Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Ysbyty Gwynedd (Emergency Department)
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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Ysbyty Gwynedd Emergency Department as part of its programme of assurance work. Ysbyty Gwynedd operates within Betsi Cadwaladr University Health Board and is located in Bangor, Gwynedd.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015.

Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

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

We spoke to the directorate general manager, head of nursing, matron and clinical lead on 21 February and a band 6 and band 7 ward staff on 23 February 2022 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- **How do you ensure that the environment is safe for staff, patients and visitors and that it maintains dignity and provides comfort for patients?**
- **How the staff management and governance arrangements ensure that the department is able to provide care that is safe and effective?**
- **How do you ensure that the flow of patients through the department is effective and that patients changing needs are assessed to identify acute illness and keep patients safe?**
- **How do you ensure that patient discharge arrangements are safe, including those patients presenting from vulnerable groups?**

Due to the intelligence we received prior to the quality check, we carried out additional work around patient flow, discharge, nurse documentation and patient records.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- Health and Safety risk assessment
- Most recent falls audit results
- Most recent pressure and tissue damage audit results

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We reviewed copies of the department's health and safety risk assessment, fall audits results and most recent pressure and tissue damage audit results. All were complete and up to date.

Staff informed us of the arrangements in place to ensure that unauthorised persons can't enter the department and patients with cognitive impairments can't leave unnoticed. The ward is either accessed via swipe card access, or from being let onto the ward by reception staff. In the emergency department (ED) waiting area, patients have to present to staff to be let off the ward and we were told that relatives are allowed to wait with any patients who have cognitive impairments or learning difficulties. We were also told by staff that there is a flagging process on the Symphony[1] system, whereby such patients can be highlighted and monitored through the system. We were informed that the Red Cross are also situated within the department and, if capacity allows, they or a healthcare assistant (HCA) will help support these patients if they attend the department alone.

Staff informed us that, if a vulnerable patients needs to wait to be picked up following discharge, they can be escorted to the discharge lounge to wait for their relative or carer. However, the current working hours of this lounge are only 9 – 5pm. Staff are in the process of extending this to 8pm and there are also other areas in the department where staff can take these patients to ensure they are safe and observed while waiting for discharge.

[1] Symphony – a clinical system for urgent and emergency care, supporting patient management, tracking and clinical workflow.

We were told that the department has a rapid response process in place for any missing patients, which triggers a search by staff of all local zones. The department also has a security team who work well with staff to help ensure patient safety. Staff also informed us of a system in place, whereby the three emergency departments across the health board meet fortnightly to share information across the sites. Staff expressed that they are keen to learn from each other and avoid mistakes being repeated in other emergency departments. Any lessons learned are emailed out to all staff and included in handover notes.

The following areas for improvement were identified:

Staff told us that patient toilet facilities are limited in the department, with one in major injuries department for 10 patients and only one toilet for all of the red[2] area. If a patient is in the resuscitation area, they either have to use a commode, or be transported by wheelchair to another area. Staff also reported that there are no washing facilities for patients in the department. They are able to offer patients a bowl of water and a towel to wash, however, there are no showers.

The Health Board should explore potential avenues for either increasing the number of toilets in the department, or improving access to the toilets for all areas of ED.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Generic infection control policies and Covid-19 specific policies

The following positive evidence was received:

Staff informed us of the changes implemented in the department as a result of COVID-19. The department was split into two, with one department solely for COVID positive and COVID suspect patients (Red) and the other for COVID negative patients (Green). We were told that that the space between the two doors to enter the emergency department is used to ask COVID specific questions by staff, then patients are directed to either the green or red department, depending on the information given. If a patient needs to go to the red area, they are either asked to walk round to an alternative entrance, or a nurse will escort them

[2] Red area describes the section of the department where COVID positive and suspected COVID patients are escorted to when arriving at the ED.

if they are vulnerable or too unwell. We were told that there is no waiting area in the red department and patients are either immediately directed to cubicles or to chairs supervised by nurses. There is also a separate isolation suite attached to the emergency department.

We were told that clinically vulnerable patients are flagged at reception and marked on Symphony to identify them to staff. According to staff, such patients are very proactive in identifying themselves and the department is currently working on a pathway with oncology to ensure these patients are managed safely.

Even though staff have tried to maintain social distancing whenever possible, they informed us that this is often difficult in busy periods. In busy periods, staff are able to move patients to other areas of the department if the waiting room becomes crowded. These areas have hand washing facilities and designated donning and doffing areas.

