Hospital Follow-up Inspection (Unannounced)

Prince Charles Hospital, Emergency Department and Clinical Decisions Unit

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Contents

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 follow-up inspection of the Emergency Department (ED) and Clinical Decisions Unit (CDU) at Prince Charles Hospital within Cwm Taf Morgannwg University Health Board on 18 and 19 January 2022.

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

The inspection was initially planned to focus on both the ED and CDU. However, on arrival at the unit, we were informed that were COVID-19 positive patients accommodated on the CDU. Consequently, a decision was made to focus on the services provided within the ED only, with very limited focus on the CDU.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

At the time of this follow-up inspection we found that the ED, as the front door to a wider system, continued to experience a period of heightened pressure due to an unrelenting demand on services as a result of the COVID-19 pandemic. Patient flow throughout the hospital remained an issue due to bed availability. Once again, we acknowledged that this remained a very challenging and stressful environment for some staff, who continued to work above and beyond in exceptional and challenging conditions.

We found that the health board had made significant progress in addressing and maintaining the majority of the improvements listed in the action plan drawn up following the previous inspection. However, some areas remained in need of attention and these are referred to in more detail within the relevant sections of this report.

This is what we found the service did well:

- Security and symptom checking at main entrance to ED
- Improved oversight of the waiting areas
- Clear COVID-19 care pathways
- Improved signage and information about care pathways
- Infection prevention and control
- Clean and tidy internal environment
- Auditing and reporting
- Security of paediatrics area
- Management overview of department
- Leadership and governance within the department, hospital and health board
- Safe-2-Start meetings.

This is what we recommend the service could improve:

- Standard operating procedure for the ambulatory area
- Privacy and dignity of patients in ambulatory area
- On-going observation and monitoring of patients in the ambulatory area
- Pain management
- Some areas of medication management
- Establish a consistent way to investigate outbreaks of infections
- Some aspects of nurse staffing
- Mandatory training compliance.

3. What we found

Background of the service

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

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

The Emergency Department (ED) consisted of:

- Reception area and waiting room
- Triage rooms – where patients are assessed in order to decide which are the most seriously ill and must be treated first
- Minors area – where patients with minor injuries or ailments are treated
- Majors area – where patients with more serious injuries or ailments are treated
- Ambulatory area - provides same day care to patients via assessment, diagnosis and treatment with the aim of getting patients home the same day, without having to be admitted to hospital overnight
- Resuscitation area – where the most seriously ill or injured patients are treated
- Separate paediatric treatment and waiting room
- COVID-19 positive waiting area
- GP assessment area.

The Clinical Decisions Unit (CDU) is located adjacent to the ED. Patients are admitted on to the unit directly from the ED and through direct GP referrals.

Patients who are admitted on to the CDU may require further investigations, procedures and stabilisation before being transferred to the most appropriate ward, other hospital or being discharged home.

HIW previously inspected the ED and CDU on 13, 14 and 15 September 2021, during which we highlighted a number of issues of concern which were 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. In addition to the matters dealt with under the immediate assurance process, we highlighted other areas for improvement which formed part of an improvement plan. The health board's response to the immediate assurances and other improvements highlighted was timely and robust. In addition, we received an updated improvement plan shortly after this inspection visit.

The purpose of this inspection was to follow-up on the areas for improvement identified at the last inspection.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We found that the health board had implemented and sustained the majority of the improvements, relating to the quality of patient experience, highlighted during the previous inspection. However, some areas remained in need of improvement and these are referred to in more detail below.

Areas for improvement we identified at our previous inspection

- The arrangements for the prevention and control of infections within the ED and CDU at Prince Charles Hospital did not protect patients and staff. Practices observed placed patients and staff at significant risk of harm.
- The arrangements for oversight and access to the waiting room, placed patients at risk of harm and unobserved deterioration. There were insufficient facilities to undertake essential clinical interventions.
- The use of the GP assessment area as a space for GP out of hours to assess COVID-19 positive patients, placed patients and staff at risk of infection.
- The environment was not designed in a safe way and was not always maintained to a safe level and this posed a risk of infection. The security of the department areas was insufficient and meant there was opportunities for members of the public to access all areas and this posed numerous risks including tampering with medicines, theft and threats to staff and patients.
- There were insufficient facilities for patients to use the toilet in the minors area, waiting room and GP assessment unit
- The department and GP assessment unit were significantly overcrowded to a level where this affected patients' dignity and safety.
- The paediatric area was not sufficiently staffed and the environment was not conducive to safe and dignified care.

What actions the service said they would take

- A structured improvement programme was launched in July 2021, and an initial plan developed. Progress is monitored through an executive sponsored Programme Board and upward reporting through the CTMUHB Governance Structure.

- A Project Initiation Document (PID) has been produced as the basis of the improvement programme of work. In early September 2021, this programme had completed the initial diagnostic of ED quality performance against Royal College of Emergency Medicine (RCEM) standards which identified findings consistent with the HIW review.

- An improvement director has been appointed to support delivery of the plan (which will incorporate the actions being carried forward from the review).

- Review of the risk register to align with the risk identified through the improvement programme, with a robust training and awareness strategy in place to ensure the team proactively manage the risks in line with CTMUHB guidance.

- Scheduled risk awareness session with the Assistant Director of Governance and ILG Head of Quality thus further strengthening the quality governance requirements.

- Monthly scrutiny panels to review all falls and pressure damage in line with the All Wales pathway. Whilst reviewing these cases consideration is always given to the potential delays and time spent within the ED on admission to hospital.

- Further training provided by the tissue viability nurse (TVN) across the CTMUHB. These actions are monitored within the ILG Quality and Safety meeting structure**.**

- The RCEM standards are directed at improving patient experience. An audit was completed by the Corporate Team to assess compliance in September 2021. Against the 34 Fundamental Standards, Compliance was 50%. Against 16 Development Standards, Compliance was 42%. Findings are in the process of being converted into a detailed action plan which will now be combined with the findings of the HIW review

- All staff briefed through a range of leadership and team briefs that have also been cascaded through the ED and CDU safety huddles.

- Cessation of the use of the majors corridor for patient care resulting in appropriate safe distance available to allow for donning and doffing of personal protective equipment (PPE).

- A donning and doffing champion/ monitor will be identified, and further training will be provided to the entire team. Assurance to be gained from daily Infection prevention and control (IPC) Audits.

- Head of Nursing (HoN) communicated with staff with regards to roles and responsibilities in line with the Cleanliness Standards Procedure, team leaders have been identified for the areas to ensure standards are maintained daily. Plan is in place to highlight the responsibilities of the multi-disciplinary team within the ED to maintain high standards.

- Adherence to the appropriate PPE guidance has been re-enforced to the clinical teams via several ways; Social Media, E-mail, Daily Safety Huddle.

- Staff engagement meetings. The daily morning nurse in charge review and afternoon senior leadership walk around also re-enforce the requirement for the appropriate standards of PPE, actively encouraging the team to challenge others should standards not adhere to guidance.

- Implementation of appropriate signage and posters to ensure staff and visitors are aware of PPE requirements within the department. The team have commissioned a company to install signage throughout the department and hospital site.

- A symptom checker placed 24/7 at the main entrance to the department to assess likely COVID-19 status of patients and segregate suspected or confirmed patients into an alternative waiting room. The symptom checker monitors the social distancing and PPE adherence for patients within the waiting room area to mitigate the risks as much as is possible.

- Immediate changes made to the operational policy within ED that has allowed the majors corridor to no longer be used to care for patients.

- There are a specific set of actions being progressed to revise the overall segregation of pathways in conjunction with Public Health Wales (PHW). Immediate make safes relating to the waiting room and separation of staff have been completed. The more detailed work relating to remodelling the ED is underway in conjunction with IPC and PHW.

- IPC annual audit completed in April with compliance of 61% - Immediate actions taken and completed. A further full audit completed by the IPC team of the ED on the 16th September and several actions were identified and compliance was noted to be 53% immediate measures taken to resolve the concerns.

- Ongoing monitoring of the areas continues daily with report submission between 7-9am by the nurse in charge with a report submission to HoN, Executive Nurse Director and Integrated Locality Group (ILG)[1] Nurse Director. Senior Leadership walk around of the department each afternoon to review the department acuity, IPC concerns and meet with staff and ensure strong leadership visibility.

- Review carried out of the Cleaning audit over past 12 months with average outcome of 89%.

- Housekeeping support increased to 24/7 commenced 20/09/21 with daily review of standards by the Facilities manager.

- HoN has communicated with staff with regards to roles and responsibilities in line with the Cleanliness Standards Procedure, team leaders have been identified for the areas to ensure standards are maintained daily. Plan is in place to highlight the responsibilities of the multi-disciplinary team within the ED to maintain high standards.

- Due to the footprint of ED it has been recognised within the improvement plan (June 21) that the medical staffing requirements by night are increased by one middle grade with the recognised benefits of improved flow, support for junior staff, improved safety, improved patient experience, improved referral times due to middle grade to middle grade discussion, improved four hour performance Reduce ambulance handover delays.

