of clear data with regards to the time delays in patients being transferred to the ward the team have implemented an escalation process following 60minutes of a decision to admit in order to inform the pathway decision making process. If patients are delayed >60minutes the team are required to complete a datix incident to ensure each case is reviewed in a timely manner to ascertain the reasons for the delay This pathway is further supported by the changes resulting in the cessation of the use of the majors corridor for caring for patients	**Acute Site General Manager/ Head of Nursing/ Lead Clinicians**	**Ongoing in line with PHW** **08/10/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Patients being cared for within the cubicles when admitted to ED will mitigate some of the risk within the management of C19 patients. The role of the symptom checker will specifically focus on ensuring that Covid positive patients are managed through a different access point into the department. This is continually monitored throughout the day within the bed meetings and departmental huddles with escalation to the Senior Manager on call as required. We have reviewed the issue of AGPs in resus and the use of majors corridor for red pathway patients. We have no evidence via our datix system that this has happened and reviewed the situation with the team who concur.	**Lead Nurse Unscheduled Care**	**Continuous monitoring**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		We have however reconfirmed the existing pathway for the management of AGP pathways (using ward 3) and the role of CDU cubicles for red pathway patients. The ED clinical lead will continue to monitor this issue OCT structure is place within the HB to support the management of Covid19 within the hospital sites **(Appendix 30, 31, 32).** In order to complete this work, the following steps are required in conjunction with PHW and other stakeholders/ partners: • Completion of the full Quality Impact Assessment • Resolution of the paediatric pathway issues • GP pathway patients to follow the overall pathway or find an alternative location		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• Some estate minor works to be completed • Finalise MDT staffing model to ensure zoning		
HIW requires details of how the health board will ensure that staff adhere to National guidelines in respect of hand hygiene and the use of Personal Protective Equipment (PPE).	**Standard 2.4** Infection prevention and Control (IPC) and Decontamination	Hand hygiene audits were completed monthly by the IPC team which will now be completed weekly, the required ED based weekly audits have not been completed robustly. Leads have now been identified and training will be delivered to ensure completion and compliance on a weekly basis, this will be monitored by the IPC team. The Senior Nurse, IPC and Housekeeping team have reviewed the department to ensure that hand sanitiser is available throughout the department, areas identified for additional sanitising dispensers have been installed with the	**Head of Nursing supported by Senior Nurse for IPC** **Lead Nurse Unscheduled Care**	**Ongoing monitoring** **Completed 22/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		appropriate dispensers. These will be monitored by the housekeeping team and within the daily Nurse in Charge audit framework **(Appendix 16)** Adherence to the appropriate PPE guidance has been re-enforced to the clinical teams via several ways; Social Media Email Daily Safety Huddle Staff engagement meetings **(Appendix 33, 34, 35, 36)** The daily morning Nurse in charge review and afternoon senior leadership walk around also re-enforce the requirement for the appropriate standards of PPE, actively encouraging the team to challenge others should standards not adhere to guidance.	**Head of Nursing, Acute Services** **General Manager, PCH** **Medical Lead**	**Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Implementation of appropriate signage and posters to ensure staff and visitors are aware of PPE requirements within the department. The team have commissioned a company to install signage throughout the department and hospital site.	**Acute Services General Manager**	**08/09/21**
HIW requires details of how the health board will ensure that essential equipment required to assess and monitor patients, such a blood sugar monitoring, is made available in COVID 19 waiting area.	**Standard 2.1** Managing Risk and Promoting Health and Safety **Standard 4.1** Dignified care	All equipment required for the Covid 19 triage room has been reviewed (16/09/21) and labelled ensuring the equipment is not taken from the area, this will be monitored daily by the nurse in charge.	**Head of Nursing**	**Completed 17/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
HIW requires details of how the health board will ensure that appropriate access to toilets will be provided for patients using the department.	**Standard 2.4** Infection prevention and Control (IPC) and Decontamination **Standard 4.1** Dignified care	The current template due to the partition within the waiting area has removed the availability of an additional 2 toilets for the minors waiting area. Whilst work is ongoing with the support of PHW regarding the appropriate flow of patients in line with Covid19 requirements, the area continues to have 1 toilet available. The HB recognises that the current configuration in relation to toileting facilities is not suitable to meet the needs of a busy department. The completion of the pathway work will be the route to resolving this and the date for the implementation of the minor works will be confirmed once the pathway has been agreed To ensure the toilet is clean and checked regularly the domestic	**Acute Site General Manager**	**Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		team are now present in the department 24/7 and will provide hourly oversight of the toilet and waiting room area to ensure standards of cleanliness are maintained. This is a significant increase in cleaning resources	**Facilities manager**	**Implemented 20/09/21 with ongoing monitoring**
