Hospital Inspection (Unannounced)

The Grange Hospital, Aneurin Bevan University Health Board, Emergency Department and Surgical Assessment Unit

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department (ED) and Surgical Assessment Unit at The Grange University Hospital (the hospital) within Aneurin Bevan University Health Board on the 1 – 3 November 2021. The following areas were visited during this inspection:

- Outside the Emergency Department including the Ambulance Bay
- Waiting Room
- Triage
- Majors
- Resuscitation (Resus)
- Rapid Assessment Unit (RAU)
- Children's Emergency Assessment Unit (CEAU) and Short Stay Unit (SSU)
- Paediatrics Emergency
- Covid Corridor
- Surgical Assessment Unit (SAU).

We did not inspect the areas known as the:

- Medical Assessment Unit (MAU)
- Covid Ward A1.

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

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we 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. This was despite all the efforts of staff who were working hard under pressure from the number of patients presenting at the ED.

There were a number of issues identified where the health board needs to address issues to improve patient experience and to ensure dignified and timely care. This includes work required to the physical environment of the waiting room to ensure that it is fit for purpose.

Until the flow of patients into and through the ED can be improved, the health board may find it difficult to address a number of our concerns.

We observed all staff striving to deliver good quality, safe and effective care to patients, within very busy units. However, the comments of staff in the staff survey show that they could not always deliver the care they wanted to.

This is what we found the service did well:

- Patients, including those on ambulances were provided with food and drinks during their time at the unit
- The permanent internal bilingual signage that showed where the patient was on their journey through the unit was very good
- Paediatric patients were seen in a timely manner
- There were aspects of medicines management which were noted as positive
- There were designated specialist treatment rooms
- Patients thought the ED was clean and COVID-19 compliant
- Patients were triaged for COVID-19 outside the ED

- The controlled drugs register checks were completed in full
- We found evidence of good teamwork and support amongst nursing and medical teams within all units
- We found that management and leadership was focused and robust
- Practice educators were in place and more were being recruited
- The preceptorship and mentoring programme in the SAU
- Patients were generally complimentary about their time in the ED and SAU.

This is what we recommend the service could improve:

- The waiting area was a major cause of anxiety for patients, with little privacy, and for staff due to the inability to triage and medically manage patients in a timely manner
- Reducing the delay in being able to find patients a space in the ED, will result in less time being spent by patients in chairs
- Complete all areas of the patient records as required, to ensure there is a full record of treatment, observations and medication
- Ensuring patients are offered hand wipes or the ability to wash their hands before and after meals
- Reducing the over reliance on agency and bank staff
- The flow of patients from the ambulance bay through the ED and out into the other wards or discharge
- Increasing the mandatory training compliance so that all staff complete the training on a regular basis
- Appraisals process, including ensuring all staff receive an annual appraisal.

We had some immediate concerns about patient safety which were dealt with under our immediate assurance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. These were in relation to the delivery of safe and effective patient care. Details of the immediate improvements required are provided in Appendix B, which includes the following:

- Patients in the waiting areas were not overseen by staff at all times and could deteriorate without being seen by staff
- Infection control issues surrounding the COVID corridor, including issues of potential cross contamination and staffing
- Poor staff survey results where staff believed they could not always deliver the care they wanted to, due to a number of issues
- Resuscitation trolley checks were not signed as completed.

3. What we found

Background of the service

Aneurin Bevan University Health Board (ABUHB) covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. The health board employs over 14,000 staff, two thirds of whom are involved in direct patient care. ABUHB is responsible for promoting wellness, preventing disease and injury, and providing healthcare to a population of approximately 594,164 people[1].

The Grange University Hospital was opened in November 2020, ahead of schedule, to help the health board respond to winter season pressures and the second wave of COVID-19. The hospital has 560 beds (including trollies and cots) and features a 24-hour acute assessment unit, emergency department (ED) and helicopter pad. It provides a 24/7 emergency service for patients that need specialist and critical care.

The hospital provides care for people who are seriously ill or have complex problems or conditions that cannot be safely managed at one of the enhanced Local General Hospitals (eLGH). The following services are available at the hospital:

- Emergency admissions for major illnesses and injuries and those in need of resuscitation
- Emergency Surgery and Trauma care
- Major and Co-morbidity (more than one serious condition) Surgery
- Emergency Assessment Unit
- Children's Assessment Unit.

The ABUHB Flow Centre is a new service based at Vantage Point House, Cwmbran, set up to provide pre-hospital streaming and transport co-ordination

[1] Stats Wales

across the hospital sites. The service is run by a multi-disciplinary team consisting of call navigators, triage/transport nurses and medical consultants.

The areas covered by the inspection and numbers of beds were:

Triage – A team of nurses with triage skills will rapidly assess all the patients who book into the ED. Each patient will be categorised in order of urgency to be seen by the doctor. The triage nurse will then allocate these patients to an area to be nursed/seen by the doctor. The triage nurse can redirect patients to other hospitals/GPs if appropriate.

Majors – An area containing 27 spaces for patients. One is used for electrocardiograms (ECGs)[2], four for assessment, one for ear nose and throat (ENT) patients and two trolleys removed to change to a six chair area. There is also an immediate release area and a mental health assessment areas. Majors is an area where patients have their assessments, care and treatments. The type of patients who will present to majors are stable chest pains, shortness of breath, history of seizures, collapses and abdominal pains. Patients are often referred to a speciality from majors, for example the medical, surgical or orthopaedic team. There will be one nurse to four patients in Majors.

Resuscitation (Resus) – The department has eight resus bays for those patients who are critically ill. One bay in Resus is for a child who needs resuscitation. The nurses working in this area will have their immediate life support qualification and care for the sickest patients in the department. The type of presentations in resus would be a segment elevation myocardial infarction (STEMI)[3], major trauma, cerebrovascular accident (CVA)[4], cardiac/respiratory arrest and patients with a significant altered conscious level. There will be one nurse to two patients in Resus and a Resus lead.

[2] An ECG is a simple and useful test which records the rhythm, rate and electrical activity of your heart.

[3] https://www.wales.nhs.uk/ourservices/unscheduledcareconditions/acutemyocardialinfarction

[4] A cerebrovascular accident is also called a CVA, brain attack, or stroke. It occurs when blood flow to a part of the brain is suddenly stopped and oxygen cannot get to that part. This lack of oxygen may damage or kill the brain cells. Death of a part of the brain may lead to loss of certain body functions controlled by that affected part.

Rapid Assessment Unit (RAU) – This area has a dedicated ECG room and four cubicles to assist with assessments and care of the patients in the waiting room. Two qualified nurses and a healthcare support worker (HCSW) would usually be allocated to work in assessment. The RAU also includes an area outside the majors office where patients need to be monitored and they sit on chairs, to await a bed space or discharge.

Children's Emergency Assessment Unit (CEAU) – This is staffed by ED and paediatric nurses. The unit has two separate waiting areas, one for COVID positive patients and one for COVID negative patients. There is a cubicle in adult resus that is dedicated for children and a high care room in CEAU. ED paediatric nurses will be based in CEAU. However, cover from adult nurses was sometimes required. The clinical area in CEAU includes a triage room, 10 designated assessment spaces (six cubicles and four curtained bays), a nurse assessment room, plaster room, two treatment rooms, consultation room and a child protection suite. The SSU comprises six inpatient single occupancy cubicles, with en-suite facilities, in the area adjacent to CEAU.

Covid Assessment Zone – Patients will be streamed to the appropriate triage area from outside the department depending on their answer to set COVID-19 related questions. The patients who enter via the COVID entrance will be triaged in the A1 corridor outside CEAU. The patient will then be transferred to the assessment zone which is currently on ward A1 to be nursed/assessed. A1 has eight resus cubicles, eight majors' cubicles and an ambulatory area. Ward A1 was not the subject of this inspection.

Surgical Assessment Unit (SAU) – The SAU is where patients are referred to a surgical on-call team for a full assessment via the general practitioner (GP), out-patient clinics and ED. On arrival at the SAU patients remain nil by mouth until they have a senior surgical review and depending on the surgical plan this may continue.

The term emergency department (ED) is used in this report to refer to all areas described above except for the SAU and ward A1. The total number of patients in the ED, including the waiting room, at the start of the inspection was approximately 156 patients.

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.

Most patients rated the quality of the patient experience provided during their stay in hospital as very good and were complimentary about the staff in the patient survey completed.

Patients, including those on ambulances, were provided with food and drinks during their time at the unit.

The internal permanent bilingual signage that showed where the patient was on their journey through the unit was very good.

There were a number of issues identified where the health board needs to address issues to improve patient experience and to ensure dignified and timely care.

Until the flow of patients into and through the ED can be improved, the health board may find it difficult to address a number of our concerns.

The majority of staff, who told us they were not based in the ED, stated that they did not feel that the ED and the service they provided worked together to provide seamless patient treatment or care.

During the inspection HIW issued both online and paper questionnaires to patients and carers to obtain their views on the services provided. A total of 38 responses were completed. We also spoke to eight patients during the inspection. Patients were asked in the questionnaire to rate their overall experience of the service, and 84 percent of patients rated the service as 'very good' or 'good'. However, 16 percent described it as 'poor' or 'very poor'. Patients were asked how the service could be improved, their comments included:

> *"Waiting times and conditions are appalling. I've had to wait for 9hrs so far just sat in an uncomfortable chair with no options for good sleep. I felt ignored by staff until i spoke out and asked for food / drink / help"*

“No beds / trolleys, just chairs”

“The night shift seems understaffed v days especially with doctors. There is not enough space (beds) for patients to wait comfortably. Seems like only patients over the age of 65 get a bed and regular treatment”

“Very slow at every stage. Too many patients. Staff very busy.”

“Staff were very lovely and respectful despite the amount of patients they had”

“The staff were very busy but amazing, friendly, helpful and knowledgeable”

“The nursing staff are amazing however definitely overworked, they run around all night.”

Patients were asked in the questionnaires how the setting could improve the service it provided. Some comments received are shown below:

“I was sat on a chair in a corridor for 17 hours with no food or drink. This needs to be addressed”

“Less time waiting in ambulance before admission”

“Decrease waiting times”

“Triage room was very overcrowded. Better explanation on what was happening next”

“More staff to improve wait times.”

HIW issued an online survey to obtain staff views on the ED and SAU at the hospital. In total, we received 136 responses from staff at the hospital.

Staying healthy

There was information displayed about how patients could help their health and wellbeing. We saw posters displayed on weight management, healthy eating, stopping smoking and active lifestyles on posters throughout the ED. Additionally, there were posters reminding patients to wear a face mask correctly. However, there was no information regarding support groups on display other than Wales Wellbeing.

There was also information displayed highlighting the appropriate use of the ED and signposting to other services. These were seen on the COVID-19 testing

porta cabins and in several areas throughout the ED. The poster was called The Right Place. However, this advice was probably too late to allow the public to make an informed decision about which hospital / minor injury unit is appropriate for their health concern as patients had already arrived at the hospital. The health board were embarking on a series of 'Work with Us' roadshows. This is a tour around the health board area to recruit new members of staff and to ensure local residents know where they should go when they need healthcare.

There were also posters explaining that the hospital was a smoke-free environment. This also extended to the use of vapour or e-cigarettes. These arrangements complied with Smoke-free Premises Legislation (Wales) 2007. We did not see any patients smoking during our visit outside the ED. The security staff we spoke with said that they would normally ask anyone attempting to smoke to move outside the hospital grounds.

All patients we spoke with said they were not asked directly about looking after their own health.

Improvement needed

The health board must ensure that

- More leaflets or posters are available in all areas of the ED relating to support groups
- Where applicable patients should be questioned about how they are looking after their health and this should be documented on patient notes
- The Right Place message is advertised further throughout the health board area, including in health centres, clinics and GP practices.

Dignified care

We noticed that patients were moved to private rooms in the RAU for examination and assessment by medical staff. However, when the ED was under pressure, medical staff reported difficulties in accessing rooms to carry out confidential examination and history taking. The lack of appropriate private rooms available resulted in a delay in taking medical assessments. The staff also reported that intra-venous (IV) infusions and blood taking did take place in the corridors when there was no available clinical space. All staff demonstrated sensitivity in maintaining patient confidentiality at all times. However, whilst there were curtains to the ambulance triage cubicle as these were not soundproofed, the discussions could be heard outside the cubicle.

We were told that the waiting area was a major stress for patients, with little privacy and no accompanying visitors allowed, except for children's parents and carers. The hospital did not allow relatives or carers to accompany patients due to COVID-19 restrictions. This could impact on the anxiety of unaccompanied vulnerable patients or patients who were unable to express themselves adequately or retain information given to them about their treatments by health professionals. Patients we spoke with in the waiting room expressed concern that they were alone and concerned for relatives waiting for them in the car park for extended periods. This was partly mitigated with ED staff conveying information to relatives via the telephone. We noted a number of signs throughout the unit reminding staff to contact and update relatives on the patients' condition. All patients, bar one, who expressed an opinion said they had been treated with dignity and respect by the staff at the hospital. The majority of patients who expressed an opinion said they were able to maintain their privacy and dignity during their time at the ED. Almost all staff said patients' privacy and dignity was at least sometimes maintained. One patient commented that:

> *"It feels like because i am young i am not taken seriously and neither is my condition. There is no urgency at all."*

We spoke with eight patients about how they were treated and whether staff were kind and treat them with dignity and respect. They all responded positively and said that they were treated with respect and were positive about their treatment in the ED.

We were told that if the waiting room was full, efforts would be made to find additional chairs, for those waiting, to sit on. There were multiple instances observed of staff apologising to patients for the long waiting times. Staff felt frustrated that patients were being nursed in an inappropriate area and that their personal care standards were being compromised. Staff we spoke with said that this level of care was affecting staff and potentially leading to a state of physical and emotional exhaustion.

We saw staff speaking to patients with respect, courtesy and introduced themselves on initial contact. Patients we spoke with said that the majority of staff asked them how they would like to be addressed. However, we noted one member of staff going through the motions of explaining the reasons for a test. The patient had hearing issues and evidently did not understand what was happening. We confirmed with the patient that they did not hear staff properly to understand the need for the test but they allowed it anyway. The staff possibly did not know that the patient had problems with their hearing.

We observed staff trying to be discreet when speaking to patients, despite the issues of privacy as many patients were hard of hearing. All personal care was completed with the curtains drawn.

We also noted that the microphones on the reception desk were not working properly. They were at waist level on the counter and patients had to shout with their personal details to the receptionists. This created issues with privacy and dignity for the patients. There was a portable hearing loop in reception that we were told was not working correctly when tested recently. There was access to language line for translation if required.

There were no trolleys for patients in the corridors and patients would sit on chairs. The chairs were separated by Perspex screens to try to mitigate the lack of social distancing for these patients, both in majors and the RAU.

Patients appeared well cared for and appeared to be comfortable in their beds, which were set at different angles for their comfort. Staff were seen nearby and attentive to patient needs. Patients appeared to be clean and presentable with clean bedding. Staff we spoke with said that maintaining the patients dignity was challenging on the corridors where other patients could see them. One nurse reported that cancer patients accessing the 111[5] advice were directed to the ED with suspected neutropenic sepsis[6]. Waiting in a crowded waiting room prior to triage added to the risk of infection in immune vulnerable patients. An alternative pathway for cancer palliative patients' needed to be put in place to avoid attending the ED.

There were no issues with the environment of the majors area that would affect patient dignity. The toilets were clean and all the locks were working properly. However, ambulatory patients had to walk the length of majors, about 30 to 40 metres to the examination rooms at the other end of the ward. Two trolley areas in the majors area had been removed to enable the area to be used to accommodate six patients in chairs. Not all the chairs were reclining chairs so there were issues here with comfort, privacy and dignity.

Efforts were made by staff to maintain the privacy and dignity of patients in the chairs, in the corridors of the SAU. Staff were seen helping patients to go to a

[5] 111 is a free-to-call single non-emergency number medical helpline operating in parts of Wales. The 111 phone service is part of the National Health Service: in Wales the service is known as either NHS Direct Wales or 111 depending on area.

[6] Neutropenic sepsis is a life threatening complication of anticancer treatment, the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever.

suitable area to ensure they could maintain their personal care in the SAU. However, there was one elderly patient on the SAU that said they had not had the opportunity to wash and clean their teeth since leaving home, 18 hours previously. Not all patients in the corridor were on reclining chairs, which made it difficult to ensure their comfort. We were told that patients in the corridor were allocated a qualified member of staff who carried out all their nursing duties and reviewed their care regularly as they did not have a call bell.

Staff acknowledged that it was not acceptable to have patients in the corridor. However, they said that all patients were well cared for, effectively communicated with and all attempts were made to make the patients as comfortable as possible. The patients spoken with were complimentary of the staff and understood the service was under pressure. Staff risk assessed the patients in the corridor to assess if sitting in a chair in a corridor was detrimental to their care.

We were told that paediatric patients in the waiting area were informally risk assessed to ensure it was appropriate for them to wait there. There was a feeding room in the paediatric area as well as a changing area. Once in the main paediatric area, all patients were nursed in a cubicle or in a curtained pod and all staff appeared organised with noise kept to a minimum.

The ambulance triage area only had a curtain to separate this area from the ambulance corridor. Other patients and ambulance staff could therefore overhear some clinical questions and history taking. However, all staff observed were carrying out personal care discreetly and maintained patient privacy and dignity at all times before they were admitted to the majors area. Patients were brought in regularly for toileting purposes from the ambulances. Urine bottles were provided for male patients on the ambulances with the doors closed. We were told that there would be a difficulty turning patients onto bed pans on ambulance trolleys. Patients were observed on ambulances being assessed for pain by the Welsh Ambulance Service NHS Trust (WAST) staff.