Staff reported that all patients are COVID swab tested prior to admission and all staff have access to, and are trained to use, the fast result testing machine. We were informed of a contingency plan in place, whereby if the machine breaks down, patients are transported by taxi to a nearby hospital, where the patient can be tested. Staff told us this has worked well.

We were also provided with information around the systems in place to ensure infection prevention and control (IPC) measures are effective and up to date in accordance with COVID-19 requirements. Staff told us that they have closed social media groups where any updates and new guidance is communicated. Any updates are also recorded on the 'nurse in charge' log and handover sheets.

We reviewed staff mandatory training records which showed high compliance rates throughout the department. Staff informed us that intense COVID-19 training was undertaken at the start of the pandemic and that staff are expected to complete all mandatory training on the online training system. All staff are trained in donning and doffing, and are fit mask tested. In addition to this, the acute intervention team have developed more advanced training around areas such as bed washing, training around the basics of IPC, and how to consider IPC in relation to respiratory risks and mitigations.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

The key documents we reviewed included:

- Current staff vacancies (listed by band)
- Current staff sickness (listed by band)
- Current percentage completion rates of mandatory training
- Current percentage completion rates for PADR (listed by band)
- Escalation policy
- The corporate policy/process to ensure preparedness for future pandemic emergency
- Staff mandatory training records
- Copy of review report undertaken by external IPC Nurses
- Rapid Response Policy
- Copy of most recent sepsis audit
- Last 5 adverse discharge forms relating to ED
- 10 sets of patients records – 5 over the age of 70 and a further any 5 admissions
- The number and a summary line of any reported incidents relating to delays with transfer of time critical patients. i.e. vascular, cardiac - 1 copy of an ED card for one of these patients
- The number and a summary line of any reported incidents relating to delays in imaging of time critical patients. i.e. vascular, cardiac - 1 copy of an ED card for one of these patients
- Any serious incidents relating to the two above subjects
- Discharge Policy

The following positive evidence was received:

We saw evidence of a complete current staff vacancy list and a list of all current staff sickness. We were also provided with a copy of an up to date corporate policy/process to ensure preparedness for future pandemic emergency.

When asked about staffing numbers in the department, staff informed us that they were currently in the process of recruiting staff at various grades to fill vacancies. We were told that the department has a dedicated ED staffing administrator, who will flag any concerns or gaps in regards to staffing levels.

Staff also informed us of the use of medical workforce within the department. They have some doctors on zero hour contracts who will fill some of the staffing gaps and consultants will also

act down to cover junior staff if needed. We were given the example of, during busy periods, doctors helping with triaging on the ambulances, as well as with patient observations. The department also has a designated progress chaser, whose role involves monitoring and chasing up patient COVID swab results, and a dedicated healthcare assistant working in triage, to help the registered nurses.

Staff told us the pandemic has created further issues with staffing, with many staff having to isolate at different periods. All vacant shifts go out to bank and regular agency staff who have been trained to work in this department, and to use Symphony.

We were told that, in addition to the training available through ESR, staff also have access to in-house training provided by senior staff. There are weekly slots for specific doctor training which staff informed us is classed as protected time and never cancelled. Nurses who complete home training online are paid for their time and are also encouraged to undertake additional training such as the Advanced Nurse Practitioner (ANP) course.

As part of our quality check, we also asked staff a number of questions around patient flow. We were told that all admissions are recorded on the Symphony system, which is live and can track a patient's journey through the hospital. Staff informed us that they aim to get all patients triaged in ten minutes, however, this isn't always possible, particularly in busy periods. The nurse in charge is responsible for managing triage, by monitoring the Symphony screen and documenting issues or key information in the information log.

We asked staff about the identification and management of any vulnerable patients within the department, including children, patients with learning disabilities or mental health issues, dementia patients, palliative care patients and patients with substance or alcohol addictions. We were told that the department has nurses specialising in all these groups therefore, if someone came in with complex needs they would use the relevant individual.

In the event patients are waiting for long periods of time in either the waiting area or main department, staff reported that they have regular help and input from the Red Cross and the food trolley also goes round both areas three times a day to provide food and drink for patients. Despite there being no shower or washing facilities for patients, staff will provide patients with a bowl of water and a towel. Staff will also ensure beds and pressure relieving mattresses are provided as needed.