HIW requires details of how the health board will ensure that patients' privacy and dignity is maintained at all times whilst in the ED.	**Standard 4.1** Dignified care **Standard 3.1** Safe and Clinically Effective Care **Standard 5.1** Timely Access	Privacy and dignity within the department is paramount and this was recognised during the site visit. Several changes have been made to further enhance this including: • The cessation of the use of the majors corridor • Changes within the ambulatory majors area to ensure there are four additional appropriate clinical areas, appropriate comfortable seating, screens between patients along with individual equipment for each	**Head of Nursing**	**Completed 23/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		patient area. This work was completed on 23.09.21. This ensures that patients that are 'Fit to Sit' are cared for in an appropriate environment with nursing oversight. The care of these patients will be have oversight of the Nurse in Charge and discussed at the team huddles throughout the shift. • Patients are cared for in private cubicles within the department which does afford privacy and dignity. In order to ensure the department can support immediate release of an Ambulance or transfer/admission of a sick patient to the department Cubicle 7 has been ring fenced to meet this requirement **(Appendix 45)**.		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• The comfort of patients in the department is supported by British Red Cross. We provide hot drinks and food under the supervision of the Nurse in charge to support patients who are receiving active treatment in the department During periods of escalation, additional site situational risk assessment meetings take place. These focus on patient safety concerns, bed waits and ED capacity/ risk Patients that remain on an Ambulance following arrival to the hospital if there is no capacity within the department continue to be cared for by the Ambulance crew until they can be admitted in line with the SOP **(Appendix 39)**.		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
HIW requires details of how the health board will improve the flow of patients through the ED and CDU to reduce waiting times and ensure that patients receive timely and appropriate care.	**Standard 4.1** Dignified care **Standard 3.1** Safe and Clinically Effective Care **Standard 5.1** Timely Access	In line with the ED Improvement plan there is a proposal to address Flow and Safety Improvement challenges in Prince Charles Hospital, Merthyr Tydfil. Improvement Cymru and M&C locality staff will be working together sharing operational experience, expertise and experience from elsewhere to review current arrangements and design improvements. This programme has come about following a request from the CTM Executive Team. The learning from this program of work will inform other improvements related to flow on other acute sites within the CTM UHB area. This work is supported by Improvement Cymru. **(Appendix 38).** Bed meetings are in place 3 times per day with the sit rep shared with	**Chief Operating Officer, Medical Director and Exec Dir of Nursing in partnership with Improvement Cymru** **Head of Patient Flow**	**Ongoing** **Completed and Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		the Senior Leadership team and executives, these are monitored UHB wide along with the other acute sites within CTM to ensure escalation of acuity **(Appendix 60).** The HB requires multiple layers of data to provide greater insight on the day to day operations of ED, to enable it to track, trend, predict high impact workflow and understand performance. The development of an ED dashboard that captures these factors will assist in the transformation of quality care provision. A pathway of care to appropriately manage and support women experiencing early pregnancy loss is in draft (**Appendix 54**) with anticipated implementation by the 30/09/21. This pathway will ensure that women are treated in a private	**ILG Director of Operations in partnership with Clinical Audit and Quality Informatics** **Head of Nursing in partnership with the WC&F CSG team**	**26/11/21** **30/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		and dignified cubicle on the surgical ward by staff with experience in caring for women experiencing a miscarriage. The management of expected surgical patients has been reviewed and a draft pathway of care is currently in the consultation phase. This will ensure the timely flow of patients out of the ED department **(Appendix 55)**.	**Acute Site General Manager**	**08/10/21**