- Nursing funded establishment is 10 registered nurses (RN) & four healthcare support workers (HCSW); this is currently being reviewed

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

in line with the footprint of the department and the suggested changes to the department template, a staffing paper is in draft currently. Due to these challenges the staffing levels have been agreed over establishment to 13 Registered Nurse (RN) and five HCSW 24/7, this is inclusive of ensuring that the resus area has two Band six nurses present each shift- this was not previously a requirement.

- Within the review of the staffing establishment there has been consideration to the skill mix required within the staffing portfolio to support the services provided within ED. A training needs analysis has been completed to ensure all staff within the nursing establishment from Band two to seven have the skills and training opportunities required to fulfil their role.

- Staffing levels are monitored within a daily staffing proforma report which is shared with HoN, ILG Nurse Director and Executive Nurse Director, when staffing levels are not filled through bank or agency approval is sought for the use of Thornbury.

- Lead Nurse for unscheduled care has been meeting monthly with the Senior Nurse for ED to monitor the governance and management requirements of the role, performance development review (PDR). Sickness and vacancy rates form part of this meeting which informs escalation of concerns to the HoN. These meetings will now occur weekly.

- Review of incidents, concerns, complaints and patient experience feedback will provide triangulation of the effectiveness of the actions.

- Implementation of an HCSW ‘symptom checker’ role at the main door of the department to ensure that patients are directed to the correct area dependent on their presenting condition. The presence of this RN will always ensure oversight of the waiting area. Security officer is also present at the door to provide additional reassurance and support.

- Patients currently within the COVID-19 waiting area that is not within line of sight of the RN have a 30 minute rounding process in place to review the patients. The use of a call bell is being considered by the team.

- A pathway has been implemented to ensure all patients that have been triaged are prioritised and monitored in line with the Manchester Triage[2] guidance.

- An affray alarm has been installed behind the reception desk of the waiting room. This will allow rapid response in the event of a deteriorating patient being identified in the waiting room between 30 min rounds.

- An emergency nurse call bell is being installed behind the reception desk, which can be pulled to alert the medical/nursing team in the department of a medical emergency. Whilst this is being installed the team will be able to utilise the affray alarm in its place. This will be superseded once the minor works to remodel walls within the waiting area have been completed.

- As part of the ED pathway changes, additional capacity is being provided for minors which will improve waiting times within ED and reduce the number of patients waiting – aiding the reduction of risk in the waiting room.

- Doors between areas of the department have had break glass door release covers fitted.

- Magnetic security contacts have also been installed to ensure that the door system will lock and cannot be overridden. This will be monitored by the Nurse in Charge of the paediatric and minor injuries areas, whilst also re-affirming that the area is not to be used as a thoroughfare.

- The implementation of the symptom checker and security on the main door also ensures that the department cannot be used as a thoroughfare as they direct staff/visitors to the main entrance of the hospital to access other areas of the hospital.

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

- Additional signage to support the locking of doors is in production.

- In conjunction with colleagues from PHW, Improvement Cymru[3] and CTMUHB IPC, clinical and operational colleagues, a draft revised pathway has been developed. This pathway will address the issues raised within the visit relating to the overall separation of patient pathways, the use of waiting room areas, the use of the GP assessment space and unauthorised access to clinical areas

- Two outstanding issues require resolution:
    - Consistency of the current pathway with anticipated changes in the national IPC guidance (currently out to consultation)
    - Operational protocols for changes in the Paediatric Pathway to support the overall revised pathway proposal

- The pathway of care for paediatric patients is currently being reviewed to ensure the safe movement of children within the department. Due to the absence of clear data with regards to the time delays in patients being transferred to the ward the team have implemented an escalation process following 60 minutes of a decision to admit in order to inform the pathway decision making process. If patients are delayed for more than 60 minutes the team are required to complete a Datix[4] incident report to ensure each case is reviewed in a timely manner to ascertain the reasons for the delay.

- This pathway is further supported by the changes resulting in the cessation of the use of the majors corridor for caring for patients.

- Patients being cared for within the cubicles when admitted to ED will mitigate some of the risk within the management of COVID-19 patients.

- The role of the symptom checker will specifically focus on ensuring that COVID-19 positive patients are managed through a different access

[3] https://phw.nhs.wales/services-and-teams/improvement-cymru/

[4] Datix is an electronic reporting system for recording clinical incidents or 'near misses'. It allows for the sharing of the details of incidents; enabling weaknesses in the system to be identified, customs and practices to be changed and staff to be retrained where necessary. Datix allows incidents to be reported in real-time reducing delays experienced with paper systems.

point into the department. This is continually monitored throughout the day within the bed meetings and departmental huddles with escalation to the Senior Manager on call as required.

- We have reviewed the issue of Aerosol Generating Procedures (AGP)[5] in resus and the use of majors corridor for red pathway patients. We have no evidence via our Datix system that this has happened and reviewed the situation with the team who concur.

- We have however reconfirmed the existing pathway for the management of AGP pathways (using ward three) and the role of CDU cubicles for red pathway patients. The ED clinical lead will continue to monitor this issue.

- Outbreak Control Team structure is place within the health board to support the management of COVID-19 within the hospital sites.

- In order to complete this work, the following steps are required in conjunction with PHW and other stakeholders/ partners:

    - Completion of the full Quality Impact Assessment
    - Resolution of the paediatric pathway issues
    - GP pathway patients to follow the overall pathway or find an alternative location
    - Some estate minor works to be completed
    - Finalise MDT staffing model to ensure zoning

- Hand hygiene audits were completed monthly by ED staff which will now be completed weekly, the required ED based weekly audits have not been completed robustly. Leads have now been identified and training will be delivered to ensure completion and compliance on a weekly basis, this will be monitored by the IPC team.

- The Senior Nurse, IPC and Housekeeping team have reviewed the department to ensure that hand sanitiser is available throughout the

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

department, areas identified for additional sanitising dispensers have been installed.

- Appropriate dispensers. These will be monitored by the housekeeping team and within the daily Nurse in Charge audit framework

- Adherence to the appropriate PPE guidance has been re-enforced to the clinical teams via several ways i.e Social Media, E-mail, Daily Safety Huddle, staff engagement meetings.

- The daily morning Nurse in Charge review and afternoon senior leadership walk around also re-enforce the requirement for the appropriate standards of PPE, actively encouraging the team to challenge others should standards not adhere to guidance.

- Implementation of appropriate signage and posters to ensure staff and visitors are aware of PPE requirements within the department. The team have commissioned a company to install signage throughout the department and hospital site.

- All equipment required for the COVID-19 triage room has been reviewed (16/09/21) and labelled ensuring the equipment is not taken from the area, this will be monitored daily by the nurse in charge.

- The current template due to the partition within the waiting area has removed the availability of an additional two toilets for the minors waiting area. Whilst work is ongoing with the support of PHW regarding the appropriate flow of patients in line with COVID-19 requirements, the area continues to have one toilet available. The health board recognises that the current configuration in relation to toileting facilities is not suitable to meet the needs of a busy department.

- The completion of the pathway work will be the route to resolving this and the date for the implementation of the minors works will be confirmed once the pathway has been agreed

- To ensure the toilet is clean and checked regularly the domestic team are now present in the department 24/7 and will provide hourly oversight of the toilet and waiting room area to ensure standards of cleanliness are maintained. This is a significant increase in cleaning resources.

December 2021 Update

- The PCH Improvement Programme incorporates ED and Theatres and a new Flow project work stream under a 'one' programme approach.

The Programme, as it has matured and moved away from immediate make safes and diagnostic activity, is being re-set to ensure alignment with strategic objectives and delivery of Improvement activity.

- A review of the Programme's governance was undertaken by the Chief Operating Officer (COO) in September 2021, resulting in changes being made to strengthen the Programme's oversight, scrutiny and assurance arrangements to ensure robust structures and clarity of roles and responsibilities. All aspects of the Programme are managed by Triumvirate Leadership with subject matter expertise from across the Health Board.

- The following are established:
    - An executive sponsored monthly multi-disciplinary Programme Board to monitor the Programme's progress.
    - A weekly ILG Oversight Meeting to provide timely consideration of issues, risks and action planning and to drive the pace of the programme whilst also supporting the Operational Teams with delivery.
    - Weekly Improvement Project Team Meetings for ED and Theatres with the support of the programme team.
    - An Improvement Hub to lead the Programme to provide specific expertise to enhance the support available to the operational delivery teams. The hub structure is made up of staff resources that have been released to prioritise the Programme delivery. These include Planning, Programme Management, Workforce and OD, Comms and Improvement. The Hub allows wider consideration of dependencies across the system.

- In addition:
    - A robust tracking action plan spreadsheet has been developed to monitor actions across the Programme. This tool supports the rigour in driving the delivery of actions and also ensuring transparency and assurance to the Programme Board and the wider organisation.
    - A performance dashboard has been developed to allow monitoring of key performance indicators aligned to the programme's objectives.
    - The partnership arrangements with Improvement Cymru and the Delivery Unit are being strengthened to ensure that the support is tailored to meet the needs of the PCH Improvement Programme.