We asked staff about the identification and management of sepsis. They informed us that there are regular sepsis audits undertaken and there is also a dedicated specialist who provides teaching around sepsis for department staff. Staff reported that the Symphony system has made the identification and management of such patients much easier and that Symphony will be rolled out across the entire health board in the next month, creating a live sepsis dashboard across the three emergency departments.

The following areas for improvement were identified:

After reviewing the discharge policy, it was clear that it wasn't sufficiently specific to ensure safe discharge of patients from the emergency department. Staff also confirmed that there is currently no internal discharge process or checklist in place to help staff discharge patients safely. HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of, and are trained in this process, to ensure the safe discharge of patients from this department. This improvement was raised as an issue requiring immediate assurance from the health board.

During the quality check, staff also raised concerns regarding delays in accessing transport for urgent and time critical patients to access tertiary and specialist care. The issues raised related to significant delays during in and out of hours periods in accessing timely ambulance transport. This was corroborated by the evidence we requested and reviewed in relation to incident reports and associated records. The health board must provide HIW with details of the action to be taken to reduce the delays in transfers of patients with time critical conditions for tertiary and specialist care. This improvement was raised as an issue requiring immediate assurance from the health board.

Whilst reviewing patient records, it became apparent that pain scoring was inconsistent and, therefore, subsequent action was also inconsistent. In all records reviewed where pain was either the primary or secondary presentation, pain scores were either not recorded consistently or not done at all. Also, in all cases, the patient's pain was not reviewed and reassessed in a timely manner. In one case, a patient who had a persistent pain score of 7 was discharged. They then returned critically unwell four hours later and suffered a cardiac arrest and sadly died. Their cause of death was related to their presenting complaint of abdominal pain. HIW requires details of the actions to be taken to ensure consistent pain scoring and safe and effective pain management for all patients. This improvement was raised as an issue requiring immediate assurance from the setting.

We also saw evidence of inconsistencies in recording of physiological observations and NEWS[3] scoring. In many of the cases we reviewed, observations were not undertaken at a frequency which would allow for early identification of deterioration. In some of these cases observations had deteriorated when rechecked after a significant period of time. We require staff to provide us with details of the action to be taken to ensure consistent recording of physiological observations and NEWS scoring for all patients. This improvement was raised as an issue requiring immediate assurance from the setting.

[3] NHS Early Warning Score (NEWS) tool is a scoring system used to alert clinicians to signs of deteriorating health in an adult patient.

During our discussions with staff it was also raised that current oversight of the waiting area is not adequate and there often aren't enough staff to constantly monitor and support patients here. There are live CCTV feeds of the waiting room on display in the nurse in charge's office, however, this isn't constantly monitored. We require the health board to determine solutions for this and recommend a staff member be assigned to oversee the waiting area every shift.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

- Ensure that the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Immediate improvement plan

Service:	Ysbyty Gwynedd
Area:	Emergency Department
Date of Inspection:	21st – 25th February 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Governance				
HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department	**Standard 5.1 Timely Access**	We will be requesting though the symphony user group to make the discharge checklist mandatory for ALL patients across BCU (as currently it is only mandatory for those patients where a decision to admit has been made) It has been agreed by ED Leads to include extra fields to the mandatory checklist including safeguards prompts concerns and mental capacity. The use of the ED checklist for all patients had been communicated and highlighted on the daily safety briefs and shared with ED team. For interim arrangements until the above can be implemented, the amended document below will be	Nathan Rogers – Lead manager Emergency Care ED Leadership Team	End of March End of March

		utilised for the next two weeks to support discharge process whilst Symphony is amended. Professional accountability will be reinforced through the ED Leadership Team in relation to responsibility and accountability when discharging patients from ED This will be completed in the monthly ED Governance forums and departmental meetings Symphony audits of the use of the checklist will be carried out on a monthly basis for each site, and accessible to the HMT. The BCU wide Discharge Policy is being reviewed and will include specific ED discharge elements. The first draft will be available in April 2022. Incidents and Learning from Incidents are shared across the 3 sites and good practice and ideas for improvements to be shared through the Emergency Care Board	Immediate Head of Nursing and Deputy Head of Nursing YG End of March Emergency care triumvirate Head of Nursing/Clinical Lead ED End of March Assistant Area Director – Intermediate Care Services and Specialist Medicine 29 April 2022 Emergency care