HIW requires details of how the health board will ensure that all patients are monitored at the required frequency set out in local and national policies and guidelines.	**Standard 4.1** Dignified care **Standard 3.1** Safe and Clinically Effective Care	A pathway has been implemented to ensure all patients that have been triaged are prioritised and monitored in line with the Manchester Triage guidance **(Appendix 27).** This will be monitored within the daily huddle and delays in care incident reported within the datix system. Patients currently within the Covid waiting area that is not within line of	**Lead Nurse for Unscheduled Care**	**Commenced 22/09/21**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Standard 5.1 Timely Access	sight of the RN have a 30minute rounding process in place to review the patients **(Appendix 44).** The team are currently scoping the possibility of installing a call bell for patients to use should they need to call a nurse outside of the 30minute rounding. A recent NEWS audit has identified that the completion of NEWS charts is of a high standard with continuing improvement noted. **(Appendix 20 & 21)**		
HIW requires details of how the health board will ensure that all patients presenting with signs of sepsis are screened appropriately and treated in a timely way.	**Standard 4.1** Dignified care **Standard 3.1** Safe and Clinically	Compliance with the Sepsis 6 bundle is monitored monthly with a target of 85% compliance, current mean compliance since March '21 is 73% **(Appendix 40).** Bespoke training for the MDT is scheduled to take place on the following dates;	**Lead Nurse for Unscheduled Care**	**Ongoing monitoring through Audit and incident management/investigation**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Effective Care **Standard 5.1** Timely Access	28th September 2021 6th October 2021 13th October 2021 Compliance with the Sepsis 6 pathway is also monitored through the management of clinical incidents and investigations.		
HIW requires details of how the health board will ensure that all staff are aware of their duty to maintain accurate, up-to-date, complete and contemporaneous records at all times.	**Standard 3.5** Record Keeping	A review of the ED documentation was completed in July 2020 with the support of the QI team and the quantity of documentation was rationalised to reduce duplication. A baseline audit was completed of the Patient safety checklist in June '21 prior to commencing the test of change in line with QI methodology **(Appendix 17)**. Progress of the programme of improvement with regards to documentation continues to be supported by the QI team with a progress update included within **Appendix 19**.	**Head of Nursing and Clinical Service Director for emergency medicine**	**Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The recent introduction of the updated NEWS chart has been supported and monitored by the team with compliance noted in ED within the top 3 of the PCH site **(Appendix 20, 21 & 22).** Performance and compliance is monitored on a monthly basis and findings shared with the ED team. Documentation standards are monitored within several areas through the governance process, within incident review, RCA's, Scrutiny panel and concerns management. Learning and findings are shared with the clinical and managerial team through several forums but not exclusive to; Team leader meetings Safety Huddles Weekly CSG governance meetings Newsletter	**Head of Nursing and Clinical Service Director for emergency medicine** **Head of Nursing, Acute Services General Manager, PCH Medical Lead**	**Performance and compliance is monitored on a monthly basis** **Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Falls and PD Scrutiny panels Departmental meetings RCA/Incident investigation training Ward Improvement plans Action Plan Listening & Learning forum **(Appendix 23, 24, 25)** A learning framework is being developed for the organisation to identify all sources of learning and to develop robust systems for dissemination and sharing of learning to improve quality and safety of services, in addition to innovation and improvement . Medical staff annual documentation has recently been completed with positive findings noted in **Appendix 37.**		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of how it will ensure that there are robust and appropriate leadership arrangements in place with robust and effective governance processes and measures.	**Governance and Leadership**	The HB has an organisational quality governance and patient safety framework which sets out its position in respect of overarching governance arrangements. 1. Local arrangements within ILG's and its services provide assurance through: CSG meeting structure **(Appendix 51)** 2. HoN governance structure **(Appendix 46, 47, 48, 49)** 3. ILG structure **(Appendix 50)** 4. Exec support regarding improvement work 5. Escalation of concerns Policy 6. Staff feedback within the engagement plan Previous external reviews within the UHB have identified concerns in relation to leadership and culture as a cross organisational concern and have therefore developed a leadership strategy via its workforce and OD colleagues. Alongside, there	**Exec Dir of Nursing**	**Ongoing monitoring in line with UHB governance process**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		is a significant emphasis on well-being of colleagues and availability of internal and external support. The specific requirements for leadership development and support have been clarified within the Improvement Plan. We will work with the teams to be clearer about the roles and responsibilities of individuals within the team and how the broader organisational structure supports the department in caring for patients. This will include the use of existing engagement sessions and communication channels		