    - A Governance Framework, including a Risk Management Plan, accounting for governance arrangements across the wider ILG and health board, has been developed aligning with the organisational approach and methodology.
    - Timely and regular reporting underpins the Programme including weekly highlight reports on progress delays, risks, issues and achievements which is presented to the health board's Strategic Leadership Board. Reporting has continued to the Quality and Safety Committee and a progress update has been provided to the Community Health Council[6].

- An external Improvement Director was appointed and reviewed the Programme's development.

- In recognition that the improvement is the responsibility of all, a number of staff engagement events have been held and mechanisms have been adopted at CSG level to facilitate ideas from front line staff. This has been supported by Comms activities including production of ED newsletters.

- The findings of the audit, which was completed in relation to the RCEM Standards, have now been converted into a detailed action plan and incorporated within the ILG Improvement Programme plan.

- The core outcome recommendations related to the following areas: Patient pathway through the ED department, Requirement of staff being trained within specific areas e.g., Dementia, Safeguarding. The identification and review of policies and appropriate policy oversight ownership within the department. Further to these recommendations a task and finish group was established and commenced 29/11/21 to review all policies and procedures relating to ED. This is supported by corporate nursing colleagues.

- Dementia training sessions have taken place with compliance reported at 93.44% as of 25/11/21, and a further action plan to identify outstanding individuals is in place.

[6] https://boardchc.nhs.wales/what-we-do/

- Safeguarding training (adult level 2) compliance reported as 75.47% up from 46.6% the previous month.
- A focused piece of work has been progressed to review staff awareness of acts and guidance around mental health policies and procedures.
- The first ED Quality and Safety meeting took place on 24/11/21 with a monthly re-occurrence.
- Educational programme for new starters - Proposal developed for a new ED Senior Nurse for Professional Development. The Professional Practice and Quality Assurance Nurse, Lead Nurse for Professional Practice and Quality Assurance are in the process of developing a standardised framework to establish across the health board.
- A dedicated donning and doffing champion has now been identified to progress further training to the team with a plan to roll out one hour training sessions, consisting of 15 minute slots over the hour on donning and doffing for staff.
- IPC team have reviewed the department's requirement for a dedicated donning and doffing room and advised against this. They provided step by step guidance for staff on what is the appropriate donning and doffing procedure dependent on different scenarios.
- The symptom checker continues to be located 24/7 at the entrance to the Department and positive patient reports have been received. This arrangement has also been placed at the ambulance entrance which is supporting early identification of COVID-19 status.
- A daily IPC Environmental audit has been introduced to monitor compliance within the following areas: COVID-19 signage, appropriate pathways based on patient COVID-19 status, environmental cleanliness, equipment and storage, waste. The compliance rates are shared with the Executive Team on a daily basis for oversight. The compliance as of 03/12/21 is reported at 90%, having seen a steady improvement since 20/09/21 reporting at 46% compliance.
- To support visible leadership a Purposeful Leadership Walk-round (PLW) takes place on a daily basis by the senior management team. A
- PLW rota has been developed and individuals aligned. The PLW's focus on the following four areas; staff, environment, patients and any actions taken. Any reoccurring themes identified during these rounds are documented and distributed via a weekly e-mail.

- A further review of the cleaning contract hours aligned to the ED areas has taken place to ensure toilets are cleaned and checked regularly. It was identified that ED Domestic Services cover is required from midnight to 6.00am. This additional service is funded by PHW. This additional shift cover commenced on Monday December 13th. This service has been launched ahead of full recruitment of 6 staff. There are three domestics in place, trained and ready with start dates for two further staff. It is expected that a full complement of domestic staff will be in place by end of January 2022. Whilst the domestic team has been provided with a cleaning schedule, staff are specifically instructed by the Nurse in charge within ED as necessary.

- Placing a domestic supervisor on-call rota from 20:00 - 06:30 am covering the times when there is no physical presence on site is also planned as a pilot.

- Posters have been purchased to ensure staff are aware of the PPE requirements within the department and additional step by step guidance has been provided by the IPC team.

- A dedicated ED Teams Channel has been set up and the importance of correct PPE usage has been communicated. Further communication has been made via monthly Bronze meetings, staff briefings, staff newsletter and staff Facebook page.

- Appropriate signage and posters have been purchased and awaiting delivery to ensure staff and visitors area fully aware of the PPE requirements. The specific signage provides details around the following areas:
    - Zero Abuse
    - High risk area
    - All members of public and staff must cleanse hands between all areas
    - Please ensure you are wearing a hospital grade face mask and that you sanitise your hands before entry
    - Emergency Unit
    - Assessment and treatment
    - Waiting for review
    - Emergency unit waiting area
    - Main reception and waiting area
    - Emergency care centre screening area.

- Additional security has been sourced during wave four which are located at entrances to the hospital. This has provided a checkpoint to

ensure the only individuals entering the hospital are either staff members or patients who are attending appointments.

- The business case for the nursing workforce requirements has been completed and awaiting final approval by the health board. One specific resource that is built into the business case is the role of an ED Senior Nurse for Professional Development.

- Absences and use of agency staff continue to be closely monitored. Safe-2-Start daily meetings have been in place since November 2021 in Prince Charles Hospital. Attendance includes, Head of Patient Flow, HoN, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on the ED demand and key quality and safety metrics relating to patient care.

- At the meeting the Ward Managers and Senior Nurses work together to problem solve staffing challenges to support any areas of greatest need and move staff accordingly to ensure that wards and departments are in a safe to start position.

- Via the Safe-2-Start meetings, wards including ED now also provide a daily update of staff COVID-19 absences identifying day six and seven of the isolation period to enable the forward planning and return to work dates.

- To further strengthen the focus on the workforce the Performance Dashboard developed for the Programme will provide oversight and monitoring at Service, Programme and Board level of the key metrics including those related to absences, vacancies and PDR.

- Metrics relating to incidents, complaints and concerns and are also included on the Performance Dashboard.

- Within the original ED footprint the ED waiting area segregated COVID-19 and non COVID-19 patients by a wall partition. This had contributed to the reduced line of sight of patients, subsequently increasing patient's risk of harm, as these patients were not observed and monitored effectively.

- The development and implementation of the new COVID-19 Segregation Pathways along with additional receptionist red flag training has mitigated patient risk of harm. Further to this patients have continued to be screened on presentation at the front door. The screening team consist of a qualified nurse, health care support worker and security staff member. The process utilises a standardised

checklist of questions to determine if the patient is COVID-19 suspected or not suspected. Patients are then streamed into the appropriate area - pathway 1 (purple) or pathway 2 (Amber).

- Additional to the front door screening we have also implemented an Ambulance entrance screening process. This screening resource consists of a triage nurse at the ambulance entrance. COVID-19 suspected patients are immediately transferred into majors '(purple) area for triage and assessment. Non COVID-19 (amber) patients are triaged on the back of the ambulance and if an Electrocardiogram (ECG)[7] is required the triage nurse communicates through a hand held receiver to contact Nurse in Charge of amber majors to arrange for transfer of patient into triage room for an ECG and then offload if possible.

- Action cards at each entrance re information for staff re IPC processes.

- The affray alarm allows rapid response to an incident of violence and aggression, along with the presence of the security staff at the front door. Any incidents are reported and monitored through the Datix system and investigated to identify any trends.

- The emergency call bell has now been installed behind the reception desk for reception staff to pull should they need to alert the medical/nursing team of a medical emergency within the waiting area. Further to this there is now the presence of a registered nurse working out of the triage room (this room is located directly off the waiting area). Clinical oversight is now provided to patients within the waiting room by the symptom checker RN and the triage nurse. During triage the symptom checker provides oversight and vice versa.

[7] An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by your heart each time it beats. These signals are recorded by a machine and are looked at by a doctor to see if they're unusual. An ECG may be requested by a heart specialist (cardiologist) or any doctor who thinks you might have a problem with your heart, including your GP. The test can be carried out by a specially trained healthcare professional at a hospital, a clinic or at your GP surgery.

- With the magnetic security locks having been installed it was recognised that the ability to be overridden in a Health and Safety incident was required. This has been addressed - when this is overridden a ‘screecher’ alarm alerts the team that there has been a breach of the system. A Datix reported incident is generated should the alarm be activated. To date no breaches have been reported.

- With the development and implementation of the new COVID-19 Segregation Pathways, changes have been made to incorporate additional access points for patients attending the ED. Arrangements for signage production is underway to be placed at both entrances to restrict staff from entering the ED unless they have a work related reason to do so. An interim measure of immediate communication has been circulated to reinforce the message to staff to treat the ED as a clinical environment and reduce footfall within this area as much as possible.

- The screening of patients on presentation at the front door (minor’s entrance) has been continued. The screening area consists of a qualified nurse, health care support worker and member of security located within the glass foyer of the ED minor’s entrance to screen patients against an agreed checklist to determine if COVID-19 suspected or COVID-19 not suspected. Patients are then directed to the appropriate areas. Identified COVID-19 suspected patients are escorted to the appropriate area, reducing risk for both patients and staff. An additional screening triage nurse at the ambulance entrance as also been introduced. Hand held transceivers are utilised to contact the nurse in charge to coordinate movement of patients, reducing unnecessary moves within the Department, subsequently reducing risk for all.