We were told that there was regular liaison between ambulance and hospital staff. The duty operational manager (DOM)[7] liaised regularly with the crews, triage nurse and nurse in charge. The Hospital Ambulance Liaison Officers

[7] The DOM is responsible for the operational leadership and supervision of a defined group of Paramedics, Emergency Medical Technicians and Urgent Care Assistants.

(HALO)[8] was present between 10:00 and 20:00 hours. There was not a formal liaison arrangement in place overnight unless WAST deployed a DOM at times of high demand. We observed one crew express concern about a deteriorating patient to the DOM, who liaised with the triage nurse to arrange a move into resus. We believe that the input of the WAST representative at these meetings was useful, where they could report any concerns about individual patients waiting outside to facilitate quicker offloads. WAST staff also commented that communication as a whole was excellent, especially during the day when HALOs were present. Crews reported that communication overnight was not always as effective.

We were told that there were three daily site patient flow meetings between WAST staff, the HALO and senior nurses and change nurses within the ED.

We asked a series of questions about the ED environment of staff who stated they were not based in the ED. The replies were as follows

- 68 percent who answered the question said facilities within the ED were not appropriate for them to carry out their specific tasks
- 72 percent said they felt the working environment within the ED was not appropriate in ensuring their patients received the care they require at their 'point of attendance'
- 80 percent said that patients were not able to access their service from the ED in a timely way
- 54 percent said they did not feel that the ED and the service they provided worked together to provide seamless patient treatment or care
- 84 percent said that from their time spent within the ED, they did not feel that ED staff were able to perform their duties in line with patient needs

[8] Hospital Ambulance Liaison Officer are responsible for managing the ambulances that arrive at the hospital, liaising between the ambulance service and the hospital

- 48 percent said that they felt that issues raised with ED senior management team were not dealt with in line with health board process and procedures.

There was a section on the patients' notes in relation to capacity, comfort and dignity. However, these were incomplete on all notes seen.

Improvement needed

The health board must ensure that:

- Staff are reminded of the need to consider any communication issues with patients when speaking with patients
- Staff are remind about the need to ensure privacy and dignity and confidentiality when speaking to patients in areas where they can be overheard
- The communications with patients in the waiting room are improved to ensure confidentiality, including the hearing loop
- More room is made available in the main reception area and for the triage area for patients
- They consider the comments raised by staff we do not work in the ED and provide HIW with the work they are carrying out to address these issues
- The section on the patients' notes in relation to capacity, comfort and dignity is completed in full
- That patients are not required to wait on chairs overnight
- The chairs used in the corridors are changed to reclining chairs to ensure patients can wait comfortably for their treatment, especially when having to wait long periods
- The use of alternative pathways for cancer palliative patients to avoid attending the ED
- A secure soundproof confidential area be provided where ambulance staff can exchange information and handover patients away from a public corridor.

Patient information

There were permanent large bilingual signs describing the patients' journey through the various departments. There were also permanent smaller bilingual signs describing where the patient was in the ED and SAU and explaining what the area was, for example explaining the triage process in simple terms for patients along with identifying clinical need. Additionally, in the SAU there were leaflets, in addition to the permanent signage, explaining more about the SAU, triage and aims of the triage, and what happens on admittance.

Directions to the ED were clearly displayed outside the hospital. Once inside each unit, there were signs directing patients to the toilets and exits and also the emergency exits. However, the signs were small and difficult to identify from a distance. As described above there was information displayed about how patients could help their health and wellbeing.

Improvement needed

The health board must ensure that all signage is in an area that can be seen and that patients, including those with sight difficulties, can see the signs.

Communicating effectively

We noted that staff were discrete in communicating personal information with patients. Whilst all staff seen demonstrated sensitivity in maintaining patient confidentiality, the ambulance triage cubicle had curtains, which were not soundproof.

There were patient safety at a glance (PSAG)[9] board containing identifiable information in discrete places in the ED and SAU. The details on the board included when observations were next due, bloods, ECG, X-ray and treatments given or next due.

We observed most staff speaking with patients about their care and treatment in a way that they understood. One of the conversation we heard involved a nurse on triage explaining the waiting time and arranging an appointment with urgent

[9] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

care and primary care as an alternative treatment plan. Patients were moved to private rooms for their examination and assessment by medical staff.

We asked patients a series of questions about their experiences relating to their healthcare. 97 percent of patients said that they felt listened to by staff and 73 percent said they were able to speak to staff about their health without being overheard by other people. 90 percent of patients said that they were involved as much as they wanted to be in decisions about their health care and that they were given enough information to help them understand their health care.

We also noted staff wearing a Welsh speaking logo, to make patients aware that they could speak to them in Welsh. We were told that the Welsh speakers were able to offer consultations or part consultations in Welsh. Staff in paediatrics also spoke in age appropriate terms, involving the children or young person in care decisions as appropriate.

Bilingual posters were seen that had been printed from the health board website. Senior staff we spoke with said that part of the performance appraisal included enquiring about whether staff were interested in taking part in the Welsh language online training.

Patients we spoke with had mixed comments about how staff communicated with them. Five patients were positive or did not have issues. One had poor eyesight and staff were aware they needed to keep their drink topped up frequently. They said that staff were less efficient at filling the glass at night. One wasn't asked about how they'd like to be addressed. One said that they were not able to speak to staff without being overheard.

We also saw information displayed on staff working in the ED (a who's who board). Staff stated that information was not available for patients and carers to help them understand their care and journey throughout the ED. However, they stated that patients received a verbal report on the next stage of the care. There were also large boards to describe their journey through the various areas, as described previously.

We were told that telephone calls for patients were taken by a member of staff referred to as a patient liaison who would hand the message to a nurse if a relative needed to contact the patient.

Staff considered that they needed a tannoy or similar, as patients could not always hear their name when it was called, particularly when outside the waiting room. There were occasions when receptionists had to shout patient's names outside the waiting area. We were told that during one day of the inspection, one patient was in the waiting area for 13 hours as they missed their name being called and they also missed the coffee trolley.

There was a voice activated communication system used within the hospital that staff were able to wear on a lanyard.

Improvement needed

The health board must consider ways of ensuring that communication with patients waiting for care or triage is effective, on the initial call to avoid delays in treatment.

Timely care

Patients we spoke with told us about the wait they had before being admitted into the ED from the ambulance or waiting room. This varied from being seen immediately in the ED to 15 hours in total in an ambulance and a waiting area.

We checked a sample of patient records and noted that five of the ten records checked had not been triaged within 15 minutes of arrival at the ED. However, there was one instance of a wait of 165 minutes on an ambulance before being triaged.

We explored how WAST and the ED ensured that patient handover times were appropriate and took place within agreed national timescales. On the day of our arrival at the ED, mid-afternoon, there were approximately 20 ambulances waiting to move patients (offload) from the ambulances. Paramedics we spoke with reported one instance of a significant offload wait time for a patient with a fractured neck of femur overnight. We were told that there was an issue with the flow of patients within and out with the hospital. There had been insufficient discharges from the wards at the hospital and other settings to match the admissions into the ED, only two patients had been discharged that morning from the entire hospital. The volume of self-presenting patients that required admission into a speciality bed in the ED was another cause of the delays for offloading patients.

Overnight during the inspection we noted that there had been two patients waiting for 10 hours in an ambulance without a medical assessment. Both patients were clinically stable, they had been triaged and had received analgesia. We were told

that urgent calls from WAST required age, sex, history, injuries/illness, condition, estimated time of arrival (ASHICE)[10] were taken directly to resus.

The average triage time on the day of our visit was approximately 45 minutes due to additional pressure on the triage team to triage self-presenting waiting room patients. There was a target to complete the triage within 15 minutes and compliance was monitored. Both the triage nurse and nurse in charge (NIC) reported that the greatest clinical risk within the ED were the patients in the waiting room who had not been triaged. Ambulance patients had clinical supervision of trained paramedics and vital signs monitoring. There was a difference of opinion on who was ultimately responsible for the patient. WAST staff stated that hospital staff were ultimately responsible for the patient once they were booked in and reported to triage nurse on arrival. ED staff believed responsibility should be joint care as there are two health professionals looking after one patient in the ambulance. The health board stated that there was joint care responsibility.

A health board self-assessment completed as part of a HIW local review of WAST handovers stated that the ongoing monitoring and escalation of patients was the responsibility of the WAST team prior to handover. The provision of the fundamentals of care and ongoing treatment prior to handover was jointly managed by WAST and ED staff.

WAST staff we spoke with were not aware of any policy in place to divert patients to other hospitals, other than if a major incident had been instigated. All movement of patients within the health board is controlled by the health board managed patient flow centre. Additionally, there may not an alternative appropriate hospital within the health board area to divert a patient too. We also saw a pilot taking place with an operator using a clinical patient management software to redirect any suitable patients, when they were being triaged.

There had been occasions, we were told, when the delay in offloading patients from ambulances had resulted in an inability to respond to other urgent calls. We

[10] ASHICE is mnemonic acronym used by emergency medical services to pass the important details of a patient over to a receiving hospital, or other definitive care provider. An ASHICE message is generally undertaken in order to pre-alert a receiving emergency department that a critically ill patient is being brought in

were told that if an urgent release was needed, it took time to offload the existing patient before they could leave for the red call. This would usually result in the failure to attend the call in the eight minute response time. Again this was anecdotal.

We spoke with WAST staff about any occasions when delays in offloading had resulted in an inability to respond to other urgent calls. Also, whether these incidents resulted in patient harm. All WAST staff questioned reported many incidences of patients being on the floor at home for several hours after falling, waiting for the arrival of the ambulance. These long lay incidences resulted in pressure area breakdown[11], aspiration pneumonias[12], dehydration[13] and acute kidney injury (AKI)[14]. All WAST staff had examples of ambulance delays in the community leading to delayed treatment and patient harm. The Royal College of Emergency Medicine report called 'Crowding and its Consequences[15]' (November 2021) referred to recent evidence that poor flow contributed to patient harm.

We noted that patients were not being received into the ED from ambulances in a timely and effective way. In majors, there were delays in offloading and the handover of patients within 15 minutes of arrival as required by national guidelines. We were told that there had been multiple breaches of handover timelines. There were delays in triaging patients on the back of ambulances

[11] Pressure sores are wounds that develop when constant pressure or friction on one area of the body damages the skin. Constant pressure on an area of skin stops blood flowing normally, so the cells die and the skin breaks down. Other names for pressure sores are bedsores, pressure ulcers and decubitus ulcers.

[12] Aspiration pneumonia is a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs. Signs and symptoms often include fever and cough of relatively rapid onset.

[13] Also known as: water loss, fluid loss.

[14] Also known as: acute renal failure, acute kidney failure.

[15] https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Why_Emergency_Department_Crowding_Matters.pdf#:~:text=Crowding%20is%20associated%20with%20increased%20mortality%20and%20increased,Against%20the%20backdrop%20of%20long%20ambulance%20delays%202.

within 15 minutes of arrival, due to triage nurses having to triage waiting room patients.

The hospital was at full capacity, on the day of our arrival for the inspection. There were no empty beds in the ED or in the hospital. The hospital was at escalation level four, red[16]. Staff spoke to us about the previous nights' arrangements for patient flow. Patients had been boarded overnight with each ward requested to take extra patients. Medical staff were requested to review all patients fit for discharge or for step down to other hospitals, to expedite more discharges to create capacity.

There were processes in place to admit directly to the wards within the hospital, if safe to do so, and also direct admission to the Acute Medical Assessment Unit (AMAU)[17], SAU, ENT and other areas. However, whilst patients could be referred directly to specialities, during the inspection there was not the capacity in the other areas, therefore some patients' were waiting inside the waiting room to be seen.

We asked patients a series of questions about their arrival by ambulance. Of the four who arrived by ambulance, one waited in the ambulance before admission to the ED for 15 minutes, and three waited for over two hours. All four stated they received sufficient food and drink while waiting and that they were given access to a toilet during the wait. Furthermore they said that they were treated with dignity and respect by the ambulance staff and they felt safe and cared for by the ambulance staff. They all stated that the ambulance staff were knowledgeable and that they treated their condition effectively. Three of the four said they were regularly checked by hospital staff, and one answered 'not applicable'.

We also asked all patients about their experience when they arrived at the ED, they stated that assessment times varied between immediately and more than

[16] Level Four (extreme pressure) emergency admissions significantly exceeding predicted levels and available capacity, some patients are spending longer than 12 hours in A&E, A&E capacity unable to meet further demand, ambulances are spending an hour or longer transferring patients into hospital, no transfers or discharges of patients taking place and all planned admissions have been cancelled.

[17] A dedicated facility within a hospital that acts as the focus for acute medical care for patients that have presented as medical emergencies to hospitals or who have developed an acute medical illness while in hospital.

30 minutes, although one of the 37 said they were not assessed or triaged. The treatment or referral times also varied between under two hours and a wait of more than 12 hours.

ED staff suggested a dedicated ambulance triage team would facilitate early triage and carry out blood tests and ECGs in back of ambulance in a timely way.

We did not ask a question about patient flow and overcrowding, but many staff comments mentioned this specifically. A selection of relevant comments is included below:

> *"Long ambulance delays where patients are kept outside on ambulances for many hours due to lack of space within the department."*
>
> *"Patients are deteriorating and spending days in chairs with complaints that are inappropriate to sit out with."*
>
> *"They know it's overcrowded and under staffed …It's too much soul destroying working there…Staff are just leaving all the time"*
>
> *"The shortage of staff is currently a concern, in addition to the daily high attendance of patients, long ambulance waits due to overcapacity issues. This affects overall patient experience and treatment"*
>
> *"GUH does not have capacity to manage the number of admissions. Patients that are acutely unwell are managed on chairs, sometimes for days at a time. Assessment areas in the surgical admissions unit are constantly breached. Patients deemed fit enough for step down to RGH wait for days before transfer, therefore blocking acute beds. Nursing staff are rushed off their feet"*
>
> *"The department is so busy is affects all areas of care. Having worked in the NHS for [decades] I never thought I would care for children sleeping in corridors and overcrowded waiting rooms. It is not dignified or safe."*
>
> *"The physical footprint of the building is inadequate for a new 'super-hospital' - not enough space and not enough flow as well as not enough provisions for staff. Patients are constantly let down and put at risk by long waiting times, numerous transfers (especially the frail and elderly)."*
>
> *"It's embarrassing when u have to apologise for the waits when people have to que outside with their children to book in or sat on*

floors because there is no rooms to put them anywhere. Or waiting 8 + hours to see a Dr"

"The high demand of patients, staff shortages and no space to see children is having a massive impact on the care we are providing to the children. Shift after shift we are abused by parents and made to feel like we aren't doing enough when we are working the best we can with the space that we have. All the team has worked so hard to safeguard protect and care for children from the opening of the department and nothing is appreciated. I know that myself and other members of my team are really struggling. We aim to provide the best care possible and it has been quiet challenging due to the lack of space and health professionals to care for these children. Every day is a constant worry about how many children will attend the department and require emergency care and the lack of space is causing serious issues. When three or four poorly children come in at once requiring immediate treatment sometimes there is no space for these children which is very worrying for staff. It's affecting everyone mental health massively as staff don't want to come in to be abused by parents for the lack of space and the length of stay in the department. And god forbid if something was to happen the blame would be on the nurses and we would lose our pins"

"The people I work with give the most amount of care they can to patients but there is not enough space or staff to give the right care. We are firefighting every single shift and just hoping nothing seriously bad happen. Rapid assessment is the biggest risk. Normally has 2 qualified and a HCSW for up to 60 patients. How can they be expected to care for that many?"

"The ED is so thinly stretched, lack of capacity and lack of skilled staff, the standards of care is compromised."

"The newly introduced one staff nurse to five patients in green majors is not safe and bad"

"Lots of good practice overshadowed by lack of patient flow, long waits & overcrowding"

"I have never seen a busier place in the UK! It is unsafe sometimes. Priority seems to be "patient flow" rather than patient care, in many instances"

"We always want to deliver excellent care but sometimes are prevented doing so by sheer volume of patients and lack of space"

“The front door is overwhelmed and there aren’t enough adult beds in the system. There needs to be a discrete PEM service of senior opinion at least until midnight as children are being denied this at present”

“The ambulance service attempts to meet the needs of patients however it is limited in this ability. Long handover delays make patient wellbeing often impossible to maintain. Imagine keeping an elderly patient with dementia who is confused and wants to be home on an ambulance for 8 hours, reassuring and attempting to maintain their safety while preventing them from being gassed by exhaust fumes. An impossible task”

“Full capacity and high escalation causes reduced standards of care, especially for patients who are not in the correct areas.”

“Unfortunately the dangerous levels of short staffing both doctors and nursing wise and the high volume of patients pressures staff are dealing with”

“It’s dangerously under staffed, too small for the capacity and I fear nursing staff are going to have a serious incident on their hands the further in to the winter we go! Staff are off sick, including myself I, I had two months off with work related stress as a senior member of the team I felt useless in trying to escalate staff concerns and the safety of our patients. There are many times I fear a mum arriving with a baby not breathing and I don’t have the space nor staff to put them or that a child deteriorates without us noted due to having so many other patients, you just can’t physically get around every patient. Observations are missed, medications are missed.”

“As per my previous comments, patients stuck in waiting rooms for 12+ hours, some only being given a chair for 36 hours in sub-wait or in ambulatory in a1. Not appropriate!”