HIW requires assurance from the health board that our findings are not indicative of a systemic failure to provide safe, effective and dignified care across all services.	**Governance and Leadership**	At a Health Board level, there is an organisational Quality Governance and Patient Safety Framework which is committed to the delivery of safe and effective care, demonstrating how the HB receives line of sight awareness of its services. Improvements to performance indicators, quality metrics and ILG reporting to Q&SC committee has	**Executive Director of Nursing**	**Ongoing with monthly Executive monitoring**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		enabled greater clarity and oversight of service delivery and patient experience. This is evidenced through its reports through to Board. Concerns in relation to PCH ED had been escalated prior to the HIW review and an action plan agreed with executive monitoring of progress Following the HIW Visit, this has been enhanced with the sharing of the PCH findings across the Health Board as a trigger for greater degrees of scrutiny into our services within the existing framework We have commenced a review of the existing governance framework from service delivery through to Board and expect the conclusion of that work to be presented in November		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The ILG recognises the existing challenges and has deployed an Improvement Programme to focus on ED, Theatres and Wards and will be used as an operating model for future improvements The Improvement plan was initiated for ED and Theatres in June 2021 **(Appendix 8, 52)**. Progress was monitored a weekly basis but has now progressed to a monthly meeting between the ILG Directors and Executive team **(Appendix 6,7, 53)** and upward reporting through the UHB Governance Structure. This will now revert to weekly A PID has been produced to further support this work **(Appendix 9).** Further assurance was sought of the wards within PCH and an		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		assurance framework was put in place to review all ward areas with very positive outcomes identified **(Appendix 53).**		
The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients on both the ED and CDU.	**Standard 7.1** Workforce	Due to the footprint of ED it has been recognised within the improvement plan(June '21) that the medical staffing requirements by night are increased by one middle grade with the recognised benefits; Improved flow, Support for junior staff, Improved safety, Improved patient experience, Improved referral times due to middle grade to middle grade discussion, Improved 4 hour performance Reduce ambulance handover delays **(Appendix 11)**	**ILG Director, ILG Director of Operations, ILG Nurse Director**	**Completed**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Nursing funded establishment is 10 RN & 4 HCSW; this is currently being reviewed in line with the footprint of the department and the suggested changes to the department template, a staffing paper is in draft currently. Due to these challenges the staffing levels have been agreed over establishment to 13RN and 5 HCSW 24/7, this is inclusive of ensuring that the resus area has 2 Band 6 nurses present each shift- this was not previously a requirement **(Appendix 26)**. Within the review of the staffing establishment there has been consideration to the skill mix required within the staffing portfolio to support the services provided within ED. A training needs analysis has been completed to ensure all	**ILG Director, ILG Director of Operations, ILG Nurse Director** **Head of Nursing**	**Completed November 2020** **Completed July 2020**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		staff within the nursing establishment from Band 2-7 have the skills and training opportunities required to fulfil their role **(Appendix 13, 14)** Staffing levels are monitored within a daily staffing proforma report which is shared with HoN, ILG Nurse Director and Executive Nurse Director, when staffing levels are not filled through bank or agency approval is sought for the use of Thornbury **(Appendix 12)**. Lead Nurse for unscheduled care meets monthly with the Senior Nurse for ED to monitor the governance and management requirements of the role, PDR, Sickness and vacancy rates form part of this meeting which informs escalation of concerns to the HoN **(Appendix 18, 24)**.	**ILG Nurse Director** **Head of Nursing**	**Ongoing** **Ongoing**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		An integrated dashboard to be developed in the medium term to provide greater agility of response and analysis of high impact workflow.	**Lead Nurse for Unscheduled Care, Clinical Service Director for Emergency Medcine in partnership**	**February 2022**
The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.	**Standard 7.1** Workforce	As identified earlier, there has been significant investment in providing staff with opportunities to support their well-being. This is signposted to staff via several methods within the HB including; Social media Sharepoint CTM Webpages Staff Engagement Forums Leadership Forum CEO Blog	**Chief Operating Officer, Medical Director, Exec Dir of Nursing**	**Ongoing staff support is required**