- The new COVID-19 Segregation Pathways have now been implemented. The new pathway provides the following improvements to support reduction in risk to public and staff:

    - A Welsh Ambulance Service NHS Trust (WAST) offload space to allow a transfer of COVID-19 not suspected into appropriate area.
    - COVID-19 Suspected Pathway for both Majors and Ambulatory (Purple).
    - COVID-19 Not Suspected Pathway for both Majors and Ambulatory (Amber).
    - A nurse screening area at each entrance.
    - WAST arrival area.

    - GP patients will be streamed into the appropriate pathway via the bed manager or screening nurse based on symptoms. The nursing care of these patients would be carried out by nursing staff allocated to a particular stream. Clinically, there will be a separate pathway for the patient waiting to be seen i.e. they will not be seen by an ED doctor first. However, they do require observations to be undertaken at triage.

- This change in pathway has allowed for the availability of toilets for patients.

- The Paediatric Pathway is proving to be one of the hardest areas to resolve due to the complexities. In recognition of this a working group, led by the COO and involving clinicians across ED and Paediatric, was established to develop an immediate and longer term plan.

- Initial attempts at pathway models for Paediatric patients have not proved to be effective. Whilst there have been examples of joint working there have also been challenges. The discussions to fully realise the developed immediate plan are continuing via the working group.

- A band 7 ED Paediatric Nurse appointed and commencing end of January 2022.

- A daily IPC Environmental audit has been introduced to monitor compliance within the following areas: COVID signage, appropriate pathways based on patient COVID-19 status, environmental cleanliness, equipment and storage, waste. The compliance rates are shared with the Executive team on a daily basis for oversight. The compliance as of 03/12/21 is reported at 90%, having seen a steady improvement since 20/09/21 reporting at 46%.

- With the development and implementation of the new COVID-19 Segregation Pathways an additional blood sugar monitor has been purchased to ensure equipment remains in its dedicated area reducing the risk of contamination. This is further monitored daily by the nurse in charge.

- The development and implementation of the new COVID-19 Segregation Pathways has resulted in the wall partition being removed, subsequently opening up the waiting area to the original footprint, allowing patients within the ambulatory care (minors) waiting area access to three separate toilet facilities.

- A further review of the cleaning contract hours aligned to the ED areas has taken place to ensure toilets are cleaned and checked regularly. It was identified that ED Domestic Services cover is required from midnight to 6.00am. This additional service is funded by PHW.

- This additional shift cover commenced on Monday December 13th. This service has been launched ahead of full recruitment of six staff. There are three domestics in place, trained and ready with start dates for two further staff. A full complement of domestic staff is anticipated by the end of January 2022.

- Whilst the domestic team has been provided with a cleaning schedule, they are specifically instructed by the Nurse in charge within ED as necessary.

- It is also the intention to place a domestic supervisor on-call rota from 20:00 - 06:30 am covering the times when there is no physical presence on site.

What we found on follow-up

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection of the department relating to the quality of patient experience (as detailed above). However, some areas remained in need of improvement and these are referred to in more detail below.

During the inspection we distributed HIW questionnaires to patients to obtain their views on the services provided. A total of four questionnaires were completed. We also spoke to a number of patients during the inspection. Patients who contributed to the inspection were generally happy with the service received.

Staying healthy

We saw good interactions between staff and patients with staff attending to patients' needs in a discreet and professional manner. Patients we spoke with commented positively on the way staff carried out their duties.

There was information posted throughout the ED regarding COVID-19, infection control and how to prevent the spread of germs and infection. These included clear and easy to read instructions on effective handwashing.

Dignified care

We noted considerable improvement in how patient's dignity was being promoted within the ED compared to what we saw during the previous inspection.

The environment within the department was clean and tidy, adding to the sense of patients' well-being. However, we found discarded cigarette stumps directly outside entrances into the department and some tiles were missing from an area of the suspended ceiling near the main entrance to the ED. This is unsightly and does not give a good first impression to patients and visitors.

We observed staff being kind and respectful to patients and saw efforts made to protect patients' privacy and dignity when providing assistance with personal care needs. Patients confirmed that staff were kind and sensitive when carrying out care.

However, we found that the clear plastic/perspex screens, used in the shared cubicles within the amber ambulatory area, did not offer adequate levels of privacy for patients. Also, consideration should be given to limiting the number of patients accommodated in the cubicles at any one time in order to ensure privacy and dignity.

We observed a male patient who was intimidating in his manner accommodated next to vulnerable patients who were visibly uncomfortable by his presence and behaviour. The health board must monitor the mix of patients accommodated within the cubicles in order to ensure that the mix does not put patients at risk of harm or cause distress.

Staff were seen to treat each other in a supportive and respectful way.

Improvement needed

The health board must:

- Ensure that all entrances into the department are kept clean and tidy.
- Review the use of plastic/perpex screens in the shared cubicles within the ambulatory area in order to ensure that patients are offered adequate levels of privacy. Consideration should be given to limiting the number of patients accommodated in the cubicles at any one time in order to ensure privacy and dignity.
- Monitor the mix of patients accommodated within the cubicles in order to ensure that the mix does not put patients at risk of harm or cause distress.

Patient information

Notice boards have been provided in prominent areas within the department displaying information about COVID-19 and explaining what patients should expect in terms of their treatment and journey through the department.

A pre-recorded voice announcement system has been installed which plays background music and gives advice, in both Welsh and English, on COVID-19, hand washing and warnings about abuse against staff. The system was also set up to announce waiting times. However, this particular function was not working on the first day of our inspection. We brought the matter to the attention of one of the ED senior managers who took steps to resolve the matter.

Communicating effectively

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner.

Patients told us that staff took time to explain things to them. However, one patient we spoke with told us that they sometimes received conflicting information from staff with a nurse telling them one thing and the doctor telling them something different.

Improvement needed

The health board must ensure that staff give patients accurate and consistent information about their care.

Timely care

We found that patient flow through most areas of the department had improved.

The recent formation of an ambulatory area had resulted in the reduction in the number of patients being cared for in the corridors. However, there was confusion amongst some staff as to the intended use of this area and staff working within this area felt under additional pressure. Staff told us that this area was often overcrowded with patients waiting a long time for admission onto hospital wards. Although not overcrowded during the inspection visits, we noted that one patient had been waiting for treatment for over 48 hours.

We suggested that consideration be given to drawing up a standard operating procedure (SOP) detailing how this area is to be used. The SOP should, amongst other matters, set out the parameters of the care needs of the patients to be accommodated, anticipated maximum time that patients are accommodated

within this area and the expectation on staff in terms of the observation of patients.

We saw that all patients were being triaged appropriately. However, we found that there was a need for more experienced triage nurses in the department in order to cover all shifts.

Oversight and monitoring of patients within the main waiting area had improved since the previous inspection. However, we found that this could be further enhanced by the triage nurses undertaking a visual scan of patients in the waiting room when calling patients in to the triage room.

There were no significant issues with moving patients from ambulances into the department during the inspection.

Improvement needed

The health board must:

- Draw up a standard operating procedure (SOP) for the ambulatory area detailing how this area is to be used. The SOP should, amongst other matters, set out the parameters of the care needs of the patients to be accommodated, anticipated maximum time that patients are accommodated within this area and the expectation on staff in terms of the observation of patients.
- Consider ways to further enhanced the observation of patients in the main waiting area and encourage the triage nurses to undertake a visual scan of the waiting area when calling patients in to the triage room.

Individual care

Planning care to promote independence

We found that there were generally good care planning processes in place which took account of patients' views on how they wished to be cared for.

Through our conversations with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their care needs.

People's rights

We saw that staff provided care in a way to promote and protect patients' rights.

We found staff protecting the privacy and dignity of patients when delivering care. For example curtains were used around individual bed/treatment areas when care was being delivered.

We found that Mental Capacity assessment and Deprivation of Liberty Safeguards (DoLS)[8] assessments were being conducted as necessary.

Listening and learning from feedback

Patients and their representatives had opportunities to provide feedback on their experience of services provided, through face to face discussions with staff.

There were formal systems in place for managing complaints and there was a formal complaints procedure in place which was compliant with Putting Things Right[9].

[8] DOLS are a part of the Mental Capacity Act 2005 that provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm.

[9] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed “Concerns”. This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

Delivery of safe and effective care

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

We found that the health board had implemented and sustained the majority of the improvements, relating to the delivery of safe and effective care, highlighted during the previous inspection. However, some areas remained in need of improvement and these are referred to in more detail below.

Areas for improvement we identified at our previous inspection

- Patients were not always monitored at a frequency which would identify deterioration and changes in their condition. Patients were not always screened for sepsis and the appropriate response to this was missing.