			Triumvirate across the Health Board	15 March 2022
The health board must provide HIW with details of the action to be taken to reduce the delays in transfers of patients with time critical conditions for tertiary and specialist care	**Standard 5.1 Timely Access**	The current process is calls are placed to WAST control either via the 999 route or direct access route. Concerns are escalated through the BCUHB calls with ODU input. Development of intra hospital criteria for rapid transfers to be created with ODU/WAST/NCCU input This is being reviewed with WAST to identify a direct clinical line to support rapid triage in conjunction with the ODU. The health board now has a specific transfer service (ACCTS) that supports critical care transfer but currently only has 1 EA and crew is so is very limited and a review of operational capacity and demand is being completed.	DGM EC – YG/ WAST ODU/NCCU ODU operational team Clinical Lead for ACCTS	May 2022 May 2022 May 2022
HIW requires details of the actions to be taken to ensure consistent pain scoring and safe and effective pain management for all patients	**Standard 3.5 Record Keeping**	Weekly Matron Observation Audits ongoing Daily Shift Leader Audits which	Matrons/ Heads of Nursing (3 sites)	Completed

		include specific questions around pain scores and pain management and the actions taken are to be launched with immediate feedback during both day and night shifts Assessment of patient's pain scoring to be made mandatory in Symphony when recording patient's observations. Alongside local workplace competencies, a National RCN framework which include the management of pain and observations will be launched for all Registered Nurses Sharing of concerns noted with ED teams, through safety briefs, departmental meetings and governance forums, highlighting the importance of appropriate pain management in the ED	Matron/ Heads of Nursing (3 sites) Lead Managers for Emergency Care Heads of Nursing (3 sites) ED leadership team	11 March 2022 March 2022 To be launched in March 2022 End of March 2022
Staff must provide HIW with details of the action to be taken to ensure consistent recording of physiological observations and NEWS scoring for all patients.	**Standard 3.5 Record Keeping**	Weekly Matron Observation Audits are being completed Daily Shift Leader Audits which include specific questions around patient observations and escalating the results are to be launched with immediate effect during both day and night shifts	Heads of Nursing (3 sites) Heads of Nursing (3 sites)	Completed 11 March 2022

		RCN Emergency Nurse management competencies which include the management of pain and observations are being launched for all registered Nurses Staff are being reminded of the importance of recognising non-verbal signs of pain and listening to patients and their families. This will be monitored through the observational audits and is included in the RCN competencies Sharing of concerns noted with ED teams, through safety briefs, Departmental meetings and governance forums, highlighting the importance of appropriate assessment and action taken when assessing patients observations/presentation	Heads of Nursing (3 sites) ED leadership team	Launched in March 2022 End of March 2022

Ysbyty Gwynedd (Emergency Department) Representative:

Name (print): Geraint Farr
Role: DGM Emergency Care
Date: 14th March 2022

Improvement plan

Setting:	Ysbyty Gwynedd
Ward/Department/Service (delete as appropriate):	Emergency Department
Date of activity:	21st – 25th February 2022

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

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

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	Staff to explore potential avenues for either increasing the number of toilets in the department, or improving access to the toilets for all areas of ED.	**Standard 4.1 Dignified Care**	COVID restrictions have resulted in the creation of 2 ED's with social distancing. There are facilities for both Red and Green ED's along with access to additional toileting facilities in the porta cabin to support. As a service ED currently has 14 toileting facilities within the department and meets the standards in line with Health and Safety for an emergency department of the size.	DGM EC/ HoN EC	Complete

2	Staff are required to improve their oversight of the waiting area. It is recommended that a staff member be assigned to this role on every shift.	**Standard 3.1 Safe and Clinically Effective Care**	This has been identified through the ED business case and funded; this is to have the capacity to support the waiting room with a HCA who can escalate concerns with the triage nurse. Due to short notice sickness and ongoing recruitment this is an ongoing challenge; we are utilising red cross, Security who are based in the waiting room, along with reception staff and when we have 8+ staff we can allocate oversight. Red cross/ Security have an oversight in that any patient who raises a concern i.e. feels unwell, looks unwell they will escalate to the NIC / Triage nurse to support and ensure the patient is safe. Red Cross walk around the waiting room at set times to see if patients require any support, such as either toileting or if possible anything to drink along with ensuring they are ok.	DGM EC/ HoN EC	Complete

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

Name: Geraint Farr

Date: 22/03/2022