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		A learning event for EDCDU colleagues has taken place with further engagement planned to discuss the HIW findings openly and without apportioning any blame; to encourage involvement reflection and exchange of ideas on improvement and change. Provision of direct 'open access' support to affected colleagues. Significant emphasis has been placed on face to face listening and engagement sessions with the team immediately following the visit to ensure that the teams have an opportunity to share and express views. The leadership team at all levels have significantly enhanced visible leadership presence through walk-		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		arounds and modelling the values and behaviours of the Health Board		

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): Gareth Robinson

Job role: Chief Operating Officer

Date: 24th September 2021

Appendix C – Improvement plan

Hospital: Prince Charles Hospital

Ward/department: Emergency Department and Clinical Decisions Unit

Date of inspection: 13, 14 and 15 September 2021

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the i-pad provided for patients' use is working and that patients are able to make use of it to maintain contact with their relatives and friends.	3.2 Communicating effectively	Two I-pads have been provided, one for CDU patient use and one for ED. These have been reviewed by the IT department to ensure they're configured appropriately. The I-Pads have been logged onto and checked for adequate internet reception whist in the areas of required usage and both in working order. The dedicated IT staff contact has been communicated to the teams should they experience any future problems. The I-pads are held on stands to support ease of use for patients and minimise risk	ED Deputy Clinical Service Group Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		in line with Infection, Prevention and Control. Communication plan is in development which will incorporate the strategy to ensure patients are fully aware that the I-pads are available for use to maintain lines of communication with family/ friends.		
Delivery of safe and effective care				
The health board must review the proposed triage room layout to ensure that it is fit for purpose, accessible to people with poor mobility and that it does not cv compromise staff safety.	2.1 Managing risk and promoting health and safety	The proposed new ED layout will incorporate two triage rooms in reception for both respiratory pathways will meet RCEM standards. Future phasing options for full ED design are being reviewed with architects and funding discussed with Welsh Government. We have building works planned for the interim triage arrangements for the 11th and 12th December.	Locality Director of Nursing	11/12 December interim building works.
The health board must review the medication management policy.	2.6 Medicines Management	The current Policy was updated last year with addendums for Covid. The Draft for	Clinical Director and Head of	01/03/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the new Policy is currently out for consultation.	Medicines Management.	
The health board must ensure that there is a system in place to keep all policies in date		The Health Board approved a revised Policy for the Development, Review and Approval of Organisational Wide Policies in January 2021, which outlines the process for the development, consultation, approval, dissemination and review of key organisational documents such as policies, strategies, procedures, guidelines and protocols. The Health Board's SharePoint page acts as the library for these written control documents indicating the review period. There is further work required to further improve the system to monitor and support more timely reviews by document authors and this is built into the work programme of the Corporate Governance Team, however this programme of work has been adversely impacted by COVID and on-going capacity issues. A risk assessment has been undertaken to consider the impact	Assistant Director of Governance & Risk	31 May 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		of not progressing at the pace the Health Board would have liked. The pace of the work has also been compounded by the Health Boards response to the Covid-19 pandemic as functional leads/authors have not had the time and/or capacity to undertake timely reviews and updates to their written control documents during this time. As an interim measure the Health Board will ask leads to undertake an assessment to ensure written control documents are extant and extend a review period to allow for a more robust review to be undertaken using a risk stratification approach. The Policy for the "Development, Review and Approval of Organisation wide Policies" and the Risk Assessment Tool for Policies are attached at **appendices 1 and 2.**		
The health board should consider providing lockable cabinets or lockers within the ED for patients to store their medication.		Based on Medicine management advice lockable cabinets will be procured for each of the cubicles and will be installed as soon as the delivery has been received.	ED Deputy Clinical Service Group Manager	Ordered 19/11/2021 and installation will be based