What actions the service said they would take

- Privacy and dignity within the department is paramount and this was recognised during the site visit. Several changes have been made to further enhance this including:
    - The cessation of the use of the majors corridor.
    - Changes within the ambulatory majors area to ensure there are four additional appropriate clinical areas, appropriate comfortable seating, screens between patients along with individual equipment for each patient area. This work was completed on 23.09.21. This ensures that patients that are 'Fit to Sit' are cared for in an appropriate environment with nursing oversight. The care of these patients will be have oversight of the Nurse in Charge and discussed at the team huddles throughout the shift.
    - Patients are cared for in private cubicles within the department which does afford privacy and dignity. In order to ensure the department can support immediate release of an ambulance or transfer/admission of a sick patient to the department cubicle seven has been ring fenced to meet this requirement.
    - The comfort of patients in the department is supported by British Red Cross. We provide hot drinks and food under the

supervision of the Nurse in Charge to support patients who are receiving active treatment in the department.

- During periods of escalation, additional site situational risk assessment meetings take place. These focus on patient safety concerns, bed waits and ED capacity/risk

- Patients that remain on an ambulance following arrival to the hospital if there is no capacity within the department continue to be cared for by the ambulance crew until they can be admitted in line with the Standard Operating Procedure (SOP).

- In line with the ED Improvement plan there is a proposal to address flow and safety improvement challenges at Prince Charles Hospital. Improvement Cymru and Merthyr and Cynon locality staff will be working together sharing operational experience, expertise and experience from elsewhere to review current arrangements and design improvements. This programme has come about following a request from CTMUHB Executive Team. The learning from this program of work will inform other improvements related to flow on other acute sites within the CTMUHB area. This work is supported by Improvement Cymru.

- Bed meetings are in place three times per day with the sit-rep shared with the senior leadership team and executives, these are monitored CTMUHB wide along with the other acute sites within CTMUHB to ensure escalation of acuity.

- The health board requires multiple layers of data to provide greater insight on the day to day operations of ED, to enable it to track, trend, predict high impact workflow and understand performance. The development of an ED dashboard that captures these factors will assist in the transformation of quality care provision.

- A pathway of care to appropriately manage and support women experiencing early pregnancy loss is in draft with anticipated implementation by the 30/09/21. This pathway will ensure that women are treated in a private and dignified cubicle on the surgical ward by staff with experience in caring for women experiencing a miscarriage.

- The management of expected surgical patients has been reviewed and a draft pathway of care is currently in the consultation phase. This will ensure the timely flow of patients out of the ED department.

- A pathway has been implemented to ensure all patients that have been triaged are prioritised and monitored in line with the Manchester Triage

guidance. This will be monitored within the daily huddle and delays in care incident reported within the Datix system.

- Patients currently within the COVID-19 waiting area that is not within line of sight of the RN have a 30 minute rounding process in place to review the patients. The team are currently scoping the possibility of installing a call bell for patients to use should they need to call a nurse outside of the 30 minute rounding.

- A recent National Early Warning Score (NEWS)[10] audit has identified that the completion of NEWS charts is of a high standard with continuing improvement noted.

- Compliance with the Sepsis 6 bundle[11] is monitored monthly with a target of 85% compliance, current mean compliance since March '21 is 73%.

- Bespoke training for the MDT is scheduled to take place on the following dates; 28th September 2021, 6th October 2021, 13th October 2021.

- Compliance with the Sepsis 6 pathway is also monitored through the management of clinical incidents and investigations.

- A review of the ED documentation was completed in July 2020, with the support of the Quality Improvement (QI) team and the quantity of documentation was rationalised to reduce duplication. A baseline audit was completed of the patient safety checklist in June 2021, prior to commencing the test of change in line with QI methodology. Progress of the programme of improvement with regards to documentation continues to be supported by the QI team with a progress update included.

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

[11] The Sepsis 6 care pathway and bundle is a recommended approach to diagnosing and treating sepsis.

- The recent introduction of the updated NEWS chart has been supported and monitored by the team with compliance noted in ED within the top three of the PCH site. Performance and compliance is monitored on a monthly basis and findings shared with the ED team.

- Documentation standards are monitored within several areas through the governance process, within incident review, root cause analysis (RCA), Scrutiny panel and concerns management. Learning and findings are shared with the clinical and managerial team through several forums but not exclusive to; team leader meetings, Safety Huddles, weekly CSG governance meetings, newsletter, falls and pressure damage scrutiny panels, Departmental meetings, RCA/Incident investigation training, Ward Improvement plans, Action Plan Listening and Learning forum.

- A learning framework is being developed for the organisation to identify all sources of learning and to develop robust systems for dissemination and sharing of learning to improve quality and safety of services, in addition to innovation and improvement.

- Medical staff annual documentation has recently been completed with positive findings noted.

December 2021 Update

- With the continued importance placed on maintaining patients' privacy and dignity within ED the following changes have been made:
    - To improve patients comfort whilst within the department the support of the Red Cross service continues to be welcomed which provides basic care and refreshments. Red Cross also support with the transport and resettlement of discharged patients.
    - The metal seating within the waiting areas has been reviewed and a quote to replace this seating has been obtained. The replacement seating will provide a fully upholstered seat and back to support patient comfort.

- A Gynae pathway has been developed with an immediate solution in place via a dedicated cubicle and pathway to a protected bed for patients on an inpatient ward. Whilst this has been helpful a developed plan has been agreed to establish a Gynae Day Assessment Unit adjacent to ED. The logistical arrangements are being finalised.

- The partnership with Improvement Cymru has been further strengthened over the last three months with specific activities included

within the Programme's Plan. The activities are monitored through the PCH Partnership Project Team meeting consisting of membership from the Programme, Improvement Cymru and the Delivery Unit.

- An example of the collaborative activities has included a Leadership Programme via Toyota with staff from ED participating in the sessions with a focus to date on streamlining and efficiency of processes being explored.

- The Delivery Unit also forms part of the Partnership collaboration with a focus on identifying flow operational processes and discharge pathways on the site and in the community.

- Development and implementation of Safe-2-Start daily meetings (8-8.30am) have been in place since November 2021 in Prince Charles Hospital. Attendance includes, Head of Patient Flow, HoN, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on ED demand and key quality and safety metrics relating to patient care. At the meeting the Ward Managers and Senior Nurses work together to problem solve staffing challenges to support any areas of greatest need and move staff accordingly to ensure that wards and departments are in a safe to start position.

- A Performance Dashboard for the Programme has been developed to monitor impact of activities and improvement including in relation to quality, safety, the environment and the workforce. The Dashboard incorporates Tier 1 targets as well as Emergency Department Quality Delivery Framework (EDQDF) measures and locally identified additional measures.

- A Surgical Assessment Unit (SAU) has been set up which consists of four assessment trollies. The forward plan once COVID-19 restrictions end is for GP referrals to go directly to SAU. Further progress is being made to employ Advanced Nurse Practitioners (ANP) to support the SAU and extension of SAU as 'hot clinics'. It's envisaged that these hot clinics will enable patients to be discharged and return for appointments. Further to this, additional rapid point of care COVID-19 testing kits have been purchased to speed up the flow to the unit.

- NEWS training record in place to monitor delivery of training sessions for all staff bands.

- The Sepsis tool is currently being revised and the Clinical Audit and Effectiveness Department is in the process of building an audit proforma to place onto the AMaT (Audit Management & Tracking)

System to monitor and support improvement, also allowing for a standardised approach across the Health Board.

- Compliance is audited via the outreach team and results are shared with teams and discussed at governance meetings to identify any trends/improvements required. Concerns/Incidents and action plans are compiled and compliance is monitored. Current compliance for PCH ED is 55.56% (mean) April - Nov 21.

- The Critical Care Outreach team has identified areas where further training is required and in response staff have developed a programme to deliver the following training: Sepsis, Acutely Unwell, Acute Life Threatening Recognition and Treatment (ALERT), Central Venous Catheter (CVC) and Total Parenteral Nutrition (TPN) on a regular basis.

- In addition further oversight of Sepsis 6 compliance is provided to the Improvement Programme via the Key Performance Indicator Dashboard.

- From 01 December the patient safety checklist audit was placed onto the health board wide AMaT system. This allows for continuous monitoring and documentation of the audit outcomes, along with the ability to benchmark. The following increase in compliance was reported during a spot check audit:
    - October 2021: 12.2% compliance
    - January 2022: 68% compliance

- ED NEWS documentation audit has continued to be monitored. This audit has also been placed onto the health board AMaT system. Compliance for the month of December was reported at 66%.

What we found on follow-up

We found that the health board had implemented and sustained the improvement highlighted in the action plan drawn up following the last inspection of the department relating to the delivery of safe and effective care. However, some areas remained in need of improvement and these are referred to in more detail below.

Safe care

We found that the introduction of the daily Safe-2-Start meetings, which took place every morning, afforded senior managers an opportunity to highlight and manage emerging issues and ensure adequate staffing within the various wards

and departments through the hospital. This ensured the effective allocation of staff into those areas where shortfalls or additional service pressures had been identified.

Patient flow meetings were held throughout the day to enable effective management of bed spaces and reduce pressures on various wards and departments. Staff we spoke with were aware of the patient flow escalation process.

Appropriate measures had been set in place to enhance the security of the paediatric area. At the time of the inspection there was not always a paediatric trained nurse on duty within the area which presents a risk to both patients and staff. However, the health board has indicated in the December update that a band 7 ED Paediatric Nurse has been appointed and will be commencing duties end of January 2022.