“The department regularly has very high numbers of patients and ambulance waiting outside which is incredibly unsafe. There is no patient flow, no space to see patients. Any escalation plans seem to be ineffective and futile for that matter as every day is essentially a 'critical incident' or a near one. Not once have ambulances been put on divert and the department 'closed' when this appears to actually be the safest option”

“The department is almost always at full capacity and consistently escalated. Senior nurses work hard to make room for patients but it

is simply impossible with the number of patients in the department and hospital. Sometimes moves are barely made to gain a resus or red release space due to no beds available in the hospital which is unsafe"

"The department is always at capacity. This has become the "norm""

"It is all well and good escalating but there is no way of dealing with the number of patients when we can't get people through the system. If the department didn't constantly have 30+ patients waiting to go towards/ step down then we might be able to see patients in an appropriate space, not chairs, in offices, back of ambulances etc"

"The department is always over capacity. Bed managers never do anything when we escalate and just think it's acceptable to keep patient on ambulances and in the waiting room for 12 hours. There is no flow through the department. How are we meant to do our job when there is no room!"

"We are full most of the time. Too many sick patients end up stuck in the waiting room because there is no flow and nowhere in ED to put them"

The main theme for patients we spoke with were the waiting times, from the waiting times for ambulances at home, the time spent in the ambulances on arrival at the ED and the time spent waiting in the waiting room. However, patients said that ambulance staff were 'brilliant'. Additionally, patients described staff as brilliant in very difficult circumstances.

We were supplied with a number of charts and statistics, after the inspection that showed the following numbers, for the period 1 April 2021 to 1 November 2021:

- Median[18] total time in ED – 6 hours 7 minutes
- Four Hour Compliance in ED – 44 percent

[18] In statistics and probability theory, the median is the value separating the higher half from the lower half of a data sample, a population, or a probability distribution. For a data set, it may be thought of as "the middle" value.

- 12 hours compliance in ED – 78 percent
- Number of over 4 hour breaches – 104
- Number of over 12 hour breaches – 41
- Triage median wait – 31 minutes
- Clinician median wait – 2 hours 02 minutes
- Referral to speciality median wait – 2 hours 30 minutes
- Bed allocation median wait – 7 hours 43 minutes.

These times varied from a low of 3 hours 31 minutes median daily time in ED to a maximum of 9 hours 31 minutes. There was also a low of 12 minutes to a high of 1 hour 15 minutes median daily triage wait. Senior staff also wanted to point out that whilst these times were not acceptable for the patients, overall in the health board, the averages were lower. This was because they also had to manage three other minor injury units in their eLGHs at Nevill Hall Hospital, the Royal Gwent Hospital and Ysbyty Ystrad Fawr.

The inspection team were also aware of the current pressures being felt in this hospital as with other hospitals in Wales and on WAST in general. In addition, the team understood that until the patient flow could be improved, starting with the ability for patients to be managed in the community and then flowing back into the ED, it was difficult to improve on these figures. This flow included being able to discharge patients into care homes, from and to community hospitals and from and to wards in the hospital and other eLGHs.

There was not a system in place to inform patients of the average waiting time for patients at the ED. The health board stated that the Royal College of Emergency Medicine did not support systems to display waiting times and that the health board supported this.

Doctors we spoke to were also frustrated with the amount of time that patients spent in beds in majors before being moved on to another area and in not being able to find appropriate rooms to assess patients. They also said that the care they provided once they saw patients was good, the problem was being able to see those patients.

Access to the paediatric area was considered to be good, with children being seen quickly. The unit was colourful, light, bright and airy and attention had been paid to the detail to make the area less intimidating for children.

A recent Community Health Council[19] Engagement Report called "7 days in the ED at the Grange University Hospital" dated September 2021, recommended that '…. Information about waiting times and waits for treatment would be helpful. The health board reply stated that work had already been triggered to introduce an electronic waiting time 'board' within the ED Waiting Area. Additionally an update on progress would be provided to the CHC.'

Improvement needed

The health board is to provide HIW with the update on the actions taken to:

- Introduce an electronic waiting time board
- Reduce the waiting times for patients
- Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms.

The health board must ensure that staff in the ED and WAST staff are all aware of their responsibilities for the patients when in the ambulance until they have been offloaded into the ED, including for pressure relief.

Individual care

Planning care to promote independence

The doors on the corridors were all the same colour and did not help to assist patients with sensory problems or cognitive difficulties. Nursing staff, including HCSWs, that we spoke with said that staffing levels at times meant there were not sufficient staff to encourage patients to move. There were physiotherapist and occupational therapists available during the day. We were told that maintaining the patients' own independence was encouraged in the SAU.

The patients in the CEAU did not require assistance in being active. However, the nursing assessment included sensory and mobility documentation.

[19] Community Health Councils (CHCs) are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

We were told that when the ED was ‘gridlocked’ staff were unable to promote independence as staff time was limited and they were unable to always devote time to individual patient requirements. However, we did note several HCSWs assisting patients to walk down the corridor and to assist in repositioning patients after long waits in the various chairs.

In the sample of patient records that we checked we noted that care and treatment given was documented on the patient care records, with care planned in a way that promoted independence. The assessment or treatment plans seen were based on an individualised patient need. There was only clear evidence on transfer of care or discharge planning on one of the three records checked in SAU. For one patient waiting in the RAU who was considered to be fit for discharge by a medical consultant, there was no documented evidence that plans for discharge home had been planned. Additionally, no transport had been ordered, neither had community support been requested. There was also no evidence of appropriate support in place for both patients about to be discharged from the SAU. It was also not recorded when the patient was medically fit to be discharged from the SAU.

In resus and majors, the patient notes showed that there was clear evidence of transfer of care or discharge planning. It was also recorded when the patient was medically fit to be discharged. In two out of five cases, there was no evidence of appropriate support in place for the patients about to be discharged in assessment or treatment plans or records. However, important decisions such as Do Not Attempt to Resuscitate (DNACPR)[20] had been documented where appropriate.

We asked staff a series of questions in this area, their percentage (%) replies are given below:

[20] A DNACPR decision is a written instruction that tells medical staff not to attempt to bring a person back to life if their heart stops beating or the person stops breathing.

Questions / Answer Choices	Always or usually	Some-times	Never	Not applicable
I am satisfied with the quality of care I give to patients	43%	50%	7%	0%
Patients and/or their relatives are involved in decisions about their care	74%	22%	2%	2%
Patient independence is promoted	78%	17%	1%	4%
The organisation has the right information to monitor the quality of care across all clinical interventions and takes swift action when there are shortcomings.	42%	47%	11%	0%
Overall I am content with the efforts of my organisation to keep me/ patients safe	30%	51%	19%	0%

Comments from staff included:

> *"Staff shortages are impacting the standard of care I am able to provide to my patients"*
>
> *"The people I work with give the most amount of care they can to patients but there is not enough space or staff to give the right care."*
> *"We are firefighting every single shift and just hoping nothing seriously bad happen."*

Improvement needed

The health board must ensure that:

- Patient records are completed in full including clear evidence of a transfer of care and discharge planning
- The necessary arrangements are in place to ensure that transport had been ordered and community support had been requested.

People's rights

We noted there were specific and suitable places for patients to meet with family and friends in private. However, there were not any tea or coffee making facilities in the room. Whilst the room was plain, the seating was adequate and well placed. There was also a dedicated viewing room for bereaved relatives. There was a multi faith room that was situated on a different level to the ED.

Due to COVID-19 restrictions, patients' family and carers were discouraged (apart from in the children's assessment unit) from providing assistance with, and be involved in, the patients care. However, vulnerable patients, such as patients living with dementia and patients with learning difficulties could be accompanied by relatives. Staff believed that the lack of relative support placed additional demands on the nursing staff to provide all care, especially at times of peak demand. Staff also told us that the relatives' rooms in the RAU was usually occupied by patients waiting for beds or used to assess patients by doctors when space was at a premium.

In paediatrics, the equality impact assessments were also carried out and the spiritual, religious or pastoral needs of patients were discussed on admission and plans developed. Where paediatric patients were critically ill, they were allocated a staff member to ensure that the patients and carers were updated and they were offered an area to allow privacy when available. There was good access for wheelchairs in paediatrics.

Whilst we did not observe a specific room for the relatives in resus, the health board stated that there was a relatives' room – this had a sink and cups etc and that tea and coffee would be provided on request. A patient was noted in resus, where a decision was made that there was no further treatment for the patient as they were at end of life, in a normal cubicle. They were subsequently moved to majors where they were allocated a cubicle that could be closed for privacy. Resus is an inappropriate environment for patients at the end of life, as once it has been decided there was no more treatment, the patient should be moved to a more appropriate environment.

Staff we spoke with said, regarding equality and diversity in the organisation, that all patients were treated according to their clinical need. They all said that they were aware of the importance of individual needs and rights. Equality and diversity awareness was part of the mandatory training requirements for staff. Staff were also aware of individual requirements of various religious faiths, including after death.

Senior staff we spoke with said there was level access to the ED, with unisex toilets. There were disabled parking spaces close to the front of the ED. The toilet

in the main waiting room opened inwards, which caused some issues, but the ED were trying to change that.

We noted permanent signs throughout the ED, as mentioned above. These stated that everyone was assessed using the same scale of priority categories and that staff treat the most serious cases first. Including that patients who arrived by ambulance would be assessed in the same way as people who walked in. We asked patients about whether they agreed with the statement that they felt they could access the right healthcare at the right time (regardless, on grounds of the nine protected characteristics[21]). However, six said they could not and six answered 'prefer not to say'. Additionally, two patients answered the question as to whether they had faced discrimination when accessing or using this health service, ticking the 'prefer not to say' box.

Improvement needed

The health board must ensure that:

- The location of the room for patients at end of life should be reconsidered to ensure that the patient and relatives are able to spend their remaining time together at peace in a secluded or quiet area
- Further arrangements are put in place to ensure that all patients are made to feel that they can access the right healthcare at the right time.

Listening and learning from feedback

There was information displayed in the ED about how patients and families were able to supply feedback about their care, although the writing was small. CHC posters were also seen with details of assistance available to raise concerns as required. Information was also displayed on 'Putting Things Right'[22].

[21] Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

[22] Putting Things Right relates to the integrated processes for the raising, investigation of and learning from concerns within the NHS across Wales.

Senior staff we spoke with said that patient compliments were all shared with staff and if a specific member of staff was made they were also told of this. Any patient feedback was also shared with staff. They stated that patient satisfaction survey results were uploaded onto the health board dashboard. Some complaints had been received relating to the waiting area. They told us how complaints were dealt with. The main complaints related to the waiting area. We were told that the ED were working on communicating with patients through a video loop to be installed in the waiting area, relating to 'Choose Well[23]' and violence and aggression. In addition, there have been engagement events with staff to give them and higher management the opportunity to meet, be open about their experience and to discuss and share. They also referred to Schwartz Rounds, which were group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare. The Director of Planning told us of the plans to build an extended waiting room, which should be in place by January 2022. However, there was not a facility in place to inform the patients of the results of the feedback.

We asked staff to answer a series of questions relating to feedback from patients or service users within their directorate or department. The percentage (%) replies are given below:

Question / Answer Choices	Agreed	Disagreed	Don't know
Patient or service user experience feedback was collected.	60%	12%	28%
They receive regular updates on patient / service user experience feedback.	36%	46%	18%
Feedback from patients / service users is used to make informed decisions.	27%	19%	54%

Improvement needed

The health board must ensure that:

[23] 'Choose Well' in order to encourage the public to think about and make informed decisions on which health care service is appropriate for different illnesses and injuries.

- A system is put in place to ensure that patients are made aware of the actions being taken as a result of their feedback
- They address the staff perception that no action is taken on patient feedback
- Staff are all made aware of the results of the feedback and of the actions they are taking to address the comments made.

Delivery of safe and effective care

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

Overall, 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. This was despite all the efforts of staff who were working hard, under pressure from the number of patients presenting at the ED.

We had a number of immediate concerns relating to the safe care of patients, and these were dealt with under our immediate assurance process.

Patient notes we checked were clear and easy to navigate, with a structured rapid assessment pathway. There were aspects of medicines management which were noted as positive.

Safe care

Managing risk and promoting health and safety

The main waiting room in the ED had treatment rooms to one side where staff would triage patients from the waiting room. There was limited visibility of the waiting room from the reception area, and the staff who sat in this area also had limited knowledge of first aid. There was CCTV in the waiting room, this was monitored on an ad hoc basis from a monitor in an area known as the RAU.

If the condition of a patient deteriorated, the unit were reliant on:

- Reception staff informing staff in the RAU if they saw anything relating to a patients' condition
- Patients informing reception staff
- Triage staff noticing anything when they went into reception to call out the names of the next patient
- A staff member seeing an incident on the CCTV monitor.

The Director of Planning told us that there were both short terms plans (by January 2022) and longer term plans (by mid-year 2022) to move the waiting area, to ensure better patient visibility.

Children's Assessment Unit - The waiting area is closed off from the ward and requires a swipe card to access. We were told that there was a receptionist there most of the time, but not all the time. As child health can be unpredictable and deteriorate quickly, relying on parents is not acceptable. Whilst staff observe the children often, if the ward is busy it may not be as regular as required. Staff should be able to observe all the children in the department.

The Director of Planning also told us that plans were in place to extend this assessment unit, but this is unlikely to be completed before August 2022.

SAU – We were told that patients sitting in the chairs along the corridor wall were allocated a qualified member of staff who undertook all their nursing duties, reviewing their care regularly. However, the unit were aware that the patients did not have a call bell. Staff sitting in the reception area had limited visibility of the majority of the patients sitting in the chairs and staff were not present in this area at all times. During the visit, one HIW Inspector noticed a patient in some distress who said they were having a panic attack. There were no nursing staff visible in the area at that time. The Inspector asked a healthcare support worker (HCSW) in a nearby room to assist the patient.

If the condition of a patient deteriorated, the unit were reliant on:

- Reception staff informing staff in the SAU if they saw anything relating to a patients' condition
- Patients informing reception staff
- Staff noticing anything when they attended to another patient.

HIW was not fully assured that the unwell patients, in the various waiting areas, were being sufficiently monitored at all times.

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.

We noted in majors and resus that patient risk assessments were completed, dependant on individual assessments. The environment was spacious with room

for patients to move around. The layout was designed for ambulance only access. We observed emergencies being escalated rapidly between majors, resus, medics and cardiology. We were also told that there was a cardiac arrest team and stroke team on call 24 hours a day.

Escalation of the unit was managed through regular huddles and site meetings. Staff were clear about what they had to do when the ED was at, or close to capacity and they stated that the ED had been 'severely compromised' for the past four days. In general there was a robust escalation policy in place to escalate the issue up the chain of command. We were told of teleconferences between WAST and senior health board, bronze, silver and gold commands[24]. The nurse in charge could reallocate staff to areas of high acuity from less busy areas when staffing levels allowed. We were told that the number of triage nurses could be increased from two to three during peak demand. The WAST HALO regularly communicated and updated triage nurses and the nurse in charge of the clinical condition of patients in ambulances.

We noted on the outside of the ED and into the RAU that the area was generally clutter free, well lit and clean, with a well maintained infrastructure. The majors ward areas and surfaces were mainly clear except for any work in progress. The corridors were generally clear of any obstructions. There was tape on alternate chairs in SAU to encourage social distancing, but the chairs were facing the opposite direction to the television.

Security was very visible, to give assurance against violence and aggression. Security staff on site had body cameras that could be activated where necessary. ED staff reported that intoxicated patients or those presenting with mental health problems could pose a patient management problem if they were verbally or physically aggressive. However, there was training for de-escalation techniques (although not all staff had completed this training in the last two years) and there was CCTV available throughout.

The mental health assessment room had ligature free door handles and was risk assessed. The furniture in the room was also designed to avoid harm to patients and staff. We were told that the room was often occupied and other high risk patients would be nursed on the chairs in the RAU, that were generally visible to staff.

[24] Gold (strategic), Silver (tactical), Bronze (operational) command structure.

On the first day of the inspection the waiting room was overcrowded and patients in wheelchairs were observed to have difficulty in manoeuvring between patients. The triage and assessment room doors were narrow and the RAU was small and cramped. There was not adequate physical space in the waiting room for the volume of patients self-presenting. We observed the potential for overcrowding leading to breaches in social distancing. The environment was also uncomfortable to wait in for extended periods. There appeared to have been an underestimation of the anticipated demand and types of patients that would present to the service at the planning stage of the health board's new care model. These included patients not attending the appropriate service and self-presentations. The model was not designed for these patients and we were told there had been a conscious decision made not to have a minor injury unit[25] at the hospital. There were three minor injury units in the health board area as described above. The ED was designed as a major trauma centre to treat major emergencies and resuscitation, which could require onward intensive care.

Those patients who were in custody, would be recognised on the system with blue dots and the psychiatric room would be used on occasions to ensure patient dignity. We were also told that when the ED was full, patients in custody would be sent to the police van to wait. However, staff had concerns when sending patients back to wait in police cars or vans as police officers were not medically trained. They may not be able to identify deteriorating patients and may be unsure how to escalate the issue. We were also told there was a policy for managing high risk prisoners.

A member of staff we spoke with were not aware of any specific policy or standard operating procedure (SOP) for children on ambulances, However, we were told that the majority of paediatric patients were offloaded into the children's assessment unit immediately as capacity and flow was generally better there than in the main ED.

In the paediatric area we were told that there were regular health and safety risk assessments. There was a mental health consulting room in paediatrics that would be used for children and adults in crisis as described above. Patients would be managed in this room by staff from the appropriate areas. The area was co-located within easy reach of the main ED. During the early hours of the day, before 09:00 hours there was only one registrar to cover all of paediatrics. Due

[25] https://111.wales.nhs.uk/localservices/minorinjuryunit/

to COVID-19 the majority of toys and aids to keep paediatric patients interested, had to be removed, for infection control reasons. Parents and carers were advised to bring small toys to distract the patients. The children's ED and CEAU were co-located, but staff reported to two different directorates. There were clear lines of escalation in both areas and there was collaborative working, between both areas.