Improvement needed	Standard	Service action	Responsible officer	Timescale
				on delivery date
The health board must review the intentional rounding arrangements to ensure that the care needs of patients who have been assessed as requiring one to one care, support and supervision are fully met at all times.	3.1 Safe and Clinically Effective care	The ED Patient Safety checklist is now implemented into majors. The arrangements for completion of the ED Patient Safety Checklist, which forms part of the process, has been reviewed by Clinical Audit and resulted in the following actions in order to improve compliance rates: i. 500 full colour versions of the checklist have been printed for staff and a weekly plan is in place to ensure ongoing supply. ii. Clinical audit team has provided training for band 7 staff in how to complete the audit. The compliance will be reported to the monthly PCH Improvement Programme Board.	Head of Nursing	Review completed and implementation underway. On-going monitoring through the improvement programme. Update on compliance o be provided at next update point Dec 2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The nurse in charge handover document has been created and implemented to ensure that specific patient safety needs are highlighted at the start of each shift and staff are aware of the overall safety and patients in the department. A new team handover process has been introduced.		
Quality of management and leadership				
The health board must ensure that staff have access to training opportunities, and designated time to undertake training, in order to develop their knowledge and competency base. This training should cover service specific as well as mandatory subjects.	7.1 Workforce	A training needs analysis for staff has been completed including mapping against ESR mandatory training. A number of training opportunities are being progressed for staff including in-house and external training courses There is an increase in the compliance of mandatory training for example Children's safeguarding 71.7%, Dementia 93.44% and Adult level 2 Safeguarding 75.44% up from 46.6%. During Summer 2021 HEIW undertook an inspection visit. Most of the actions	Lead Nurse for ED and Clinical Director for ED	Delivery underway. Monthly monitoring of statutory and mandatory training via PCH improvement programme. Further update will be provided, with

Improvement needed	Standard	Service action	Responsible officer	Timescale
		have been completed and weekly training sessions are on-going. A job description has been created for a Senior Nurse for Professional Practice with an aim to appoint early in the new year. As well as these training opportunities Merthyr and Cynon ILG is working collaboratively with Improvement Cymru in relation to supporting flow a coaching approach is being provided with the aim of embedding improvement skills within the workforce. An example of such development opportunities includes working with Toyota. Details attached at **appendix 3**.		evidence, of improvement. Target date for appointment of senior nurse for professional practice is 14 January 2021
The health board must reflect on the less favourable staff responses to some of the questions in the HIW online questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.		A number of changes have been made directly affecting the leadership approach within the department. These include a new clinical lead for ED (appointed a matter of days before the HIW visit) and new nurse leadership at site and ILG level. This has given the leadership team	Locality Director of Operations	New appointments made Bespoke Leadership Programme in place and

Improvement needed	Standard	Service action	Responsible officer	Timescale
		an opportunity to reset the working relationships with all staff groups. This will take time for staff to have confidence in the authenticity of the changes, but based on the increased staff engagement, time spent by the leadership teams with colleagues both in and away from the department, example behaviour and specific engagement and communications approach, we are confident that staff will rapidly note improved management and leadership Investment of a full Time WOD Lead and a Comms Lead have been made to support the PCH Improvement Programme to focus on cultural and leadership improvements. The Leadership Programme has been developed and is currently being rolled out across the management of ED and PCH more widely. A route map and high level plan have been developed. Attached at **appendix 4.**		plans ongoing to 2023

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The Communications Lead has been engaging with staff within the ED department to inform the Comms Plan. Whilst the Communication Plan evolves immediate actions such as a staff newsletter has commenced drawing from the staff feedback. In addition to this Outlook Cards have been designed to gain an understanding of how staff are feeling and measure against well-being. These have been completed and are ready to roll out.		

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): Catherine Roberts

Job role: Locality Director of Operations

Date: 19/11/2021