Managing risk and promoting health and safety

General environmental audits and risk assessments were being undertaken on a regular basis in order to reduce the risk of harm to patients and staff. These were being formally reported to senior managers.

However, on the first day of the inspection, we found numerous cupboards and doors to rooms used for medicine preparation left unsecured. Chemicals were also seen in unlocked cupboards and on work surfaces in store rooms. The maxillo facial treatment room was of specific concern. In this area we found sharp implements on work surfaces and drugs such as local anaesthetic and adrenaline not securely stored. This room was situated in the ambulatory area where patients with mental health presentations were accommodated. All these issues presented a significant risk of harm to patients and staff.

We brought this to the attention of the Head of Nursing who took immediate steps to address the issues highlighted.

Preventing pressure and tissue damage

We saw that staff assessed patients regarding their risk of developing pressure damage to their skin on admission to the ED. We saw that staff were taking appropriate action to prevent patients developing pressure and tissue damage through provision of pressure relieving equipment and regular positional changes.

Patients were being moved on to trolleys and where possible on to beds where this was deemed necessary following assessment.

Reclining chairs had been purchased for use within the ambulatory area to enhance the comfort of patients and reduce the risk of pressure area damage.

However, we found little evidence of on-going assessment for those patients remaining within the ED for over 24 hours.

Improvement needed

The health board must ensure that staff undertake and record regular and timely on-going assessment of patients whilst within the ED.

Falls prevention

From examination of a sample of individual care files, we saw evidence that risk assessments were undertaken to reduce the risk of falls.

Falls were reported via Datix and were highlighted at the Safe-2-Start meeting held each morning.

Infection prevention and control

We found significant improvements in the infection prevention and control arrangements with in the ED. All areas within the department were seen to be clean and tidy.

There were good links with the IPC team and with PHW.

Staff had access to and were appropriately using personal protective equipment (PPE) such as disposable gloves and aprons to reduce cross infection. Hand washing was taking place as required and hand sanitising stations were strategically placed throughout the department for staff and visitors to use, to reduce the risk of cross infection.

As previously mentioned, we also found improvement in the management of COVID-19 negative and COVID-19 positive patients with appropriate screening at the main entrance into ED and clear amber and purple pathways. Most of the staff members spoken with told us that the improvements made within the department had made the environment safer for patients, staff and members of the public.

The resuscitation area still allowed for mixing of COVID-19 positive and COVID-19 negative patients. However, advice had been sought from PHW with regards

mitigating risks within this area. Any risks should be documented and reviewed regularly through Datix or the department's risk register.

As was the case during the previous inspection there was an outbreak of COVID-19 within CDU. Although this was being managed appropriately, there was no consistent process in place to investigate such outbreaks.

Improvement needed

The health board must:

- Monitor and documented the risks involved in providing care for both COVID-19 positive and COVID-19 negative patients in the resus area and escalate any issues through Datix or the department's risk register.
- Set up a consistent process to investigate COVID-19 outbreaks.

Nutrition and hydration

We saw that patients' eating and drinking needs had been assessed. We saw staff assisting patients to eat and drink in a dignified and unhurried manner. We also saw staff providing encouragement and support to patients to eat independently.

Patients had access to food and drink with a range of vending machines located within the main waiting area.

The provision of meals for patients accommodated within the minors, majors and ambulatory areas was more formally managed and prioritised depending on assessed need and length of time that they had been waiting within the department.

The meals appeared well presented and appetising with patients telling us that the food was very good.

Medicines management

We found medication management processes to be generally well managed and compliant.

However, we highlighted some issues around the storage of medication which we escalated to the Head of Nursing who took immediate action to address the issues.

We also highlighted an issue with staff having to go from the ambulatory area to the majors area in order to get specific items of medication. Not only is this time consuming but it also leaves the ambulatory area short staffed. In addition, it introduces an additional step into the medication administration process which could lead to errors.

Medication administration charts were, in the main, completed correctly. However, we noted that one patient was administered oxygen but this had not been formally prescribed.

We found that control drugs were being stored and checked appropriately.

Improvement needed

The health board must:

- Take measures to ensure that staff do not have to go leave the ambulatory area in order to get certain items of medication from the majors area.
- Ensure that Oxygen is not administered to patients unless it has been formally prescribed.

Safeguarding children and adults at risk

There were written safeguarding policies and procedures in place and the majority of staff had undertaken appropriate training on this subject.

Staff spoken with were aware of safeguarding responsibilities and the staff working within the paediatric area indicated that there were robust reporting/referral processes in place.

We suggested that any patients who are subjected to Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards and Safeguarding be discussed at the Safe- 2- Start meetings.

We were told that there were good links to mental health services and crisis intervention teams.

Medical devices, equipment and diagnostic systems

The department had a range of medical equipment available which was maintained appropriately and portable appliance testing was undertaken as required.

There was a process in place to report defective or broken equipment and any issues were raised daily at the Safe-2-Start meetings.

Effective care

Safe and clinically effective care

There was evidence of multidisciplinary working between the nursing and medical staff.

There were comprehensive policies and procedures in place to support staff in their work.

We saw that formal care pathways were in use. We found that staff were performing and recording regular, routine observations on patients within both the amber and purple majors areas and were escalating issues appropriately when there was a deterioration or change in a patient's condition. However, this was not always the case within the ambulatory area where we found that, in the case of one patient, that symptoms of sepsis had not been clearly identified, monitored or escalated in a timely way. This meant that there was a delay in the patient receiving treatment. In addition, repeat observations of four other patients, who were clinically unwell, had not been undertaken for over six hours. We brought this to the attention of the Head of Nursing who took immediate action to address the matter by introducing an enhanced process of monitoring and observation of patients which was overseen by the nurse in charge.

We found that pain was being assessed and pain relieving medication was being administered according to need. However, we saw little documented evidence of pain scores and effectiveness of pain relief being re-assessed.

Improvement needed

The health board must ensure that staff monitor and document pain scores and the effectiveness of the pain relief administered.

Record keeping

We viewed a sample of patient care notes and found them to be generally well maintained and easy to navigate.

Staff were seen to be maintaining accurate and contemporaneous records of the care given.

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 services review and monitor their own performance against the Health and Care Standards.

We found that the health board had implemented and sustained the majority of the improvements, relating to the quality of management and leadership, highlighted during the previous inspection. However, some areas remained in need of improvement and these are referred to in more detail below.

Areas for improvement we identified at our previous inspection

- Staff were very unhappy, stressed and struggling to cope with their workload.
- The arrangements for leadership and governance external to ED were not effective or supportive. This meant that staff felt unsupported and not listened to. This had led to a culture of front line staff feeling abandoned and unsupported. There were significant issues identified which the leadership team were unaware of. This posed a significant risk to patient and staff safety.

What actions the service said they would take

- The HB has an organisational quality governance and patient safety framework which sets out its position in respect of overarching governance arrangements.
- Local arrangements within ILG's and its services provide assurance through:
    - CSG meeting structure
    - HoN governance structure
    - ILG structure
    - Exec support regarding improvement work
    - Escalation of concerns Policy
    - Staff feedback within the engagement plan

- Previous external reviews within the CTMUHB have identified concerns in relation to leadership and culture as a cross organisational concern and have therefore developed a leadership strategy via its workforce and Organisational Development colleagues. Alongside, there is a significant emphasis on well-being of colleagues and availability of internal and external support. The specific requirements for leadership development and support have been clarified within the Improvement Plan.

- We will work with the teams to be clearer about the roles and responsibilities of individuals within the team and how the broader organisational structure supports the department in caring for patients. This will include the use of existing engagement sessions and communication channels

- At a health board level, there is an organisational Quality Governance and Patient Safety Framework which is committed to the delivery of safe and effective care, demonstrating how the health board receives line of sight awareness of its services. Improvements to performance indicators, quality metrics and ILG reporting to Q&SC committee has enabled greater clarity and oversight of service delivery and patient experience. This is evidenced through its reports through to Board. Concerns in relation to PCH ED had been escalated prior to the HIW review and an action plan agreed with executive monitoring of progress

- Following the HIW Visit, this has been enhanced with the sharing of the PCH findings across the Health Board as a trigger for greater degrees of scrutiny into our services within the existing framework

- We have commenced a review of the existing governance framework from service delivery through to Board and expect the conclusion of that work to be presented in November

- The ILG recognises the existing challenges and has deployed an Improvement Programme to focus on ED, Theatres and Wards and will be used as an operating model for future improvements

- The Improvement plan was initiated for ED and Theatres in June 2021. Progress was monitored a weekly basis but has now progressed to a monthly meeting between the ILG Directors and Executive team and upward reporting through CTMUHB Governance Structure.

- A PID has been produced to further support this work.

- Further assurance was sought of the wards within PCH and an assurance framework was put in place to review all ward areas with very positive outcomes identified.

- Due to the footprint of ED it has been recognised within the improvement plan (June '21) that the medical staffing requirements by night are increased by one middle grade with the recognised benefits;

    - Improved flow
    - Support for junior staff
    - Improved safety
    - Improved patient experience
    - Improved referral times due to middle grade to middle grade discussion
    - Improved four hour performance
    - Reduced ambulance handover delays

- Nursing funded establishment is 10 RN & four HCSW; this is currently being reviewed in line with the footprint of the department and the suggested changes to the department template, a staffing paper is in draft currently. Due to these challenges the staffing levels have been agreed over establishment to 13 RN and five HCSW 24/7, this is inclusive of ensuring that the resus area has two Band six nurses present each shift- this was not previously a requirement.