The SAU had up to date health and safety risk assessments. The SAU was in close proximity to all diagnostic areas. Patients in custody were regularly admitted to the SAU and there was an established process followed, although we did not see any written procedure. There was a resus team available 24 hours a day and an outreach team available between 7:00 hours and 19:00 hours linked to the intensive therapy unit. Whilst the SAU sits within the ED footprint, it is managed by surgical services that could also cause some conflict. Both paediatrics and SAU were aware of the escalation process.

We were told that whilst the environment and equipment was all new and in a good state of repair we were told that there had been ongoing issues with the folding chairs. The hinges kept breaking and needed repair. However, maintenance were aware of the issues. The waiting area was too small for the current numbers of patients that were presenting to the ED. Some patients said they would wait outside of the waiting room on occasion, by choice due to COVID-19. They could then miss their name being called out by triage staff or could miss the drinks trolley.

As previously mentioned there was large signage in various areas of the ED and SAU that would show where they were on the patient journey and would they could expect next on the journey in the SAU, paediatrics and the ED. This signage was bilingual and provided useful information to the patients to better understand why they were in that location.

Improvement needed

The health board must ensure that a procedure is put in place for the management of patients in custody that ensure that their dignity and safety is maintained, should their condition be liable to deteriorate. This procedure should be agreed with the local constabulary to ensure they are aware of the procedure.

The health board must inform patients of the current plans in place to change the design of the ED, including the changes to the waiting rooms and any plans for an additional minor injuries area.

Preventing pressure and tissue damage

Pressure risk assessments were completed in majors, resus, paediatrics and the SAU as required. There was a system of intentional rounding[26] in place depending on the patient risk and there were also beds with pressure relieving mattress available in these areas. However, there was no evidence of pressure risk assessment seen in the RAU, despite there being elderly and frail patients sitting on chairs waiting for a space in majors. We were also told that there had been several occasions where there were insufficient pressure relieving mattresses available for patients at risk.

The paramedics we spoke with stated that tissue viability was not part of their training and day to day practice and they would be unable to classify different grades of pressure damage. We were told that the risks were recognised by ED staff and some mitigation was in place, with some patients being put on a repose mattress[27] on the ambulance. The repositioning of patients and skin inspection is difficult in a confined space on a narrow trolley. Only nurses were trained on the Waterlow[28] scoring, pressure relief techniques and the classification of pressure damage. This is not included in paramedic curriculum. The joint care document helps to facilitate shared care and sharing information between hospital staff and WAST staff. The lack of clarity between ED and WAST staff over who was responsible for patients waiting to offload was still in evidence at the hospital. This was also evidenced as part of the HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover'[29].

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[26] Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

[27] The Repose Mattress Overlay has been designed for use on a standard single bed where it has proven to provide effective pressure redistribution for patients at very high risk. Repose Mattress is an inflatable pressure relieving device and is designed for temporary mitigation of potential pressure damage. It is the only equipment available that is portable enough to be used on an ambulance trolley.

[28] Waterlow score is the score that is used to assess the risk of Pressure ulcer that occurs in the pressure points of the human body due to the pressure or combination of shear and pressure.

[29] https://hiw.org.uk/sites/default/files/2021-10/20211007WASTReviewHandoverDelay-EN.pdf

We were told of the practical difficulty in repositioning patients on ambulance trolleys, which were not designed for pressure relief, to relieve pressure points. Many patients may already have pressure damage before ambulance arrival, for example from sleeping in chairs at home or being on the floor for a period of time after falls. Additionally, for some patients there would be a general deterioration in health, nutrition and mobility in the weeks or days prior to admission. When patients were moved from an ambulance into the majors' clinical area, pressure relieving mitigation was available on a pressure mattress.

Patients with pressure issues should be managed in the ED not in the back of an ambulance. This also pushed the problem out of the hospitals sight, could be a safeguarding issue and also affected the response times for vehicles to attend other calls. The ambulance was tied up and this depleted the availability to respond to 999 calls in the community and there is then the potential for missing red calls with subsequent implications for the patients and families. Extended pre-hospital ambulance waiting was a contributor to harm regarding pressure area breakdown[30]. The majority of patients waiting in ambulances were also elderly, with pre-existing morbidities.

We checked a sample of patient records and noted that two of the patients had been on the floor for an extended period of time prior to the ambulance arrival due to the delayed response time. As described above, the inspection of skin on an ambulance was difficult and not always practical. We also noted that there was no evidence of repositioning in the RAU, although patients were fit to sit and could move around if needed. One patient record we checked, had been on a chair for seven hours and staff were observed moving the patient and help them stand up and walk to the toilet. However, this was not formally documented.

For patient records we checked in majors and the SAU we noted that pressure ulcer risks were assessed and that patient's skin was assessed on a regular basis, depending on the patient requirements. An appropriate care plan was developed and documentation indicated repositioning, where needed. There was also evidence of pressure relieving aids on the beds of these patients. Where required, patients with high Waterlow scores were also assessed.

[30] All Health Acquired Pressure Ulcers (HAPU) are reportable to the Welsh Government reportable and must be entered on datix and investigated using the All Wales Pressure Ulcer Investigating tool.

Improvement needed

The health board needs to ensure that:

- Pressure risk assessments are completed in full for all patients
- Sufficient pressure relieving mattress are available for patients at risk.

Falls prevention

Falls risk assessments were observed as being completed as appropriate and that patients were encouraged to wear shoes or slippers when walking around the ED. Patients waiting on ambulances would be observed by at least one WAST staff member at all times.

We were told that all falls were recorded on Datix, the incident management system used in the NHS in Wales. However, staff we spoke with, including agency staff, said that they did not always receive feedback on the Datix they submit, in majors. That being said, most staff were able to describe examples of lessons learned that had been shared. We were told by one member of staff that there would be insufficient staff to enable patients who required support to walk within the ED to safely use the toilets and other methods would be used. We did note that the ED was under considerable pressure due to the volume of patients presenting at reception.

Call bells were available for patients in majors, but not all patients had easy access to them. We observed one patient asking for help verbally because of this. There were also call bells for the patients on beds in the SAU, patients in the SAU chairs area, we were told, would be observed at times. Patients in the fit to sit chairs or corridor area were asked to call for help from passing staff. The issue of patients being observed at all times is covered in the immediate assurance above.

Multidisciplinary teams (MDT), including physiotherapists and occupational therapists (OT) were observed in the ED on several occassions. Additionally, we saw that physiotherapist and OTs carried out the relevant assessments prior to patients being deemed safe for discharge.

We checked a sample of patient records and for those admitted following a fall there was an assessment and physiotherapist input prior to discharge. The physiotherapy assessment of care was planned around individual needs. There was a referral service to the physiotherapist, which was effective in meeting the patient needs. We also noted that patients were not left with trolley sides down, unless there was a bedside table holding food or drinks in place.

Improvement needed

The health board must ensure that patients in beds have easy access to the call bells.

Infection prevention and control (IPC)

There were two small porta cabins outside the ED to screen patients for COVID-19, one for use by adults and one for children and their parents or carers. A HCSW manned these porta cabins and they asked a series of triage screening questions and they also took the temperature of the patient or carer. Those patients with suspected COVID-19 based on the initial screening were then directed into a corridor of the ED, known as the 'COVID corridor'. The remainder were directed into either the main ED or the paediatric ED. There were a number of security staff in this area to ensure the patients or carers took the correct route and did not try to enter the ED without first being screened.

Approximately 15 metres down the 'COVID corridor' there was an area with equipment for a patient to be briefly triaged and tested for COVID-19, using a point of care test kit. The patients would then sit in soft chairs, with screens between each patient, along this corridor. Positive patients would then go into a COVID-19 assessment area. Negative patients would go into the waiting room unless a cubicle was available. At the end of the corridor, approximately 80 metres long, was the COVID-19 ward known as A1. The area was not a public thoroughfare, other than the other patients in the corridor passing each other. There would normally be two members of staff on duty, one qualified nurse and one HCSW. Staff would wear the appropriate PPE with patients (apron, mask and gloves).

We noted the following points:

- There were no wash hand basins for patients or staff in this area, although there was sanitising gel available
- The staff manning this station would have to go into the non-COVID paediatric area to print off the 'casualty cards' for each patient and then return to the COVID-19 corridor
- Staff from other areas, such as resuscitation, the main ED or the paediatric area could and did pass this area from time to time if they needed to walk between these areas creating additional footfall and risk of cross infection
- The staff on duty in addition to testing the patients, would also have to monitor the patients in case their condition deteriorated, view patients

in an ambulance with suspected COVID-19, from time to time, as well as the testing in the corridor. If the staff in this area needed additional support because of the number of patients, they would escalate to the nurse in charge of ED. We were told this would then be risk assessed to see whether another member of staff should be sent to assist this area, but there was not always someone available.

HIW consider that this provided a risk of cross contamination, a failure in infection prevention and control and of being unable to appropriately manage the patients in this area. We were told by the director of nursing that as a result of our observations, there will be a rapid installation of a sink, but that infection control considered that the wearing of PPE provided sufficient mitigation.

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.

We spoke with the IPC head of service who told us that the IPC team provide a seven day a week service. Audits were completed regularly with almost three whole time equivalent safety advisors to support the wards to complete these audits. However, we did not see IPC results displayed in any area of the ED. We observed social distancing in all communal areas and all staff wore a minimum of a face mask at all times.

In the paediatric area there was a clearly identified one way system around the ward with a clear pathway for COVID-19 suspected or confirmed (red) or other (amber) patients. Staff were encouraged to challenge non-compliance with social distancing, bare below the elbow and hand washing. The waiting area was separated into individual pods to reduce cross infection.

In the SAU we also saw socially distanced pods, separated by Perspex screens in the corridors and triage areas to provide social distancing. Patients that were sent to the unit by GP referral, would go into SAU through the main hospital and a swab team tested all admissions.

In the remainder of the ED (except the COVID corridor) we also noticed staff were bare below the elbow, washed their hands regularly and maintained social distancing where possible. Although because of the nature of the work and some of the areas, such as the RAU, the cramped areas did not always allow for social distancing. Staff would all wear face masks.

All staff we spoke with were aware of the standards they should follow on IPC. There had not been any issues in the supply of PPE. There were sinks available in the majority of the ED for staff to wash their hands and there were sanitising gels available throughout.

During the inspection we saw domestic staff regularly clean the areas. In the main ED there was a cleaning environment team that undertook an enhanced level of cleaning, using a chlorine disinfectant with access to hydrogen peroxide and ultraviolet light for enhanced and deep cleaning. There were also twice weekly meetings to discuss any issues. All furnishings appeared to be in a good state of repair and were all wipe clean.

Ambulance staff we spoke with said that they followed the decontamination process when they transferred potentially infectious cases from the ambulance into the ED. We were also told that the ED would be alerted if any chemical contaminated patients were being moved into the hospital to ensure a decontamination room was available. There was direct access to the decontamination room from the ambulance bay via swipe access doors. Any contagious patients would be transferred to a negative pressure isolation suite in the ED.

The majority of patients we spoke with said that the area was clean, tidy and all surfaces were cleaned. Additionally, they said that all staff washed their hands at every visit. We asked patients a question about the cleanliness of the area, 95 percent of patients said that the setting was ‘very clean’ or ‘fairly clean’, the remainder said it was not. We also asked patients a question about COVID-19 compliant procedures being evident during patient visits. 89 percent said procedures were followed where appropriate, eight percent said they were not and remainder answered that they did not know.

Senior staff we spoke with said that infection rates were low in the ED. If any issues were identified they would be investigated using root cause analysis with a team of doctors and infection control nurses as necessary. Any lessons learned would be cascaded to staff. Any healthcare aquired infections would also be investigated in the same way. We were also told that the ED were looking at changing the way of swabbing patients with suspected COVID-19, using a

temporary structure in an external space and also completing the Manchester[31] triage for those patients in this area.

We asked a series of questions of staff regarding to what extent the statements reflected their view on how much your organisation had adapted to becoming COVID-19 compliant.

Question / Answer Choices	Strongly agree or agree	Disagree or strongly disagree
My organisation has implemented the necessary environmental changes	69%	31%
My organisation has implemented the necessary practice changes	75%	23%
There has been a sufficient supply of PPE	85%	15%
There are decontamination arrangements for equipment and relevant areas	82%	18%

Comments were received in relation to COVID arrangements, shown below:

> *"Having worked previously in pandemic for another large UHB, in comparison my organisation is excellent, and really puts the safety and protection of staff and patients priority with COVID"*
>
> *"I'm not aware of decontamination units"*
>
> *"However the department was not built to have a covid area and running 2 EDs is difficult."*
>
> *"We need more UV machines to help decontaminate the Red areas"*
>
> *"Although I agree that there are changes made for covid, there is inadequate space in the covid (red) area of ED which on most shifts results in patients (sometimes more than 10 on particularly bad*

[31] 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.

days) sat lined up the corridor. The corridor has no toilet and no hand washing facilities. It also is next to the paediatric Emergency assessment unit and red triage staff have to walk in to CEAU to book in ?covid patients and also to wash hands. The corridor is almost the full length of the hospital which leads to the red area and if patients need to use the toilet or any emergencies then have to be taken up the full length of the corridor."

"The issue is staff jumping between A1 COVID ward and Green ED every day. A1 should be staffed separate from Green ED. Have their own COVID staff"

"The whole covid system here is awful. A1 ward is so far away from A&E. A1 should be MAU as a whole, MAU become SAU or our Covid place. The covid corridor is dangerous in every aspect, people are spread along the corridor, there are no emergency bells/dignified areas, no toilets whatsoever. It's disgraceful and undignified and I do not feel confident working in such an area. Especially when before I've had extremely poorly patients given to me in there with no access to proper oxygen tanks, buzzers, toilets, sluice access etc."

Additionally, 72 percent who expressed an opinion said infection prevention and control procedures were 'always' or 'usually' followed with 26 percent saying they 'sometimes' were.

Nutrition and hydration

We noted that patients were not assessed to establish their ability to eat and drink and then given support. Generally, if staff noticed that a patient was not eating in majors then assistance was given. There was a system in place to provide food for patients through a meal trolley and regular drinks. We also noticed British Red Cross staff assisting in delivering sandwiches to patients and in providing hot drinks to patients. However, some patients struggled to eat in the beds, when they were not repositioned. We also did not observe patients being offered hand washing or hand wipes prior to or after eating. We also noted food and drinks being taken to patients in ambulances, this would normally be cold food such as sandwiches and mainly during the day. This is due to the policy of not supplying hot food to patients in an ambulance.

We noted that fluids and food was recorded for some patients, but fluid output was not generally recorded on the All Wales Fluid Balance charts. We also noted that the All Wales Nutrition Pathway was not widely used in most areas of the emergency pathway, although there was some evidence of use in majors. Nursing staff we spoke with commented that nutrition assessment was not

suitable for emergency pathway care as it was designed for ongoing care and patients should be moved out of the ED within four hours. The poor flow contributed to patients having to be fed in the ED. If patients were in the ED for extended periods, practice changes would be required to train ED staff in the use of the nutrition score and pathway. The poor compliance with filling in the nutrition scores potentially reflected this lack of training.

Fluids including intra venous (IV) fluids were noted as being monitored on majors on the All Wales Nutrition charts. However, patients receiving IV fluids on ambulances and the the corridors were not recorded on the All Wales Fluid Balance chart. Staff on the RAU reported that nutrition charts were not routinely completed due to the anticipated short stay of patients.

In the paediatric area staff worked collaboratively with patients and carers to ensure adequate fluids and nutrition was taken. Additionally, food outside of meal times was available such as fruit and yoghurts. Staff had requested a larger fridge, as the current fridge was too small to keep these sandwiches and healthy snacks. Nutrition charts were noted as being completed for all fluid and food consumed.

There were regular reviews in the SAU of patients nutrition and good documentation was observed. Fluids, including IV fluids, were recorded on the All Wales Fluid Balance charts and nutrition charts were also completed for all fluid and food consumed.

Staff we spoke with said that patients had access to a choice of what to eat and drink if they had been in the ED for a long period of time. There were three scheduled meals per day, with drinks of tea and coffee available five times a day. All patients had access to water and squash if required. The water jugs seen were mainly in easy reach of patients depending on mobility. All hot meals served were temperature checked before serving. The food looked appetising with good sized portions. Patients we spoke with said that there was a good choice of food that was tasty and hot. Help was given to cut up some foods for one patient with poor eyesight. Another patient said they had help with eating toast when asked. Generally patients we spoke with were complimentary about the access to food and drink.

We checked a sample of patient records and noted that a joint care form was completed for patients on the ambulance to record hydration, nutrition, toileting, analgesia and presure area care on an ambulance. It was noted that WAST and ED staff liaised closely to see if patients waiting on an ambulance were able to eat and drink according to their clinical condition. The British Red Cross staff were available to cater for patients on ambulances during office hours. At other times, WAST staff were responsible for feeding patients.

We saw that nutritional risk assessments had been completed for patients on the basis of triage and frailty need, once patients had been admitted into the ED. In one of the six relevant patient records we noted that the fluid chart was incomplete with regard to fluid output. However, overall the nutritional and hydration needs had been addressed to a reasonable standard. There was only one patient record checked who was nil by mouth. An assessment had been made in relation to the duration of this and there were plans in place to maintain nutrition and hydration.

Improvement needed

The health board must ensure that:

- Assessments are carried out on patients about their ability to eat and drink
- That appropriate support is given to those patients who needed support
- Patients are repositioned prior to eating, to ensure that they are able to eat and drink the food
- Patients are offered hand washing or hand wipes prior to or after eating and that they are encourage to use these facilities before and after meals
- Nutrition and fluids are recorded appropriately on the relevant documentation
- All staff are trained on the use of the All Wales Nutrition charts.

Medicines management

We considered the arrangements for the checking of the contents of resuscitation trollies in the various areas of the ED. The records in the resus and majors areas showed there were a number of gaps in the record of checks completed in October 2021 on both units. This demonstrated that the resuscitation equipment had not always been checked daily. We reviewed the contents and we found the items to be in date and serviceable.

HIW consider that the lack of regular checks meant that there was a risk to patient safety, as the resuscitation trollies in both units may not be sufficiently stocked, or equipment / medication may not be in-date and ready for use, in the event of a patient emergency. We were told by the director of nursing that as a result of this and a previous failing in another inspection, the health board have now

issued an organisational-wide alert. This is to ensure that these checks were carried out daily and evidenced. The health board will be carrying out a health board wide audit to ensure compliance with these checks.

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.

The ED used an automated medication dispensing systems that could only be accessed by authorised staff. This system gave an electronic record of medication removed and by whom, all access attempts were electronically recorded. Medications were then re-ordered automatically by the system.

We observed drug administration in majors and resus and noted that it was calm and safe. All patients in the ED were observed with identification bands. However, we did note an instance where a staff member was called away from the drugs round to help a patient that was wandering and the medication for the patient was left by the side of the table. The member of staff returned ten minutes later to ensure that the medication was then administered correctly. Additionally, there were difficulties in maintaining patient confidentiality when administering medication to patients waiting on corridors. This was because patients would be asked their name and date of birth in an area where other patients could hear the reply.

The daily controlled drugs (CDs) check was carried out by two registered nurses, using the automated medication system inventory adjustment and this was cross checked to the CD register. We noted that there were no omissions in the daily check in the CD register.

Fridge temperatures were recorded daily and any out of range temperatures would be reported to the nurse in charge of the area for their further action. We were told that the nurse in charge would then inform pharmacy staff of the potential effect on the medication stored. The ED had a dedicated pharmacist during the day. Staff reported difficulties in obtaining certain medication during out of hour's periods. There was an on call pharmacist or site manager available to access medicines out of hours.

Sharps boxes, to dispose of medical supplies such as needles or similar medical supplies were stored in a disposal area off the main corridor. All boxes were observed to be locked, signed and dated.

To take out (TTOs)[32] documentation was completed for patients being discharged, including the over labelled medication from the pharmacy.

Improvement needed

The health board must ensure that:

- Staff on a medication round, wear the appropriate tabard and are not disturbed when dispensing medication
- Further attempts are made to maintain patient privacy when asking patients to confirm their information during the dispensing of medication.

Safeguarding children and adults at risk

Staff we spoke with were all aware of the escalation processes for safeguarding in addition to being aware of the All Wales guidance. We were told of a safeguarding checklist and that all suspected non-accidental injuries were reported. Staff were also able to describe the social service referral process and the out of hours contacts. The paediatric staff we spoke with said that all paediatric staff were trained up to level two child protection and had a good understanding of safeguarding issues, including escalation. They also told us of team days incorporating guest speakers on safeguarding. The NIC said that staff appeared clear about raising safeguarding concerns. Triage staff appeared to be very vigilant to safeguarding concerns and knew the protocols for escalating these concerns.

Patients at risk of abuse including domestic violence were identified using a hurt, insult, threaten, scream (HITS)[33] tool and there would be a subsequent multi-

[32] The TTO (to take out), is a form that should be completed for all patients being discharged from hospital. It both summarises the patient's hospital stay for their general practitioner and acts as a prescription to order the drugs they need to take home with them.

[33] HITS is an easy to use screening tool and scale that stands for Hurt, Insult, Threaten and Scream. The tool includes four questions that physicians can provide to patients via a questionnaire to assess risk for Intimate Partner Violence (IPV). The questions can also be asked verbally.

agency risk assessment conference (MARAC)[34] referral. Adults at risk of harm who were unable to protect themselves from that harm were also referred. We were told that patients with a high risk of self-harm behaviour would be observed in an area within the RAU, outside the majors office. At the triage stage, staff also told us that documentation was completed on patients with a risk of absconding, including a physical description of the patient.

There appeared to be limited understanding of Deprivation of Liberty Safeguards (DoLS)[35], in the main ED. However, we were told that the forget me not flower symbol was used for patients living with dementia on the emergency care system. Additionally, in majors and resus, staff were aware of DoLS but there was little evidence of documentation of patients mental capacity in the notes seen.

We were told that there was a designated area, with an absence of ligature points, within the main ED suitable for those in mental health crisis. There was also a cubicle in the paediatric area that had been risk assessesed as appropriate for a patient assessed as at risk of self-harm and suicide. Staff stated that they had access to training regarding female genital mutilation, although they believed this was not a common occurrence locally.

During our inspection there were no patients under constant observation, due to safeguarding concerns. All patients we spoke with said they felt safe in the ED and were willing to speak up if required.

[34] A multi-agency risk assessment conference (MARAC), is a meeting where information is shared and a co-ordinated action plan developed in high-risk domestic violence situations. The primary aim is to safeguard those experiencing domestic violence. MARACs are attended by representatives of relevant agencies such as local police, probation, health, child protection, housing practitioners, domestic violence advisors and other specialists from the statutory and voluntary sectors.

[35] DoLS - The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect vulnerable adults, who may become, or are being deprived of their liberty in a care home or hospital setting. These safeguards are for people who lack capacity to decide where they need to reside to receive treatment and/or care and need to be deprived of their liberty, in their best interests, otherwise than under the Mental Health Act 1983 (MCA Code of Practice). The safeguards came into force in Wales and England on the 1st April 2009.

Improvement needed

The health board must ensure that:

- Additional training is given to staff to raise their awareness and knowledge of staff on DoLS
- Documentation is completed in full on the capacity of patients in their notes.

Blood management

Staff we spoke with said they used the All Wales Transfusion[36] documentation to ensure that a safe system for blood transfusion was in place. Blood products were not stored in the ED but were transferred from the hospital blood bank when required. We were told that agency staff do not take part in pre-blood transfusion checks. All trained staff we spoke with were aware of the post transfusion reactions and the requirements for patients to be monitored. Pathology and laboratory staff were responsible for maintaining adequate supplies of blood products.

Staff in resus referred to the massive transfusion protocol that would be instigated when patients arrived requiring large volume of blood products. Those members of staff we spoke with were aware of the expiry time of blood products when issued from the blood fridge. We were told that cool boxes were used to store multiple blood units for trauma. Again, staff we spoke with were able to describe the safe and appropriate use of blood components and products. This involved double identity checks by two qualified and trained nurses, prior to the administration of the blood transfusion and the use of the All Wales Transfusion documentation.

[36] Includes a pre administration checklist, prescription section and observation chart. Any special transfusion requirements (e.g. irradiation of blood/component or cytomegalovirus (CMV) negative or must be indicated on the prescription section of the record and special requirements are discussed in appendix. Any transfusion-related drugs must be prescribed on the All Wales in-patient medication chart. Blood components can only be prescribed/authorised on The All Wales Transfusion Record by Doctors and staff who have successfully undertaken the non-medical authorisation of blood component course.

Datix would be used to report any adverse reaction with blood management and transfusion. However, staff we spoke with, were not aware of reporting via the Serious Hazards of Transfusion[37] (SHOT).

> Improvement needed
>
> The health board must ensure that all staff are made aware of SHOT and the importance of reporting any instances.

Medical devices, equipment and diagnostic systems

The equipment at the ED appeared to be new and in a good state of repair and recently installed. The areas had all the equipment needed to meet the needs of the patients. Faults were reported and equipment that was taken out of circulation was removed from the patient facing areas to await removal to electrical and biomedical engineering (EBME).

All commodes seen had been decontaminated and cleaned and were labelled after use.

Effective care

Safe and clinically effective care

Patients and carers that we spoke with were all complimentary of the care overall, with overwhelmingly positive comments on staff from all disciplines. We also spoke to a number of staff in the various areas of the EDs. In majors, staff were aware of the clinical pathways in place and were aware of how to access the relevant clinical policies and procedures in place via the health board intranet. Staff were also made aware of patient safety notices.

In the RAU and triage there were also stroke[38] and STEMI protocols for patient pathways, that were audited by the medical team. Staff said that they knew how

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[37] SHOT is the United Kingdom's haemovigilance scheme. It collects and analyses anonymized information on adverse events and blood transfusion reactions. When SHOT has identified risks related to transfusion, it produces recommendations within its annual reports to improve patient safety.

[38] https://www.wales.nhs.uk/document/180006

to access the relevant clinical policies and procedures but would not have time to access these during most shifts. Staff said that there had been an increasing use of bank and agency nurses who were not familiar with all health board protocols and procedures. Staff in the RAU said that best practice guidelines and care was delivered at the minimum level and believed that staffing and acuity prevented them from delivering the best possible care.

Staff felt that their personal standards of care were comprimised due to the sheer volume of patients and that patients were nursed in inappropriate areas. Staff described their frustrations in not being able to deliver care and treatments in a timely manner due to acuity. They felt they were able to deliver the minimum standards in order to deliver safe care for all patients but not their best care. All patients asked felt they were looked after and appreciated the staff were 'run ragged'.

In paediatrics and SAU the audits included health and safety and quality assurance. Staff in SAU said that best practice was facilitated for newly qualified staff by the Journey of Excellence (JOE) preceptorship[39] scheme. The journey of excellence competency based support programme, incorporated opportunities for rotation within and between divisional specialist areas. During this period staff would initially be of supernumerary status, then a novice period and finally a competent practitioner. Each stage would be supported by appropriate training days and objective setting.

Both paediatrics and SAU had an establishment that was currently fit for purpose. However, sickness and maternity leave would leave gaps in the rota that would be filled by bank or agency staff.

We saw evidence of regular audit activity, but the results of these audits were not displayed, in the main ED and SAU areas. These included dignity and essential care investigations, where the recommendations were shared with the staff in the relevant area. Additionally, there were one patient, one day audits that related to the care given to the patients, the records of the care and the environment around the patient. There was also a triage working group that met on a weekly basis to discuss triage audit results. We were told that triage nurses had ten sets of assessments audited before they were deemed competent.

[39] Preceptorship is a period to guide and support all newly qualified practitioners in the transition from student to autonomous practitioner.

Senior staff we spoke with said that they completed a number of audits, and the results were laminated to display to staff in the office. They said that risks were monitored throughout the day at the three daily safety huddles. They go through the safety in the ED and also look at ambulance issues, as well as the various areas in the EDs. We were also told there was a live risk register on Datix as well as three monthly meetings to discuss the risk register. One of the current risks relates to exhaust fumes from the ambulances outside the ED.

In the survey we asked staff whether senior managers were committed to patient care, 56 percent who expressed an opinion said senior managers were, 32 percent said they sometimes were, but 12 percent said they never were.

Sepsis

Staff were aware of the sepsis six[40] screening tool and identified cases as soon as they were able to. The national early warning score (NEWS)[41] and sepsis six screening tool were seen as being followed in practice, in majors and resus. When identified, patients were isolated where possible and treated along national guidelines. Nursing staff in the RAU reported that all doctors were receptive and approachable to concerns regarding the deterioration of patients and acted rapidly to instigate a sepsis six bundle. However, WAST staff reported delays in communication relating to antibiotics within the timeline, on some occasions, over the past few weeks for delayed ambulance patients. Again these were anecdotal comments and not witnessed during the inspection.

We were told by the practice educators that sepsis training was available for staff, this started at induction and the educators delivered the training, about how to recognise sepsis, what to do and how to complete a bundle.

From the sample of patient records checked we saw evidence that pain was being measured, actioned and evaluated in majors and the SAU. This was documented on the NEWS chart. Generally patients did not complain of pain, although one patient indicated that although they had paid relief, it was

[40] The Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.

[41] 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.

insufficient and they wanted to find out what was the cause. In majors and resus, sepsis was recognised and managed in a timely manner.

In the RAU and triage, staff were aware of flagging sepsis patients on questioning. The NEWS score was regularly calculated to ensure that sepsis risks and deterioration was captured early. We were told and saw evidence of the use of pain scores on triage as well as the use of Paediatric Glasgow Coma Scale (PGCS)[42] by triage nurses.

50 percent of patients agreed that care of patients / service users was the organisation's top priority, but 25 percent disagreed.

> *"As per my previous comments, patients stuck in waiting rooms for 12+ hours, some only being given a chair for 36 hours in sub wait or in ambulatory in a1. Not appropriate"*
>
> *"Standard of care cannot be seen as being toileted, fed sandwiches, developing pressure sores and further breakdown of skin caused by urine, and overall lengthily delays outside of A&e. History shows the lack of care provided by the Health Board by patients dying outside of A&e in ambulances. Members of the public arriving via own transport outside of A&e with family members in cardiac arrest due to no available ambulances"*
>
> *"Too dangerous to be a patient here accident waiting to happen"*
>
> *"I think money is the organisations top priority. Staff are the organisations lowest priority. Patients sit somewhere in the middle"*
>
> *"I feel we can never give the care that the patients need because we are always short staffed."*

51 percent agreed that the organisation acts on concerns raised by patients / service users and 23 percent disagreed.

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[42] The Paediatric Glasgow Coma Scale (British English) or simply PGCS is the equivalent of the Glasgow Coma Scale (GCS) used to assess the level of consciousness of child patients. The PGCS comprises three tests: eye, verbal and motor responses.

Only 31 percent of staff agreed they would recommend their organisation as a place to work and 36 percent disagreed. The remaining 33 percent neither agreed nor disagreed.

> *"I would strongly recommend that no-one should work in ABUHB and especially GUH. I would certainly not recommend it patients and would feel afraid if my family needed to attend."*

> *"Since the move to the Grange I no longer feel pride and a sense of achievement in my work. Work pressures and lack of staff mean I dread going in to work and don't feel I give a good standard of care. There are too many patients most shifts with unsafe levels of appropriately trained staff to care for them and I fear that serious incidents will occur because of this"*

Again, only 20 percent of staff agreed they would be happy with the standard of care provided by their organisation for themselves or for friends or family, 53 percent disagreed and the remaining 27 percent neither agreed nor disagreed.

> *"I fear the day I have to bring my own children to this department. It's dangerously under staffed, too small for the capacity and I fear nursing staff are going to have a serious incident on their hands the further in to the winter we go"*

> *"I would be nervous for a family member to be admitted to hospital at the moment as it is not physically possible to provide the best level of care to all patients as we just do not have the resources"*

> *"I would be mortified to bring my own children to the department. Although the nurses and doctors are wonderful and do their best the wait times are horrific and frustrating. There are not enough staff, waiting areas (nursing in corridors) beds, bathrooms, A&E just is not big enough for the volume of patients and nowhere near staffed well enough"*

> *"Personally for myself, if any of my family members or friends needed urgent medical care I would take them to a different hospital out of the AB Health Board/Welsh Hospitals"*

Quality improvement, research and innovation

Senior staff we spoke with described the quality improvement activities that had taken place. These mainly involved working on triage times, including redirection of patients, and the instigation of the RAU to improve the patient waiting times.

Additional Manchester triage training, led by the Nurse Consultant[43], was considered as excellent and had been effective in assuring safe and effective assessment at the 'front door'.

The ED had also welcomed the work of St Johns Ambulances, to support WAST colleagues and the British Red Cross in delivering patient care and comforts. These were widely appreciated by staff, patients and their relatives.

Record keeping

We viewed a total of 13 patient records in the various areas throughout the ED and the SAU. Notes we checked were clear and easy to navigate, with a structured rapid assessment pathway. Paper notes were folded and put into numbered metal racks in the RAU, which were situated away from members of the public or other patients. Medical staff document their notes on the digital system, when they saw patients.

Overall, we noted that the assessment of mental capacity was not documented in all patients as there was a presumption of mental capacity that negated the need for the assessment.

The records showed that the effectivenes of the care and treatment was evaluated regularly and that they were up to date and completed after care and treatment. In the main, documentation was legible and of a reasonable standard. Entries were signed, dated and timed in 10 of the 13 records checked. Nursing staff caring for a patient on a shift would sign the information form to demonstrate who was caring for the patient. Patient information was available at handover in majors and resus but was not seen in the SAU and in RAU. As described above there was evidence that other members of the MDT contributed to the patient's treatment plan, where a medical assessment and examination had been completed. Casualty assessment documents were not always completed fully.

Overall we considered that the quality of records was of a reasonable standard indicating the plan of care and management of patients whilst in the ED. The records were up to date and contemporaneous and were kept in an area that was

[43] The role of nurse consultant was introduced in the late 1990s to strengthen leadership in nursing, improve patient outcomes and enhance the quality of healthcare services. Nurse consultants have a wide-ranging remit that includes expert practice, professional leadership and consultancy, education, and service development.

not accessible to the patient and out of view of other patients. Triage records were concise and gave a good history of the patients complaint to staff. However, we noted that for three patients there was not evidence that oxygen had been prescribed, although the patient was using oxygen. Also as described above there were instances where fluid charts, sepsis pathway notes and capacity assessment were incomplete.

However, we did note that there were boxes of paper records awaiting scanning at the back of the reception desk. Some papers were considered to be on the verge of falling out of the boxes and could result in some notes being mis-placed or mis-filed. Whilst the contents of the notes could not be seen by patients in the reception area, we considered it did not give assurance to the public that records were stored securely.

Improvement needed

The health board must ensure that:

- All entries in patients records are completed in full, signed, dated and timed
- Paper records are appropriately stored away from patient view
- All medication is appropriately prescribed and signed
- Patient information is made available on handover and takeover.

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 observed all staff striving to deliver good quality, safe and effective care to patients, within very busy units. However, the comments of staff in the staff survey show that they could not always deliver the care they wanted to, due to a number of issues.

We found evidence of good teamwork and support amongst nursing and medical teams within all units.

We found that management and leadership was focused and robust, however, there was a reliance on temporary staff (bank and agency).

Governance, leadership and accountability

During our inspection, we invited staff working on the units to provide their comments on topics related to their work. As referred to above, HIW issued an online survey to obtain staff views on the ED and SAU at the hospital. In total, we received 136 responses from staff at the hospital. Not all respondents answered all the questions. The staff grades included care assistants, consultants including consultant paediatricians, doctors, emergency medical technicians and paramedics, HCSW, nurses and other roles. The staff stated that they had been in their current role from under six months to over 10 years. The majority of staff (111) said the ED was their base, and 25 said they regularly visited the ED to work, but it was not their base. We also spoke to a number of members of staff and senior staff during the inspection, both while we were inspecting the various areas and as formal interviews.

The HIW online survey indicated that staff were feeling overworked, due to understaffing, the volume of patients, and a shortage of ED experience. In addition, the survey indicated that staff believed there was insufficient space in the ED, hospital and the community to cope with the patient numbers.

We made arrangements for staff to be able to complete an online survey relating to their experience at the various areas within the ED and the SAU at the hospital. The survey was open between the 1st and 5th of November 2021.

Based on the responses received there were a number of tick replies to various statements. Whilst the majority of these were not negative, the number of 'sometimes' and 'never' or similar less positive replies, were considerably worse than has been previously noted on inspections. There were also a number of negative and strong comments made by staff.

From what we saw during the inspection, and the comments made to HIW inspectors, the management and leadership was good. We also noted the environment was quiet and calm, with staff going about their work efficiently, treating patients with respect. However, based on the survey comments, staff clearly feel that:

- There were insufficient staff to deal with the number of patients presenting, in a timely manner
- There is insufficient space to treat patients in a timely manner
- Some staff may not have sufficient experience in the ED
- General frustrations with patient flow as a whole
- Not being able to provide the level of care that patients deserve based on the above.

We also spoke to medical staff who had similar concerns regarding the availability of beds to move patients into, outside of the ED and being unable to treat patients because there were no treatment rooms available.

The percentages of the various replies and the staff comments are described elsewhere in this report. We were also told of a number of initiatives within the areas covered that have been introduced including the weekly nursing news and that 19.44 whole time equivalent staff were being recruited.

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.

We were provided with the daily situation reports during the inspection, which showed the numbers of patients in the various areas of the hospital, including the ED as well as the other minor injury units in the health board. This showed that there were more patients in the ED, than there were beds for them in the hospital and other eLGHs within the health board. The risks and issues related to the demand in the hospital and the (eLGHs) front doors remained higher than predicted, as well as staffing issues and COVID-19 presentations.

We were provided with the majority of the information we requested as part of this inspection after the feedback session. The health board dashboard of the health care standards showed that all the scores were good apart from communications which was recorded as 67 percent. Additionally we were sent training compliance percentages for each of the areas within the ED.

The CEAU SOP supplied, had the purpose of providing an overview of how the (CEAU) and Paediatric Short Stay Unit (SSU) would function. The SOP aimed to provide assurance that the CEAU and SSU provided safe and effective care to children in CEAU or by redirecting to alternative care providers and setting. The SOP ensured that the environmental processes and procedures were adhered to when emergency and GP patients attended the CEAU. Also, to ensure they were triaged, assessed and treated in a timely manner, promoting safety and effective quality care.

We asked a series of questions of staff about what happens when incidents and errors occur:

Question / Answer Choices	Agreed	Dis-agreed	Comment
Have you seen errors, near misses or incidents affecting staff in the last month.	63%	37%	
Had seen errors, near misses or incidents affecting patients in the last month.	70 %	30%	
The last time they saw an error, near miss or incident they reported it.	79%	6%	15% not applicable
Their organisation treats staff who are involved in an error, near miss or incident fairly.	49%	11%	40% neither agreed or disagreed
Their organisation encourages them to report errors, near misses or incidents.	83%	4%	13% neither
Their organisation treats reports of errors, near misses or incidents confidentially.	54%	8%	38% neither agreed or di
When errors, near misses or incidents are reported, their organisation takes action to ensure that they do not happen again.	52%	13%	35% neither

They were informed about errors, near misses and incidents that happen in the organisation.	42%	21	37% neither
They were given feedback about changes made in response to reported errors, near misses and incidents.	37%	22%	41% neither
If they were concerned about unsafe clinical practice, they would know how to report it.	95%	5%	
They would feel secure raising concerns about unsafe clinical practice.	70%	19%	11% did not know
They were confident that their organisation would address their concerns.	40%	29%	31% did not know

Staff reported, as above, that they did not always receive regular feedback on the Datix they completed with regard to poor flow and overcrowding. They stated that this made them less inclined to report in the future. One questioned what the point was and that they did not have time to Datix anyway. Staff comments on these areas in the survey included:

> *"Today I reported a patient that was admitted two days ago with acute pancreatitis and had been managed in a chair since admission"*
>
> *"We datix daily on near miss"*
>
> *"We datix everything! Majority of the time it is the only way we can cover our backs! When you have over 40-60 patients in the department and your short staffed medication is going to run late, checking and observing patients is delayed, staff don't get breaks, parents are constantly abusive"*
>
> *"We try to always report errors, near misses and incidents"*
>
> *"Concerns raised to hospital staff regarding patient with a suspected neck of femur. Unable to toilet patient and provide further pain relief. Datix completed regarding hospital delays outside A&E, quality of care provided, and harm caused. No initial actions taken by hospital staff. Response via health board due to datix raised. "*
>
> *"Raised numerous datix s about long patient waits, ASHICEs not being admitted on time etc. This practice has been getting worse not better."*
>
> *"Trauma calls were not put out for patients who met the Major trauma network escalation criteria, this lead to delay in CT trauma*

series and diagnosis. Some diagnosis were severe injuries, there were delayed diagnosis and treatment duration of several hours in some cases. Most of these cases were silver trauma. This was dealt with through discussion and evaluation at Governance meetings, and changes initiated. This is undergoing audit"

"Yes to my clinical lead. No to incident reporting. If I did, then I would not have enough time to see patients or would constantly be leaving work late. These events occur every shift. The consultants are aware of the issues but they themselves feel powerless to implement change due to the impositions placed on them by the health board. Fundamentally the place is unsafe"

"I do feel there could be more cross divisional shared learning. Some of what is needed with learning from incidents is more resource which is not always available due to lack of staff out there and lack of resource to the NHS"

"…We datix every shift and I've emailed right up to director of paediatrics and whilst they listen the department is still the same"

"Consultants are informed but juniors often aren't informed of these near misses"

"I am not too sure about feedback, as we all work too different and might not have a chance in time for feedback"

"Reported error …still not received an update"

Senior management we spoke with said that all incidents were reported on Datix and would be reviewed by the nurse in charge and then reviewed by the serious incident team. Depending on the severity of the incident the review could be carried out at corporate or directorate level. A senior clinician from ED would attend the serious incident meetings. Any actions plans would be fed-back to staff, through various methods including the nursing newsletter, email, and the online messaging application or to individual staff. We were told that staff would report incidents and that staff were aware of the list of incidents that should be reported. These included falls, pressure damage, medication errors, shortage of staff and patients held on ambulances, this would be done each shift. However, staff we spoke with said they felt they did not have sufficient time on the shift to complete Datix. Any concerns would be initially managed locally, and signed off at a directorate level. The concerns would be entered onto Datix.

We asked staff a series of quesions in the survey about the organisation they worked for, they replies are as follows:

Question / Answer Choice	Always or usually	Some-times	Never
My organisation encourages teamwork	80%	17%	3%
My organisation is supportive	59%	35%	6%
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	62%	35%	3%
There is a culture of openness and learning within the organisation that supports staff to identify and solve problems	57%	33%	10%
The organisation has the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings.	42%	47%	11%
Overall I am content with the efforts of my organisation to keep me/ patients safe	30%	51%	19%

A management structure was in place and senior staff described clear lines of reporting to the wider health board management team. Roles, responsibilities and lines of accountability were also described. However, we noted that in paediatrics the non-clinical operational responsibility was held jointly between ED management and the family and therapies management. We were told that this may cause an element of tension in the area.

Senior staff we spoke with described the on-call system, with a senior nurse at work throughout the week with onsite cover. There was an on call consultant during the silent hours. Additionally, senior staff were able to describe the gold, silver and bronze on call out of hours arrangements, with managers available during the core hours.

Senior managers we spoke with told us that whilst the four hour response time compliance at the ED were under 50 percent, the other minor injury units in the health board area had four hour response times over 90 percent. This meant that overall, the health board were just below the Welsh average for response times. The hospital was designed to accept ambulance only admissions, from patients with the most acute injuries or illness. However, the unprecendented demand, together with the pressures of COVID-19 had resulted in the issues described above in the staff comments. These included very long waiting times on

ambulances and in the waiting room. In addition, the inability to discharge patients out of the ED into wards in the hospital and in the community, as those hospitals were also full had added to the issues.

There were plans in place to build temporary and permanent additional waiting room space outside and adjoining both the main and paediatric EDs. Whilst these plans were in place, they will not be operational until 2022.

The inspection team saw evidence of good management throughout the areas inspected. This included ward managers ensuring they came in early to see the night staff in the SAU, a positive rappour between the senior nurse and staff in resus and majors and doctors and nurses working well in the paediatric area. We also saw strong leadship in paediatrics between flow co-ordinators, senior nurses and service managers, with the issues of the child at the centre.

We noted that triage staff were resilient and worked hard in a difficult working environment and that they balanced the risk to patients in the waiting room and the risk in the ambulance well.

We also visited the health board patient flow centre that is adjacent to the WAST headquarters near to the hospital in Cwmbran. The purpose of the flow centre is to aid the flow and direct patients to the correct places within ABUHB. It also assists with the step up and step down system. We were told that the majority of calls were from GP and healthcare professionals. The flow centre was operational 24 hours a day.

We were told staffing at the flow centre had not been a problem and they had recently recruited more non-clinical staff members, using bank staff when necessary. There were four non-clinical staff and four clinical staff on duty and there is also a consultant available on most days. Non-clinical staff go through specific training on using the pathways for each health condition such as falls, chest pain, stroke etc. They were supported by the clinical team who oversee decision making. The ability for the flow centre to facilitate the step up step down of patients depends on patients being identified early for discharge.

HIW published a Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover, as described above. The review recommended that health boards, and Welsh Government should consider what further actions were required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach was required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Improvement needed

The health board must ensure that staff are reminded of the need to complete a Datix report in every instance that met the relevant criteria.

The health board should consider the separate reporting arrangements in the CEAU and SSU, to address any potential conflicts.

The health board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.

Staff and resources

Workforce

Staffing

We noted that the paediatric area was well staffed during the inspection and able to provide all care requirement. Staff we spoke with also felt that there were sufficient staff numbers to meet clinical demand. We were told the senior and lead nurses review the acuity and use their professional judgement to staff the area accordingly. Staff understood their responsibilities when escalation was necessary for staffing reasons. There was also evidence seen during the inspection that the MDT worked well together. There was a paediatric emergency medicine consultant with dedicated session time allocated to paediatrics. Additionally, there were at least two registered children's nurses on duty.

Whilst the Nurse Staffing Levels (Wales) Act (2016) do not apply to the ED, there is a ratio and skill mix required within the ED establishment. We noted that staffing levels in majors throughout the inspection showed a deficit of a safe level of permanent staffing, in majors, during the inspection. There were shortages on all shifts and a high use of agency staff. Staff we spoke with indicated that they struggled on occasions in the ED. Senior staff were aware of their responsibilities when escalation was necessary for staffing reasons. However, the health and

care standards[44] dashboard for Standard 7.1 Workforce[45] (Health services should ensure there were enough staff with the right knowledge and skills available at the right time to meet need) – showed 100 percent compliance for the hospital since April 2021. We saw evidence of physiotherapists and OTs on the ward.

With regard to the reception, triage and RAU, staffing was within the agreed template during the inspection, but staff stated that acuity was stretching staff in all areas. Additionally, last minutes sickness or unplanned absences affect the staffing levels. We were told that acuity at the front door had been overwhelming in the past few days. Additionally, one member of staff said that the previous day had been the busiest shift of their career. Staff on triage and the RAU felt particularly stretched as demand was outstripping resources and triage times were not within the Manchester triage guidelines. At times of high demand, staff would recommend an extra nurse to carry out treatment for patients waiting in ambulances. When the area is overstretched, triage nurses were pulled to triage waiting room patients. The triage training group had regular meetings and staff had mentored sessions and training sign off. This promoted a safe and an evidence-based triage process. Safe and effective triage decisions have a fundamental impact on patient safety and outcomes in the ED.

HCSWs reported that the number of frail elderly patients requiring additional support and care had increased. We saw excellent co-operative working in the RAU between ECG technicians, triage nurses and receptionists. The work of the British Red Cross volunteers was appreciated by triage nurses and WAST staff. Also, we saw good collaborative working observed between porters and radiology staff.

In the SAU we also observed the MDT working well together, there were also rotational opportunities available for staff to the inpatients wards in the hospital and to wards on the Royal Gwent.

We were told by senior staff that an additional 19.44 whole time equivalent staff were being recruited, including two practice educators, to address the staffing issues described. Senior staff said that they follow RCEM guidelines when

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[44] https://gov.wales/sites/default/files/publications/2019-05/health-and-care-standards-april-2015.pdf

[45] Health services should ensure there are enough staff with the right knowledge and skills.

staffing the ED and that additional staff were requested following papers sent through the management structure. They said that the staff roster was reviewed daily to ensure there were the relevant and qualified skill mix on the ward. We were also told of the roster creators who send out the requests to the hospital bank and agencies to cover the shortfalls.

Sickness in the ED was described as high at 10 percent, whereas staff turnover was low at four percent. However, agency staff usage could be as high as 40 percent. The ED attempted to block book agency staff that were known to have the necessary induction and training, in addition to being able to access the hospital management system.

The Nurse Consultant we spoke with said they received incredible support from senior managers and from consultants and doctors. The deputy head of nursing for the health board told us that there was a close team in the ED, due to the work of the two nurses in charge. Additionally, one of ED sisters described the senior management support as ‘fabulous and faultless’.

The Nurse Consultant described the culture in the ED as very supportive, with a team approach. This was especially good considering the challenges that had been with the reconfiguration when the hospital opened, COVID-19 and the demand on the ED. The deputy head of nursing said that the culture was challenging at the moment, and that some staff only know working in this hospital. There may have been challenges with combining the different cultures in the Royal Gwent and Nevill Hall hospitals and there was still work to do, but all the changes were made with the patient at the heart of the work.

We checked the staffing rotas for the three months August to October 2021, the rotas covered all areas of the ED and a range of staff bands and skills mix. The areas were at the levels to ensure safe staffing, there were a substantial number of agency staff employed.

We were provided with the staff induction programme and the relevant organisational management structure for the urgent care division. We also saw the minutes of various meetings including a Patient Safety Forum, which showed the areas that were looked at such as audits, Datix and staffing. In addition, there were actions following the discussion including lessons learned for the staff.

The latest minutes of the band five nurses meeting covered topics including staffing and red resus, Datix, training and induction, and wellbeing and team building. The minutes included reference to discussions on staffing and skill mix, number of patients, wellbeing and the care that the nurses can provide in light of numbers of patients presenting to the ED. One nurse said they feared for their registration, resulting in the concerns being taken home by staff. We were also

supplied with copies of a document called the nursing news. This is a weekly update of any changes in the ED sent by the NIC.

In reply to the request for information relating to the hospital or health board policy relating to dealing with patients on ambulances in ED, we were provided with the self-assessment provided for a previous HIW WAST review and supporting documents.

Equality

We asked whether staff had faced discrimination at work within the last 12 months. 23 percent said they had (25 out of 111 staff), this included eight percent (9 out of 111 responses) who answered 'prefer not to say'. 85 percent of staff agreed that they had fair and equal access to workplace opportunities (regardless of the nine protected characteristics), five percent disagreed and the remainder preferred not to say. Additionally, 87 percent of staff who expressed an opinion agreed their workplace was supportive of equality and diversity, six percent said it was not and the remainder preferred not to say.

> *"I …have frequently heard discussions (in non-clinical areas) between staff that has been derogatory towards Transgender people (not patients - people in general). I have challenged these people when I have heard this but don't feel my concerns have been taken on board. I feel this could be detrimental to any transgender people who attend as patients as they have a fixed view on what the staff perceive as a life style. I've also heard derogatory comments between staff about attendances of people who have attempted suicide. As someone who has had MH concerns previously I find this very concerning and I find their behaviour discriminatory."*

All but one of the staff who expressed an opinion said English was their preferred language. However, only 44 percent of staff said patients were asked to state their preferred language and only half said that arrangements were in place to meet the needs of patients who had stated their preferred language is Welsh.

Senior staff we spoke with described how equality and diversity was promoted in the organisation. This included training days organised by workforce and organisation and development, where talks have been made. They said that the surrounding area had a diverse population as did the workforce. Attempts have been made to ensure the necessary equipment is accessible and considerate of people's needs.

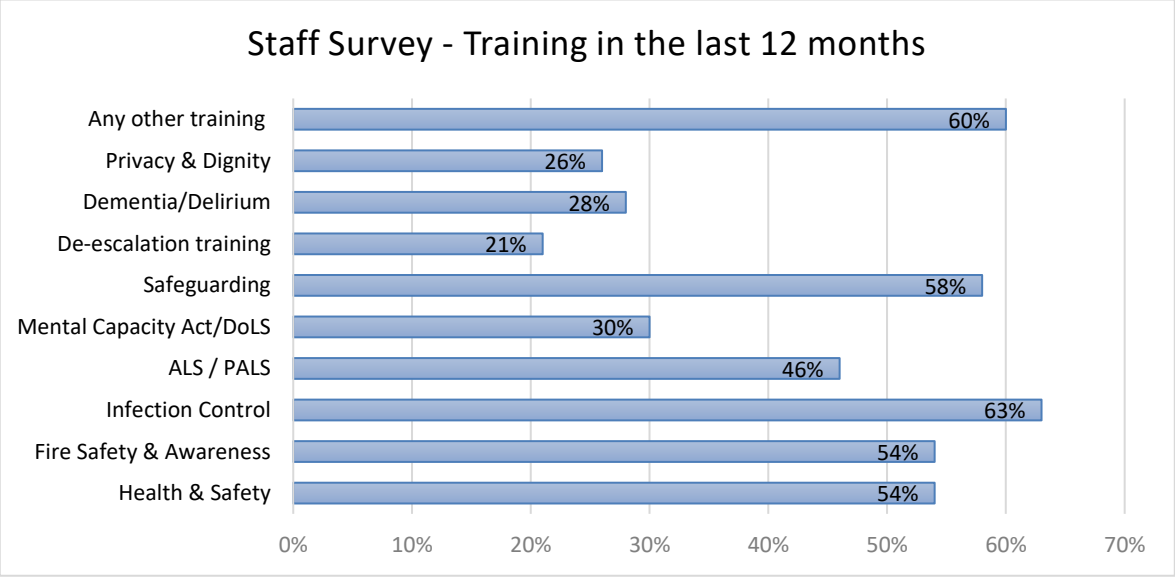
Improvement needed

The health board must ensure that processes are in place:

- To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to
- To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken
- To address the concerns of staff who believe they are not being able to care for patients as they believe they deserve to be treated
- To address potential issues with the wellbeing of staff.

Training

Staff who completed the questionnaire answered the question, yes in the last months to the question, have you had any training, learning or development (paid for or provided by your organisation) in the following areas as given in the graph below. It should be noted that some training does not have to be completed annually:



We received several comments on training, that staff would find useful, some of which are shown below:

> *"Preventing pressure sores/areas. Managing patients with cognitive issues such as dementia"*

"Training in long term care of patients on the back of ambulances, pressure sore prevention, toileting and changing patients who have been on an ambulance for a long time"

"Bloods and Cannulation"

"Mental health, we see so much mental health problems in the department but never have any training on how to best look after them"

"Trained to use all equipment that my band is allowed to such as blood gas and blood sugars. I feel this should have been done before I started as it impacts on my ability to help in emergency situations"

"Any training would be useful! Especially as we're expected to work in area's such as resus, paeds, covid. This is the most unorganised trust I've ever worked for, and everyone around me is saying the same"

"Injury training/plaster care/minor injuries as haven't received any since working at GUH and combined teams but expected to look after them and triage appropriately"

We also received general comments on training, some of which are shown below:

"I do a lot of training in my own time as the department is unable to release all the time I need to stay up to date with the skills I use daily. I am supported as much as the department can allow but it has been so busy and staff shortages are a constant battle."

"I joined the trust recently, I had no uniform on the day I joined, I had no pre inductions/ training. I was put with a mentor … for 1 week/3 shifts when I was told it was going to be for 2 weeks/6 shifts."

"We have been made to work in a very busy emergency department with little Emergency nursing skills. Especially hard when ED cannot staff the dept and it's left to Paediatrics to run the flow of the department with no skills in certain areas like plastering and dressings etc"

"I am now asked to help deliver training for level 1 major trauma competencies. I still have to complete these competencies myself, this is going to be completed with senior medical staff prior to teaching sessions to train staff"

The nurse in charge described the level of mandatory training as below what would have been expected. Management have been unable to give staff study leave because of the demand and staff self-isolating. As the ED was also an area that attracted newly qualified nurses, there had been a need to do other training to make sure that staff were fully competent within the area. New staff were given more time as part of the induction to ensure they met the competencies and they now had access to the systems at home. We were also told that appraisals had increased from 27 percent to 55 percent recently. All band sevens were emailed with compliance and who was overdue or about to require an appraisal to enable them to identify the appraisals due at an early stage.

We were pleased to note that there were two practice educators, at band seven, who also spend some time working as a sister in the ED. As described above the ED were about to recruit two band six practice educators. We were told that the two practice educators delivered a comprehensive training package, with new staff needing a wide depth and breadth of training. They provided triage training and also training on the requirements of being a non-medical referrer when requesting X-rays. In addition to providing induction training they also facilitated separate medication, safeguarding, violence and aggression, bereavement and other mandatory training. We were also told there was a plan to update every HCSW to update their basic life support (BLS) and to provide intermediate life support (ILS) and paediatric intermediate life support (PILS) for qualified staff, delivered by the resus team.

As described elsewhere, there were preceptorship and mentoring programmes in place for new members of staff to the ED. The educators also facilitated the learning audit with the local University. The educators aimed to have all trained staff up to the level of advanced life support (ALS) and paediatric advanced life support (PALS). However, places were limited.

The overall mandatory training percentages supplied ranged from 46 percent for Aseptic Non Touch Technique (ANTT)[46] Assessment to 91 percent for personal safety modules one and two. The mandatory training for staff working in the paediatric areas showed compliance for safeguarding level one and two to be 97

[46] This is a method of working where the practitioner follows the principles of asepsis to ensure that the sterile component (key part), for example, a needle, does not come into contact with non-sterile surface. Sterile gloves are not always required to undertake ANTT as long as the key parts are not touched by anything that is not sterile.

percent. However, this was not broken down as percent completed for each level. Additionally, the records provided did not show compliance for other non-paediatric staff who were required to support the paediatric area.

83 percent said training always or usually helped them do their job more effectively and 84 percent said training always or usually helped them stay up-to-date with professional requirements. 79 percent said training always or usually helped them deliver a better patient experience.

Regarding staff appraisals and clinical supervision, we asked a series of questions with the replies as follows:

- 75 percent said they had an annual review or appraisal within the last 12 months
- Only 28 percent said they have had clinical supervision[47] in the last 12 months, 63 percent said they have not
- 43 percent said their learning or development needs were identified and 57 percent said they were not
- 66 percent who answered the question, said their manager supported them to receive training or development, and 34 percent said they did not
- 52 percent who expressed an opinion said they had received full training on all areas within the ED.

We received comments from staff setting out where they had not received full training, some are shown below:

"Grange opened without cau staff having any a&e training"

"I'm a paediatric nurse, majority of the time department is so overwhelmed with A&E patients CAU patients are neglected, I'm

[47] The Royal College of Nursing states "[Clinical supervision is] the term used to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations.

required to do minor injury and A&E care without any training! I'd rather be providing proper care to my sick CAU patients"

"Minors - not applicable in GUH at present, Resus - no training dates available, Majors - no training dates available, Paeds - not seen as a priority"

"Paediatric Life Support (limited availability of training dates)"

"Not had injury training since teams joined together within paediatrics"

"SAU have a triage area i have not been specifically trained for"

69 percent who expressed an opinion said their competency based learning objectives were signed off before they started practicing in all treatment.

Improvement needed

The health board must ensure that:

- The levels of mandatory training are increased to ensure all staff have the necessary training to do their job properly
- All staff working in the paediatric area, whether paediatric nurses, or adult nurses supporting the area must be in date with level two safeguarding. The safeguarding lead must be level three in safeguarding
- Processes are put in place to ensure that appraisals are completed annually
- The appraisals are completed in full, including identifying training, learning and development
- Clinical supervision is completed annually
- Full training is given to all staff as necessary for each area in which they work.

Wellbeing

We asked staff in the survey whether their job was not detrimental to their health, and 65 percent of staff who expressed an opinion disagreed with this statement. Staff comments included:

"Work is no longer enjoyable and a pleasant place to be. The work load has increased massively which is what we expected but GP's are not seeing the simple things or refusing to even have a telephone call with the parents and directing children to ED which then creates a massive back log for the department and a significant number of children who do not to be seen in the ED department. They are then waiting for long periods and becoming aggressive towards staff which again makes the work place a horrible environment to be in"

"I'm exhausted on my days off. I often can't sleep when I get from home because of the stress"

"Don't feel enough break is given in between nights and day shifts. Too tired to do anything on my days off"

"The job in general is now detrimental to my health since moving to GUH and with the lack of space in the department, space in the hospital as a whole and the lack of staff. Some agency staff have commented that they would not come back to the department due to the above reasons. Stress levels are at an all-time high, anxiety levels are constantly raised both in and out of shift due to the worry of being unable to complete my work to my high standards with the situation of the department and worrying about what I have missed or the pressures on other staff members"

"My mental health suffers from working here, myself and I know many colleagues cry before and after shifts"

71 percent who expressed an opinion agreed their immediate manager takes a positive interest in their health and well-being and 55 percent who expressed an opinion respondents said their organisation takes positive action on health and well-being. The staff comments included:

"GUH lacks any facility for staff rest/relaxation. Staff welfare was not taken into account when building the hospital"

"I was assaulted in work and it was reported but I have not received any support, help or even been asked how I was. This occurred …months ago"

From the staff who expressed an opinion relating to further questions about their wellbeing and support:

- 64 percent said they are offered full support when dealing with challenging situations

- 90 percent agreed they were aware of the Occupational Health support available
- 55 percent agreed their current working pattern/off duty allows for a good work life balance.

Staff comments included:

> *"My work/home balance has been accommodated well"*
>
> *"We get our shifts so last minute. We currently don't know what's we're working in 2 weeks. How are you meant to have a work life balance when you can't make plans?"*
>
> *"Breaks are often missed due to demands within the department. Lack of staff and the acuity of patients mean that things cannot wait and staff regularly end up going late for breaks sometimes going up to 6/ 7 hours without a break or even a drink. Senior nurses try their best to support breaks and move staff to help but unable to do so resulting in long waits when short staffed"*
>
> *"I frequently do not leave the clinical area to go home until 1-2 hours after my contracted finish time. This is due to staff shortage"*

Senior managers we spoke with said that they were open to any feedback from staff, including through an online messaging group, an open door policy and staff were encouraged to email or speak to the nurse in charge.

Senior staff also stated that sickness was about supporting staff and identifying any issues. They regularly made referrals to occupational health, normally within three weeks. There were telephone consultations and advice given over the phone as well as face to face. Referrals to the wellbeing service is by self-referral. During the height of the pandemic there was a clinical psychologist available in the ED and people were aware of the services available. There were wellbeing leads in the ED with responsibility for various areas.

We asked staff a series of questions about their immediate manager. From those who expressed an opinion their replies are below:

- 74 percent said their immediate manager encouraged those who work for them to work as a team
- 68 percent said their immediate manager can be counted on to help with a difficult task at work
- 58 percent said their immediate manager gives clear feedback on their work

- 49 percent said their immediate manager asked for their opinion before making decisions that affect work
- 75 percent said their immediate manager was supportive in a personal crisis.

We received comments on ‘my immediate manager’, some of which are shown below:

> *“My manager [NAME] has been so supportive, she really is trying hard, she’s constantly fighting for us and advocates for our department. Whereas the [OTHER MANAGER NAME] does NOT work with her or support a united front.”*
>
> *“Extremely supportive and empathic manager who wants what is best for staff and patients”*
>
> *“I have recently been bereaved and have had amazing support from all my managers”*
>
> *“I feel fully supported by our senior nurses, they are incredibly hard working and I always feel positive working with them. They encourage the best standards of care and act on problems immediately. True role models.”*
>
> *“I don't feel supported at all (in) my work place, especially as an NQN”*
>
> *“I have not frequently needed support for personal crisis but have found support is poor for both professional and personal matters”*
>
> *“All of the senior nurses try to help staff as much as they can but are stretched due to the amount of staff in the department and the workload that things can get missed. They always aim to be approachable and helpful when required. Teamwork is always promoted and encouraged and serious issues are never ignored.”*
>
> *“My line managers in the last 12 months have been very supportive and understanding, looking after me. Truly hard working, trying to keep patients and staff together. Working out different ways to keep patients and staff safe and happy, so important”*
>
> *“Many colleagues have not been supported through work & personal crisis and feel left to deal with this alone or come to work when they shouldn't”*

We also asked a series of questions about the senior managers, the replies, where staff expressed an opinion and staff comments are below:

- 84 percent said they knew who senior managers were

"[NAME] is always visible, always emails and shows her presence. Always listens if staff have something to say and is constantly trying to help…She takes our feedback and tries to work with the senior nurse for A&E."

"Never see our senior managers. We go to our band 6s or 7s with our problems"

- 49 percent communication between senior management and staff is usually effective

"Our senior managers are constantly within the department and looking for ways in which to improve the area taking on board staff feedback. They are always very approachable and friendly and will listen to concerns…"

"Never met or been introduced to our senior nurse. Feedback was asked for off staff only after 7 (maybe more) qualifieds left for a new job due to stress. Never had any outcome or response from feedback following its collection…Our senior nurse has never attended or called a staff meeting despite multiple issues being raised. Constant criticism of staff and ward level managers despite rarely coming to the unit"

- 38 percent said senior managers try to involve staff in important decisions

"Dr [NAME] comes in every Wednesday, on top of her ward weeks, on calls, night and day cover, to explore improvement and changes, which are helping"

- 38 of the 105 who expressed an opinion said senior managers acted on staff feedback.

We asked staff a series of questions about their work environment, the replies of those who expressed an opinion and their comments are given below:

- 26 percent said they were 'always' or 'usually' able to meet all the conflicting demands on their time at work, 10 percent said they were never able to

- 45 percent said they ‘always’ or ‘usually’ had adequate materials, supplies and equipment to do their work, eight percent said they never do

- Nine percent (11 of the 127 who expressed an opinion) said there were always or usually enough staff working in the department to do their job properly, 42 percent said there were never enough

“The newly introduced one staff nurse to five patients in green majors is not safe and bad”

“… very often there are too many patients and not enough staff to provide the standard of care that everyone deserves”

“I have never seen a busier place in the UK! It is unsafe sometimes”

“The ED is so thinly stretched, lack of capacity and lack of skilled staff, the standards of care is compromised.”

“The frontline staff try so hard to provide care of a high standard and to the best of their ability but staffing is so poor and support from managers (&higher) is so lacking it is difficult for them to safely meet the demands of the service and ensure care is of an adequate standard. Observation/assessment/treatments can be delayed, nutrition and hydration needs can be unmet and there can be lengthy waits in the department due to the pressures of poor staffing, high patient volumes and lack of space”

“Rapid assessment is the biggest risk. Normally has 2 qualified and a HCSW for up to 60 patients. How can they be expected to care for that many?”

“Staff are overworked as there are up to 10 nurses short and more HCSW each shift. This then escalates to training days being cancelled due to the department being unsafe which has a lasting effect on care, safety and staff education/ well-being”

- 56 percent said they were ‘always’ or ‘usually’ able to make suggestions to improve the work of their team / department and 13 percent said they never could

- 39 percent said they were always or usually involved in deciding on changes introduced that affect their work area / team / department, but 35 percent said they never were

- 88 percent said they knew how to escalate concerns when the department was close to capacity

"We can escalate, but nothing happens, as there is no flow/space/staff to change what is happening in the department"

"No matter how high we escalate our concerns over high acuity and no capacity we are always told to do the best we can at the time and that adults are 10 times worse than us! I feel as a management team within CEAU we cannot escalate any further than we already have! The department is at its all-time lowest and although changes are being made to help the flow in the day time, nights are worst and I fear the further in to the winter we go the more staff are going to be worried"

"Escalation to ED nurse in charge and EPIC - rarely with any help or benefit! Then to Paeds consultant and coord who usually try and help if their able to"

"Often concerns of escalation are ignored, or answered with " well there's no space" or " nothing I can do about it""

"Quite often even when concerns are escalated there is simply not the capacity to do anything about it"

"The department is always over capacity. Bed managers never do anything when we escalate and just think it's acceptable to keep patient on ambulances and in the waiting room for 12 hours. There is no flow through the department. How are we meant to do our job when there is no room?"

"It is all well and good escalating but there is no way of dealing with the number of patients when we can't get people through the system"

"Yes but no time to Datix and I have been reprimanded for datixing in the past"

"I often feel very unsupported from senior staff even when I've escalated concerns"

- 79 percent said their organisation encouraged teamwork
- 59 percent said the organisation is 'always' or 'usually' supportive
- 66 percent said front-line professionals who deal directly with patients, are 'always' or 'usually' sufficiently empowered to speak up and take

action if they identify issues in line with the requirements of their own professional conduct and competence

- 57 percent said there is always or usually a culture of openness and learning within the organisation that supports staff to identify and solve problems and 10 percent said there is not.

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 immediate concerns were identified.			

Appendix B – Immediate improvement plan

Hospital: The Grange University Hospital

Ward/department: Emergency Department, including Paediatrics, Majors and Resuscitation, and the Surgical Assessment Unit

Date of inspection: 1 – 3 November 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 ensure that there are measures in place to ensure that:				
All patients accommodated in the waiting room are observed and monitored to ensure their safety, at all times.	Standard 2.1 Managing Risk and Promoting Health and Safety	Additional cameras to be installed into main wait to observe all areas and ensure no blind spots. Triage TV already installed, a further TV to be installed into reception and majors office, this will ensure waiting area can be observed at all times.	Director of Operations Service Lead / Clinical Director / Divisional Nurse	November 2021
All patients accommodated in the children's assessment unit waiting room are observed	Standard 2.1 Managing Risk and Promoting	A call bell and additional cameras will be installed in the CEAU environment, the latter to ensure	Service Lead	December 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
and monitored to ensure their safety, at all times.	Health and Safety	view of the blind spots within the area.		
		Additional Health Care Support Workers (HCSW's) currently being recruited to improve visibility into the waiting room and to support the 'rounding' / assistance to families and children in the area. Temporary staffing will be utilised in the interim.	Senior Nurse	January 2022
All patients accommodated in the surgical assessment unit chairs are observed and monitored to ensure their safety, at all times.	Standard 2.1 Managing Risk and Promoting Health and Safety	Corridor care moved into main wait area by converting a large cubicle space to ensure patients are observed at all times.	Divisional Nurse/Senior Nurse	Completed
The health board is required to provide HIW with details of the action it will take to ensure that:				
The risk of cross contamination is reduced in the area known as the COVID corridor.	Standard 2.4 Infection prevention and Control (IPC)	Ensure robust IPC precautions and pathways are adhered to as directed by Infection Prevention and Control Team this will be monitored and audited.	Assistant Divisional Nurse/ Head of IP&C	December 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Suitable hand washing facilities are provided.	and De-contamination	Hand wash basin was installed on 5th November 2021.	Service Lead/ Clinical Director/ Senior Nurse/ Divisional Nurse	Completed
Printing facilities are available within the corridor.		Photocopier installed.	Director of Operations/ Operational Service Manager	Completed
Risks are mitigated in the corridor care when the number of patients is greater than can be managed by the normal staffing level.	Standard 2.1 Managing Risk and Promoting Health and Safety.	Staffing is risk assessed across the department, hospital and HB wide. Staff deployed as clinically appropriate. Additional substantive ED nurses currently being secured following agreement from Executive Team to increase ED Nursing establishment by 19.44WTE.	Service Lead/ Clinical Director/ Senior Nurse/ Divisional Nurse	Completed January 2022
Resuscitation equipment and medication is always available and safe to use in the event	Standard 2.6 Medicines	Safety ALERT distributed across the Health Board.	Senior Nurse / Divisional Nurse	Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
of a patient emergency within the emergency department and within all other wards and departments across the health board.	Management and Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	IA-2001-18 resuscitation trolley A new sealed system is currently being implemented across the Health Board for emergency trollies. As a priority this has now been implemented in ED**.**	Resuscitation service Senior Nurse/Divisional Nurse	Completed Completed
The health board is required to provide HIW with details of the action it will take to ensure that:				
The areas of dissatisfaction shown by staff are addressed.	**Standard 7.1** Workforce	Executive Team are leading a "People First Staff Engagement" programme to concerns highlighted through a series of internal and all Wales staff surveys. To commence w/c 15th November 2021.	Executive Director for workforce and Organisational Development	Commence November 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		ABUHB Staff Survey to commence 22nd November 2021. The on-going support being provided will identify and support the concerns raised.		
Staff are updated regularly on the action taken to address the issues raised.		Nursing News sent every Friday which contains relevant departmental information and any new developments. 'You said, we did' board to be implemented.	Senior Nurse / Divisional Nurse	Completed
		Quarterly staff meetings to be arranged.		January 2022
A similar exercise is carried out to establish the improvements in the actions taken by the health board.		Regular Health Board Wellbeing Surveys are already in place and have been used to inform our wellbeing offer across the Health Board.	Executive Director for workforce & Organisational Development	November 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		ABUHB Staff Survey to commence 22nd November 2021.		
On-going support is provided to staff, to promote and maintain staff well-being.		Fully trained and supervised peer support network to be set up from 30th November 2021, including input from Prof Richard Williams – specific to ED Access and training provided for psychological debriefing encompassing the 'critical incidence stress management' process. Access to the ABUHB staff wellbeing service. OD support provided for staff including management drop in sessions. 2 Wellbeing Consultants and 2 Band 7 Nurses – facilitating well-being sessions.	Executive Director for workforce and Organisational Development	Immediately / Ongoing

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Open door availability to meet with Senior Nurse.	Senior Nurse	Immediately / Ongoing

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: The Grange Hospital

Ward/department: Emergency Department and Surgical Assessment Unit

Date of inspection: 1 – 3 November 2022

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				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • More leaflets or posters are available in all areas of the Emergency Department (ED) relating to support groups • Where applicable patients should be questioned about how they are looking after their health and this should be documented on patient notes • The Right Place message is advertised further throughout the health board area, including in health centres, clinics and GP practices.	1.1 Health promotion, protection and improvement	A selection of Health promotion and awareness/support posters are now in place. Within the medical clerking proforma the assessing clinician will ascertain a number of social, health and wellbeing information including home circumstances, weight, BP, smoking, drugs and alcohol. Where necessary appropriate referrals will take place When patients are admitted to a ward the Patient Care Record is completed and Health Promotion is discussed Choose Well has been reinforced to service users and Health Care Professionals via the Health Board's website and social media platforms.	Service Lead / Clinical Director / Senior Nurse / Communications Team	Completed
Health board must ensure that: • Staff are reminded of the need to consider any communication	4.1 Dignified Care	The intercom/hearing loop on the main reception has now been moved which has improved communication /confidentiality during the booking in process.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed & Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
issues with patients when speaking with patients • Staff are reminded about the need to ensure privacy and dignity and confidentiality when speaking to patients in areas where they can be overheard • The communications with patients in the waiting room are improved to ensure confidentiality, including the hearing loop • More room is made available in the main reception area and for the triage area for patients • They consider the comments raised by staff who do not work in the ED and provide HIW with the work they are carrying out to address these issues		Staff have been reminded of the importance of maintaining patient privacy throughout the department. Private rooms are available if required. There is ongoing work to improve the space within the waiting room and majors area of the ED. In May 2022 a temporary structure is planned to be installed which will house a larger waiting area, triage area and assessment rooms whilst a permanent solution is developed to improve the current waiting area. When this opens the current waiting area will be redesigned to accommodate an improved rapid assessment area where the nursing staff can visualise the patients safely and patients receive timely treatment and care in an appropriate environment. Weekly meetings with WAST colleagues continue with a focus on QPS. There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		May 2022 / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The section on the patients' notes in relation to capacity, comfort and dignity is completed in full • That patients are not required to wait on chairs overnight • The chairs used in the corridors are changed to reclining chairs to ensure patients can wait comfortably for their treatment, especially when having to wait long periods • The use of alternative pathways for cancer palliative patients to avoid attending the ED • A secure soundproof confidential area be provided where ambulance staff can exchange information and handover patients away from a public corridor.		Comfortable chairs have been purchased and delivered to improve patients comfort within sub wait, Red corridor and A1. Fit to sit criteria in place and all patients in chairs are assessed with appropriate escalation to the site ops team in the event of concerns. ED escalation process is in place. All staff have been reminded of the importance of completing documentation fully. Daily one patient one day audits to continue to monitor completion of documentation. Monthly Dignity & Essential Care Inspections undertaken by Senior Nurse and Deputy Head of Nursing. Cancer pathways are in place but will depend on the patient's presentation in terms of where they need to attend. There is a dedicated ambulance triage area. A private room is available if required.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Where crews are held the ambulance triage nurse will go to each ambulance to undertake timely triage. Crews' handover at the patient's bedside to maintain confidentiality.		
The health board must ensure that all signage is in an area that can be seen and that patients, including those with sight difficulties, can see the signs.	4.2 Patient Information	All signage on the first floor has been reviewed. Plan in place to remove and install new signage where the font was assessed as being too small.	Estates Manager	May 2022
The health board must consider ways of ensuring that communication with patients waiting for care or triage is effective, on the initial call to avoid delays in treatment.	3.2 Communicating effectively	Patient information screens have been installed in the ED waiting area and the content for the screens including Choosing Well, Health promotion, support groups is being finalised Reception staff will inform patients when booking in of the approximate waiting times.	Service Lead / Clinical Director / Senior Nurse	May 2022
The health board is to provide HIW with the update on the actions taken to:	5.1 Timely access	The ED is working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good	Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Introduce an electronic waiting time board • Reduce the waiting times for patients • Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms. The health board must ensure that staff in the ED and WAST staff are all aware of their responsibilities for the patients when in the ambulance until they have been offloaded into the ED, including for pressure relief.		practice as recommended by the Royal College of Emergency Medicine. The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times. The ED and assessment units have invested in alternative roles to support medical staff and reduce the wait to be seen time (Nurse Practitioner's / Physician Assistants / Acute Care Practitioners). There is continued work across the Health Board to improve the flow of patients through the ED and assessment units. There are agreed policies with the ED and WAST in place, with roles and responsibilities outlined.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • Patient records are completed in full including clear evidence of a transfer of care and discharge planning. • The necessary arrangements are in place to ensure that transport had been ordered and community support had been requested.	6.1 Planning Care to promote independence	The HIW report has been shared widely across the teams working in ED / CEAU and SAU to share learning. Daily one patient one day audits to continue to monitor completion of documentation. Monthly Dignity & Essential Care Inspections undertaken by Senior Nurse and Deputy Head of Nursing. Nursing staff will ensure appropriate discharge arrangements and transport is in place to ensure a safe, effective and timely discharge. A discharge checklist is available within the nursing documentation. Staff have been reminded about the importance of completing a timely and safe discharge.	Band 7's / Senior Nurse / Nurse in Charge	Completed / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • The location of the room for patients at end of life should be reconsidered to ensure that the patient and relatives are able to spend their remaining time together at peace in a secluded or quiet area • Further arrangements are put in place to ensure that all patients are made to feel that they can access the right healthcare at the right time.	6.2 Peoples rights	Where possible all patients who are End of Life will be transferred to a ward cubicle. If this is not possible patients will be cared for within a cubicle in the ED or assessment units. A new End of Life ED nursing document is being implemented to improve the management of End of Life patients. Choose Well has been reinforced to service users and Health Care Professionals via the Health Board's website and social media platforms. A redirection policy in place within GUH and is constantly being re-enforced.	Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • A system is put in place to ensure that patients are made aware of the actions being taken as a result of their feedback • They address the staff perception that no action is taken on patient feedback • Staff are all made aware of the results of the feedback and of the actions they are taking to address the comments made.	6.3 Listening and Learning from feedback	All informal concerns raised are addressed contemporaneously. In line with PTR guidance, all complaints / concerns are followed up with a telephone call from a senior member of the relevant department. If unable to resolve the concerns verbally a formal response will be provided from the Chief Executive. Staff encouraged to raise concerns verbally and/or via Datix. Senior management team visible daily giving staff the opportunity to raise concerns and escalate issues. Concerns and actions will be discussed with staff members and feedback provided of actions taken.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed
Delivery of safe and effective care				
The Health Board must ensure that a procedure is put in place for the management of patients in custody	2.1 Managing risk and promoting	Patients in custody will be cared for in a private, discreet area.	Service Lead for Surgical Assessment Unit	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
that ensure that their dignity and safety is maintained, should their condition be liable to deteriorate. This procedure should be agreed with the local constabulary to ensure they are aware of the procedure. The Health Board must inform patients of the current plans in place to change the design of the ED, including the changes to the waiting rooms and any plans for an additional minor injuries area.	health and safety	ED have an agreed process in place to manage patients in custody. Communications team have informed the public of planned developments via social media.	/ Clinical Director for Surgical Assessment Unit / Senior Nurse for Surgical Assessment Unit / Communications team	
The Health Board needs to ensure that: • Pressure risk assessments are completed in full for all patients • Sufficient pressure relieving mattress are available for patients at risk.	2.2 Preventing pressure and tissue damage	Patients identified at risk will receive the appropriate pressure relieving devices. The importance of pressure area care has been shared via the nursing news in ED. All pressure ulcer Datix are reviewed by the Band 7's and appropriate actions implemented. Equipment is available for use based on patient risk assessment.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that patients in beds have easy access to the call bells.	2.3 Falls Prevention	The importance of call bells within reach has been reinforced through ED Nursing News. Daily one patient one day audits continue, which includes checking call bells are within reach. Monthly Dignity & Essential Care Inspections are undertaken by the Senior Nurse and Deputy Head of Nursing.	Senior Nurse/ Nurse in Charge	Completed
The Health Board must ensure that: • Assessments are carried out on patients about their ability to eat and drink • That appropriate support is given to those patients who needed support • Patients are repositioned prior to eating, to ensure that they are able to eat and drink the food	2.5 Nutrition and Hydration	Patients are assessed on their clinical presentation which includes eating and drinking. Patients will be repositioned to ensure they are in a safe position for feeding. Patients will be offered hand wipes prior to mealtime. This will be supported by all staff, including Red Cross and the ward assistants. The ED will ensure intravenous fluids are recorded on the All Wales medication charts.	Senior Nurse/ Clinical Director	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Patients are offered hand washing or hand wipes prior to or after eating and that they are encourage to use these facilities before and after meals • Nutrition and fluids are recorded appropriately on the relevant documentation • All staff are trained on the use of the All Wales Nutrition charts.		Fluid balance is recorded within the ED Patient Care Record which is a mirror image of the All Wales Fluid Balance Chart. The All Wales Nutrition chart is being introduced into ED. Training is included within induction for new staff.		
The Health Board must ensure that: • Staff on a medication round, wear the appropriate tabard and are not disturbed when dispensing medication • Further attempts are made to maintain patient privacy when asking patients to confirm their information during the dispensing of medication.	2.6 Medicines Management	Tabards are not used within the ED and assessment units due to the variability of timing of admissions and need for medication The correct medication administration process has been reinforced to all nursing staff. Staff have been reminded of the importance of confidentiality when checking patient's demographics prior to administering medication.	Senior Nurse	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: • Additional training is given to staff to raise their awareness and knowledge of DoLS • Documentation is completed in full on the capacity of patients in their notes.	2.7 Safeguarding children and adults at risk	Additional safeguarding and DoLS training will be undertaken and cascaded through the department. All staff to be reminded of the importance of completing documentation in full. Daily one patient one day audits to continue to assess compliance. Monthly Dignity & Essential Care Inspections are undertaken by Senior Nurse and Deputy Head of Nursing to monitor documentation. Medical notes will include a full overview of a patient's cognition and plan of care.	Clinical Director/Senior Nurse	May 2022
The Health Board must ensure that all staff are made aware of Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances.	2.8 Blood management	SHOT awareness forms part of the IV training package. SHOT awareness re-enforced via Nursing News. Any infusion incidents are reported on Datix. The blood transfusion service then report these incidents to SHOT.	Clinical Director / Senior Nurse	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: • All entries in patient's records are completed in full, signed, dated and timed • Paper records are appropriately stored away from patient view • All medication is appropriately prescribed and signed • Patient information is made available on handover and takeover.	3.5 Record keeping	The ED will ensure patients records are completed fully and all medication signed for correctly, with assessment. Via daily one patient day audits. Monthly Dignity & Essential Care Inspections are undertaken by Senior Nurse and Deputy Head of Nursing. The ED will ensure all medication is prescribed correctly, assessed through auditing. Pharmacy will undertake medicines reconciliation. Scanned notes currently stored securely within appropriate boxes in the reception area to be removed from reception in a timely manner. Nursing staff have been reminded of the importance of a thorough and comprehensive handover of patients.	Senior Nurse Clinical Director	Completed
Quality of management and leadership				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that staff are reminded of the need to complete a Datix report in every instance that met the relevant criteria. The Health Board should consider the separate reporting arrangements in the CEAU and SSU, to address any potential conflicts. The Health Board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.	Governance, Leadership and Accountability	All staff have been reminded of the importance of completing a Datix. A list of Datix applicable incidents is available across the ED and Assessment Areas. CEAU remodelling is ongoing to improve patient flow which will reduce current conflict on bed allocation and enable full utilisation of all areas. There is continued work across the Health Board to improve the flow of patients through the ED and assessment units. The Health Board will provide HIW with an update on flow improvements.	Clinical Director/ Senior Nurse/ Directorate Manager Director of Ops	Completed May 2022 April 22
The health board must ensure that processes are in place: • To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are	7.1 Workforce (Equality)	There is Open Door availability to meet with the Senior Nurse, reinforced through nursing news. Staff have been encouraged to raise concerns verbally to a senior member of staff with confidence.	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
appropriately investigated and responded to • To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken • To address the concerns of staff who believe they are not being able to care for patients as they believe they deserve to be treated • To address potential issues with the wellbeing of staff.		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken. Senior management team visible daily to allow staff the opportunity to raise concerns. Wellbeing services are available to all staff within the ED, with regular sessions. There are 2 wellbeing consultants and a Band 7 Lead Nurse in place.		
The Health Board must ensure that: • The levels of mandatory training are increased to ensure all staff have the necessary training to do their job properly • All staff working in the paediatric area, whether paediatric nurses, or	7.1 Workforce (Training)	Two Band 7 and four Band 6 Practice Educators are now in place within ED. Ongoing training programme in place for ED staff. Journey of Excellence (JoE) programme available to all new nurse starters to the Health Board.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed / May 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
adult nurses supporting the area must be in date with level two safeguarding. The safeguarding lead must be level three in safeguarding. • Processes are put in place to ensure that appraisals are completed annually • The appraisals are completed in full, including identifying training, learning and development • Clinical supervision is completed annually • Full training is given to all staff as necessary for each area in which they work.		Improvement plan in place for annual appraisals. Statutory and mandatory training. A review of staff compliance re: safeguarding will be undertaken. Dedicated time will be provided to improve current compliance. An improvement trajectory will be introduced to review compliance monthly. Staff support and achievement of PDP's will be reviewed through the PADR process.	Directorate Manager ED/Surgical Leadership Team	April 2022 May 2022

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): Amanda Hale

Job role: Head of Nursing, Grange University Hospital

Date: 16 March 2022