- Within the review of the staffing establishment there has been consideration to the skill mix required within the staffing portfolio to support the services provided within ED. A training needs analysis has been completed to ensure all staff within the nursing establishment from Band two to seven have the skills and training opportunities required to fulfil their role.

- Staffing levels are monitored within a daily staffing proforma report which is shared with HoN, ILG Nurse Director and Executive Nurse Director, when staffing levels are not filled through bank or agency approval is sought for the use of Thornbury.

- Lead Nurse for unscheduled care meets monthly with the Senior Nurse for ED to monitor the governance and management requirements of the role, PDR, Sickness and vacancy rates form part of this meeting which informs escalation of concerns to the HoN.

- An integrated dashboard to be developed in the medium term to provide greater agility of response and analysis of high impact workflow.

- As identified earlier, there has been significant investment in providing staff with opportunities to support their well-being. This is signposted to staff via several methods within the HB including;
    - Social media
    - Sharepoint
    - CTMUHB Webpages
    - Staff Engagement Forums
    - Leadership Forum
    - Chief Executive Officer Blog

- A learning event for ED/CDU colleagues has taken place with further engagement planned to discuss the HIW findings openly and without apportioning any blame; to encourage involvement.

- Reflection and exchange of ideas on improvement and change.

- Provision of direct 'open access' support to affected colleagues.

- Significant emphasis has been placed on face to face listening and engagement sessions with the team immediately following the visit to ensure that the teams have an opportunity to share and express views.

- The leadership team at all levels have significantly enhanced visible leadership presence through walk-arounds and modelling the values and behaviours of the health board.

December 2021 Update

- Local arrangements within ILG's and its services provide assurance through Monthly Clinical Service Group Assurance meetings. Further to this a monthly performance business meeting takes place with the Executive Team to provide ILG level assurance.

- The following areas have been progressed to support appropriate leadership arrangements:
    - Further investment has been made to support staff and promote and maintain staff well-being via the development of the Wellbeing, Culture & Leadership approaches and activities within the PCH Improvement Programme. This will be reviewed at regular intervals to ensure that it continues to meet the needs of the Workforce and achieve the Programme's objectives. The High Level Route Map will guide the activities over the coming months.

- The following has been delivered between Oct - Dec 21:
    - The identification of the Root Cause Analysis via a review of reports and other existing data to validate trends.
    - A Wellbeing/Employee Experience Needs Assessment has been completed via early listening sessions to identify wellbeing needs and address issues of physical and psychological safety and wellbeing.
    - An assessment of psychological safety has taken place to establish levels of psychological safety and ability of staff to fully engage in the Improvement Plan.
    - Leadership Conversations have taken place - Listening sessions to hear how the Triumvirate leadership team are doing, to assess the level of readiness to tackle the deeper leadership and cultural issues, and to help the Triumvirate understand their role in the improvement process.

- Specifically in terms of Roles and responsibilities :
    - Job descriptions are being reviewed and standardised.
    - Competency levels are being mapped to bands.
    - Recruitment is being undertaken.
    - Leadership sessions have started internally and via external experts facilitated via the Partnership with Improvement Cymru.
    - Continuation with leadership, values and behaviour framework.

- The Prince Charles Hospital Improvement Programme incorporates ED and Theatres and a new Flow project work stream under a 'one' programme approach. The Programme, as it has matured and moved away from immediate make safes and diagnostic activity, is being re-set to ensure alignment with strategic objectives and delivery of Improvement activity.

- A review of the Programme's governance was undertaken by the COO in September 2021 resulting in changes being made to strengthen the Programme's oversight, scrutiny and assurance arrangements. These arrangements include:
    - The programme's progress is monitored through an executive sponsored monthly multi-disciplinary Programme Board.
    - A weekly ILG Oversight Meeting has been established to provide timely consideration of issues, risks and action planning and to drive the pace of the programme whilst also supporting the Operational Teams with delivery.

- Weekly Improvement Project Team Meetings take place for ED and Theatres with the support of the programme team.
- An Improvement Hub to lead the Programme has been established to provide specific expertise to enhance the support available to the operational delivery teams. The hub structure is made up of Staff resources that have been released to prioritise the Programme delivery. These include planning, Programme Management, Workforce and OD, Comms and Improvement. The Hub allows wider consideration of dependencies across the System.
- All aspects of the Programme are managed by Triumvirate Leadership with subject matter expertise from across the health board.
- A robust tracking action plan spreadsheet has been developed to monitor actions across the Programme. This tool will support the rigour in driving the delivery of actions and will also ensure transparency and assurance to the Programme Board and the wider Organisation.
- A performance dashboard has been developed to allow monitoring of key performance indicators aligned to the programmes objectives.
- We have further developed the partnership arrangements with Improvement Cymru and the Delivery Unit to ensure that the support is tailored to meet the needs of the PCH Improvement Programme.
- A Governance Framework, including a Risk Management Plan, accounting for governance arrangements across the wider ILG and health board, has been developed aligning with the organisational approach and methodology.
- Timely and regular reporting underpins the Programme including weekly highlight reports on progress delays, risks, issues and achievements which is presented to the Health Board's Strategic Leadership Board. Reporting has continued to the Quality and Safety Committee and a progress update has been provided to the Community Health Council. A full Report of the Ward Quality Assurance activity at PCH was completed and presented to the Board in November with recommendation to rollout across all Sites and to continue to monitor through the Quality and Safety Committee.

- Development and implementation of Safe-2-Start - daily meetings have been in place since November 2021 in Prince Charles Hospital. Attendance includes, Head of Patient Flow, HoN, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing

position for the day within the hospital, it focuses on Emergency Department demand and key quality and safety metrics relating to patient care.

- At the meeting the Ward Managers and Senior Nurses work together to problem solve staffing challenges to support any areas greatest need and move staff accordingly to ensure that wards and departments are in a safe to start position.

- Via the Safe-2-Start meetings, wards including ED now also provide a daily update of staff COVID-19 absences identifying day 6 and 7 of the isolation period to enable the forward planning and return to work dates.

- The Business Case for the Nursing Workforce requirements has been completed and awaiting final approval by the health board. One specific resource that is built into the business case is the role of an ED Senior Nurse for Professional Development.

- To further strengthen the focus on the workforce the Performance Dashboard developed for the Programme provides oversight and monitoring at Service, Programme and Board level of the key metrics including those related to absences, vacancies and PDR. Metrics relating to incidents, complaints and concerns and are also included on the Performance Dashboard.

- Currently the organisation is supporting the funding of an additional middle grade by night, although currently unable to cover every available shift. The review of the medical workforce is currently taking place which will further support addressing this shortfall.

- Lead nurse for unscheduled care has continued to meet with the Senior Nurse for ED to monitor the governance and management requirements of the role. During this meeting the following areas are discussed, ED, Minor Injuries Unit (MIU) and Fracture Clinic in relation to quality, safety, incidents, concerns, patient experience, the environment as well as the Workforce.

- The health board continues to provide staff with the opportunities to support their wellbeing via the following methods: Social Media, SharePoint, CTMUHB webpages, Leadership forum. Since the initial HIW visit managers and leadership have continued to ensure staff are fully informed of the steps taken in providing significant investment in staff wellbeing. This has been done by providing engagement sessions on the following dates:

- 12th October, 1st November and most recently 8th December which saw 29 staff in attendance. The aim of the December session was to provide staff with the opportunity to prepare for what to expect from the publication of the HIW report on the 15th December. The session provided staff with information around the expected media interest, frequently asked questions, acknowledgement of the sensitivity of the report and further provided staff with additional well-being support options.

- To support visible leadership and model the values and behaviours of the health board, purposeful Leadership walk round (PLW) takes place on a daily basis by the senior management team. A PLW rota has been developed and individuals aligned. The PLW's focus on the following four areas; Staff, Environment, Patients and any actions taken. Any re-occurring themes identified during these rounds are documented and distributed via a weekly e-mail.

- The High Level Route Map will guide the activities over the coming months.

- The development of a communication strategy is being progressed to ensure we communicate effectively with our patients and staff. We have commenced this work by expanding our communication platforms for staff.

What we found on follow-up

We found that the health board had implemented and sustained the majority of the improvements listed in the action plan drawn up following the last inspection relating to the quality of management and leadership. However, some areas remained in need of improvement and these are referred to in more detail below.

Governance, leadership and accountability

We found that the systems and processes in place to ensure that the health board focussed on continuously improving its services had improved considerably since the previous inspection.

The majority of staff spoken with told us that there were good informal, day to day staff supervision and support processes in place within the department and that management overview had improved since the previous inspection. However, some staff still felt that there was a degree of disconnect between senior managers within the health board and those working within the ED.

Improvement needed

The health board must ensure that senior managers remain visible within the ED and that they continue to engage with staff.

Staff and resources

Workforce

We found friendly, professional staff throughout the department who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and were knowledgeable about the care needs of patients they were responsible for.

There was a high reliance on agency staff at the time of the inspection. This was due, in the main, to staff sickness and staff having to isolate following a positive COVID-19 tests. However, we found that efforts were being made to secure the services of the same agency staff where possible to ensure continuity of care and familiarity with the department.

We were informed that the health board were actively recruiting nursing and medical staff. However, recruitment remains challenging within the national context of nurse/doctor shortages.

Staff spoken with told us that staff to patient ratio fluctuated depending on the numbers and care needs of patients presenting at the ED. We found staffing levels to be generally acceptable. However, there were shortages of Emergency Nurse Practitioners (ENP) and, as previously mentioned, experienced triage nurses. We expect that the health board will continue to monitor general staffing levels within the department, both medical and nursing, and remain focuses on staff support and supervision.

The health board must also continue to monitor the fluctuations in patient numbers within the ED and apply flexibility in deploying staff from areas experiencing low demand into areas of high demand.

We were provided with staff training information and found that there remains to be variance in individual staff mandatory training completion rates. In general, training compliance was found to be low and we were told that this was due to the on-going pandemic and staffing pressures.

Improvement needed

The health board must:

- Continue efforts to recruit of staff.
- Continue to monitor the fluctuations in patient numbers within the ED and apply flexibility in deploying staff from areas experiencing low demand into areas of high demand.
- Ensure that all staff members complete all elements of mandatory training

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 conduct follow-up inspections

Follow-up inspections can be announced or 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. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

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 will also highlight any outstanding areas of improvement that need to be made.

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 summarises 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
We found that a pre-recorded voice announcement system had been installed which plays background music and gives advice, in both Welsh and English, on COVID-19, hand washing and warnings about abuse against staff. The system was also set up to announce waiting times. However, this particular function was not working on the first day of our inspection.	Patients not kept informed of waiting times which could result in patients becoming anxious, frustrated and angry.	We brought the matter to the attention of one of the ED senior managers.	Steps taken to make sure that the system announced waiting times.
We found numerous cupboards and doors to rooms used for medicine preparation left unsecured. Chemicals were also seen in unlocked cupboards and on work surfaces in store rooms. The maxillo facial treatment room was of	These issues presented a significant risk of harm to patients and staff.	We brought this to the attention of the Head of Nursing.	Immediate steps taken to ensure that cupboard doors were repaired where necessary and kept locked when not in use. Staff reminded to keep doors to treatment rooms and cupboards locked when not in use.

specific concern. In this area we found sharp implements on work surfaces and drugs such as local anaesthetic and adrenaline not securely stored. This room was situated in the ambulatory area where patients with mental health presentations were accommodated.			Medical implements stored appropriately and staff reminded of dangers of leaving such implements in public view. Medication stored appropriately and staff reminded of their responsibilities with regards storage of medication.
Within the ambulatory area we found that, in the case of one patient, symptoms of sepsis had not been clearly identified, monitored or escalated in a timely way. In addition, repeat observations of four other patients, who were clinically unwell, had not been undertaken for over six hours.	This meant that a change in condition could go unnoticed with potential delay in commencing treatment resulting in harm to patients.	We brought this to the attention of the Head of Nursing.	An enhanced process of monitoring and observation of patients was introduced which was overseen by the nurse in charge.

Appendix B – Immediate improvement plan

Service: Prince Charles Hospital, Emergency Department

Date of inspection: 18 and 19 January 2022

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
No immediate assurances were highlighted during this inspection.				

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

Service: Prince Charles Hospital, Emergency Department

Date of inspection: 18 and 19 January 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				
The health board must ensure that all entrances into the department are kept clean and tidy.	4.1 Dignified Care	A cleaning schedule has been implemented by Grounds and Gardens Team in line with rota. A sign-off procedure sheet has been created. No Smoking signage is in place across all CTM sites (including PCH). Facilities Security Team are on site tasked with challenging smoking whilst undertaking their regular patrols.	Facilities Support Manager Head of Health and Safety	Achieved. On-going monitoring via paper audits. Achieved and on-going.
The health board must review the use of plastic/perpex screens in the shared cubicles within the ambulatory area in order to ensure		Statement being submitted for replacement Perspex screens. (current screens do not offer sufficient privacy)	Deputy Clinical Services Manager	May 2022.

Improvement needed	Standard	Service action	Responsible officer	Timescale
that patients are offered adequate levels of privacy. Consideration should also be given to limiting the number of patients accommodated in the cubicles at any one time in order to ensure privacy and dignity.		The number of chairs in the cubicles have been reduced from 4 to 3.		Achieved.
The health board must ensure that staff give patients accurate and consistent information about their care.	3.2 Communicating effectively	Communication to reiterate the systems and processes to continue via briefings at the beginning of each shift and Safety Huddles throughout the day. PALS staff to be located within the Department.	Lead Nurse and Clinical Director for ED Head of Patient Safety MCILG	Achieved. On-going monitoring via staff briefing and safety huddle documentation April 2022.
The health board must draw up a standard operating procedure (SOP) for the ambulatory area detailing how this area is to be used.	5.1 Timely access	Finalise the Draft Ambulatory SOP. Drive the implementation of the new Ambulatory Care SOP.	HoN	May 2022. May 2022 onwards.
The health board must consider ways to further enhanced the observation of patients in the main waiting area and encourage the triage nurses to		Red Flag system has been introduced. On-going monitoring will continue via audit and datix.	HoN	Achieved. On-going monitoring a datix is

Improvement needed	Standard	Service action	Responsible officer	Timescale
undertake a visual scan of the waiting area when calling patients in to the triage room.				submitted in line with Red Flag events subsequently each one is investigated, and action plans generated.
Delivery of safe and effective care				
The health board must ensure that staff undertake and record regular and timely on-going assessment of patients whilst within the ED.	2.2 Preventing pressure and tissue damage	Continue to monitor the completion of the -red flag system in ambulatory and waiting areas -the ED patient safety checklist in majors which is audited daily on AMaT. The assessments are reinforced by discussions about patients of concern in the Safety Huddles.	Senior Nurse	Achieved. On-going monitoring to continue through AMaT and Safety Huddles.
The health board must monitor and documented the risks involved in providing care for both COVID-19 positive and COVID-19 negative	2.4 Infection Prevention and	Pathways in place and approved by IPC. On-going monitoring of any adverse incidents through datix.	HoN	Achieved. On-going monitoring through Datix

Improvement needed	Standard	Service action	Responsible officer	Timescale
patients in the resus area and escalate any issues through Datix or the department's risk register.	Control (IPC) and Decontamination			reporting system.
The health board must set up a consistent process to investigate COVID-19 outbreaks.		To continue to report any adverse incidents via datix and report weekly by exception and about trends to the IPC Cell meeting. Nosocomial investigation process established at HB level.	HoN RTE ILG Director of Nursing	Achieved. On-going monitoring to continue through Datix reporting system. Achieved.
The health board must take measures to ensure that staff do not have to leave the ambulatory area in order to get certain items of medication from the majors area.	2.6 Medicines Management	Work progressing to create space for a mediwell (subject to changes in covid pathways).	Clinical Services Group Manager	July 2022.
The health board must ensure that Oxygen is not administered to patients unless it has been formally prescribed.		Continue to monitor via NEWS and adverse incidents via datix.	Senior Nurse	Achieved. On-going monitoring to continue

Improvement needed	Standard	Service action	Responsible officer	Timescale
				through AMaT system.
The health board must ensure that staff monitor and document pain scores and the effectiveness of the pain relief administered.	3.1 Safe and Clinically Effective care	In place – trend audited and reported at departmental and quarterly governance and business meetings accordingly.	Senior Nurse	Achieved. On-going monitoring to continue. Via clinical audit.
Quality of management and leadership				
The health board must ensure that senior managers remain visible within the ED and that they continue to engage with staff.	Governance, Leadership and Accountability	Regular Leadership rounds will continue. Senior Managers will continue to attend staff meetings and engagement events where appropriate.	ILG Director of Nursing	Achieved and will continue via meeting minutes.
The health board must continue with their efforts to recruitment of staff.	7.1 Workforce	To implement the ED Nursing Workforce Paper to recruit the approved additional permanent and substantive RGNs, Healthcare Support Workers and Patient flow Co-ordinators.	Senior Nurse	July 2022.

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must continue to monitor the fluctuations in patient numbers within the ED and apply flexibility in deploying staff from areas experiencing low demand into areas of high demand.		In place through the Patient Safety Huddles re staffing within the Department and the Safe2Start meetings and regular formal bed meetings re redeploying staff from other parts of the Hospital Site to support. Audit trail in place.	Lead Nurse and Head of Patient Flow	Achieved. On-going monitoring to continue. Via Safe2Start/Bed meeting documentation /Spreadsheets.
The health board must ensure that all staff members complete all elements of mandatory training.		Supernumerary staff are being used to support the release of staff. Monitored on a monthly basis via Senior Nurse reporting by exception if improvement trajectory not being met.	Senior Nurse	Achieved. On-going monitoring to continue. ESR Mandatory.

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: