Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Ysbyty Glan Clwyd (Emergency Department)
Activity date: 8-10 March 2022

Publication date: 18 May 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80364-230-7

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Ysbyty Glan Clwyd Emergency Department as part of its programme of assurance work. Ysbyty Glan Clwyd forms part of Betsi Cadwaladr University Health Board.

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

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

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

Where urgent action is required following an NHS quality check, we issue an Immediate Assurance letter to the Chief Executive of the organisation within two working days. This requires the setting to undertake immediate improvements to maintain patient safety.

As part of our Quality Check, we spoke to the Charge Nurse and Matron on the 8th March 2022, the Head of Nursing, and Clinical lead on 9th March 2022 and Band 5 and 6 department staff on 10th March 2022 who provided us with information and evidence about their service. We used the following key lines of enquiry:

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

We issued an Immediate Assurance letter on 14 March 2022 due to issues listed below. The health board responded on 22 March 2022 with a full action plan to address the issues raised. We acknowledged the progress made to date, but also that some issues would take some time to address. We plan to have regular engagement with the health board as it progresses the actions necessary to ensure patient safety.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. To do this we undertook a review of 20 sets of patient clinical records.

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

The following positive evidence was received:

We were informed by staff that on entry to the Emergency Department there is a member of security staff alongside a healthcare support worker. The healthcare support worker's role is to screen and swab each patient for COVID-19 before permitting entry into the department. We were told by staff that currently the waiting area has a separate area for those with any COVID-19 symptoms.

The staff informed us they have the ability to allow patients who are being discharged from the department during the hours of 8:00am and 8:00pm to wait for transportation in the discharge lounge, which is located on the hospital premises. However, outside of these hours there is no area in which patients can wait other than within the department.

Staff informed us of arrangements in place for families and carers to support vulnerable patients with their care and treatment when they attend the department. Staff told us that patients who are considered to have a cognitive impairment are permitted to have a family member or carer present with them. We were also informed that the Red Cross are situated within the department and, if capacity allows, they can assist vulnerable patients. The Red Cross also offer soft drinks to patients, and often assist in providing transportation of patients on discharge.

We were informed by staff that each entry door in the department is accessed using a swipe identification card in order to ensure that only people with authorised access can access the clinical areas of the department. Staff also informed us that in order to access the paediatric clinical area there is a separate door which requires staff to again swipe their identification

card.

The following areas for improvement were identified:

We were informed of the arrangements for monitoring patients within the adult waiting areas. Patients with 'major' presentations (patients who would require a trolley in the majors area if available) were routinely accommodated in the waiting room while waiting to be seen.

These patients were not subject to any consistent or ongoing checks, or monitoring of their condition. This included patients with infections, mental health problems and significant head injuries.

This lack of oversight also meant that high risk patients could leave the waiting area unnoticed. In our review of 20 cases, absence was not noted in several cases until many hours later, at which point the patient may have been at significant risk of deterioration.

There were no clear lines of accountability and responsibility for the waiting areas, with arrangements for checking the area currently being ad-hoc and inadequate.

Overall, the arrangements for monitoring patients in the adult waiting areas were insufficient and meant patients were placed at risk of avoidable harm.

The health board should ensure that robust arrangements are in place to oversee, monitor and escalate patients who are located in the waiting areas. This improvement was raised as an issue requiring immediate assurance from the health board.

Infection Prevention & Control

Infection Prevention and Control

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

The key documents we reviewed included:

- Environmental Infection Prevention Control Audit
- Mandatory Training record
- Hand Hygiene Audit
- COVID screening form.

The following positive evidence was received:

Staff informed us of the changes implemented in the department as a result of COVID-19. The department has recently created ten cubicles in the majors area with dedicated hand washing facilities in each cubicle and four cubicles in the resus area, again with dedicated hand washing facilities in each cubicle. We were told that Personal Protective Equipment (PPE)[1] is also placed outside each individual cubicle area. We were informed that there were two dedicated waiting areas, a red waiting area for those patients who were confirmed cases of COVID-19 or symptomatic, and a green waiting area for those who tested negative for COVID-19 or were non-symptomatic.

We were told that all staff in the department had undergone training in relation to 'donning and doffing'[2] the relevant PPE. This training has now become part of the mandatory training process along with Infection Prevention and Control (IPC) training.

Even though staff have tried to maintain social distancing whenever possible, they informed us that this is often difficult in busy periods.

We were told that COVID-19 screening would be undertaken on arrival of the patient to the department. A temperature check and COVID-19 swabs would be taken and patients would be signposted to the relevant red or green waiting areas dependent on results and symptoms. We saw evidence of the screening questions that would be asked.

We were also provided with information around the systems in place to ensure IPC measures are effective and up to date in accordance with national COVID-19 policy requirements.

We were told that staff are required to undertake a lateral flow test (LFT)[3] twice weekly and report positive results to senior staff at their earliest opportunity.

We saw evidence of monthly hand hygiene audits which were undertaken November 2021 to March 2022, which showed 100% compliance in the department.

The following areas for improvement were identified:

We were provided with evidence of an IPC audit which was undertaken in September 2021. This identified immediate improvements were needed in order to achieve a satisfactory status.

[1] PPE- clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments.
[2]The term "donning and doffing" is used to refer to the practice of putting on (donning) and taking off (doffing) protective gear, clothing, and uniforms
[3] Lateral flow is an established technology, adapted to detect proteins (antigens) that are present when a person has COVID-19.

The audit documentation noted that the cleaning responsibility framework and cleaning frequencies were not clearly displayed in the department and there was no evidence to confirm compliance.

The generic environment, clinical room, resus equipment, oxygen/suction equipment, manual handling equipment, dirty utility, and ward kitchen was found to be dusty and/or soiled.

The audit documentation noted the sanitary fixtures in the bathroom environment were not in a good state of repair. The audit further identified that clinical rooms and store had some single use equipment being put back into drawers.

Clean linen was being stored on top of the cleaning trolley. Further information from the audit identified that there was inappropriate disposal of waste and sharps. It is recommended that the health board ensure a further IPC audit is undertaken and an action plan is completed in order to improve the IPC status in the department.

We saw further evidence that compliance with mandatory training for IPC Level 1 in nursing staff was below 75% with medical staff compliance falling under 45%. Overall compliance with this training within the whole department fell below the standard expected with only 77% compliance.

It is recommended that the health board ensures that all staff undertake this mandatory training within the department.

Safe Care

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

The key documents we reviewed included:

- Description/Mapping out of the department, including the number of beds and staffing ratios for each area of the ED
- Management structure
- Current staff vacancies (listed by band)
- Current staff sickness (listed by band)
- Escalation policy
- Number of safeguarding referrals - last 3 months

- Last four Make it Safe Reviews (specific to vulnerable patients in the Emergency Department)
- Discharge checklist
- Discharge process/pathway
- Audits in relation to RCEM
- Policy/ Process in relation to the management of patients who are intoxicated/ substance use
- Missing Persons Policy/Process
- Mental Capacity Policy/Process
- Example Observation chart
- Information on CAMHS and ED work
- 20 sets of Emergency Department records from the previous 3 months.

The following positive evidence was received:

We saw evidence of a complete current staff vacancy list and a list of all current staff sickness.

Staff told us that sickness absence always creates issues in staffing, but more so since the pandemic, with many staff having to isolate at different periods. All vacant shifts go out to bank and regular agency staff who have been trained to work in this department, and how to use Symphony[4].

Staff told us they have regular agency workers who fill vacant shifts and these staff know the department well and have access to the digital systems in advance of their shift.

We were told that in addition to the training available through the internal training system, senior staff are aiming to deliver training on different subjects on a weekly basis. There is an intention to have a dedicated study day every six weeks moving forward.

As part of our quality check, we asked staff a number of questions around patient flow. We were told that all admissions are recorded on the WPAS[5] system but this is going to be moved shortly to the Symphony system. WPAS is live and can track a patient's journey through the hospital. Staff informed us they aim to get all patients triaged quickly, however, this isn't always possible, particularly during busy periods.

There is a dedicated triage nurse on shift in the department who is responsible for managing triage. Staff told us that triage can get busy at certain times of the day and sometimes it is necessary to provide an additional triage nurse.

[4] Symphony is the clinical system for urgent and emergency care, supporting patient management, tracking and clinical workflow

[5] Welsh Patient Administration System (WPAS)
The Welsh Patient Administration System (WPAS) holds patient ID details, outpatient appointments, letters, and notes.

We asked staff about the identification and management of any vulnerable patients within the department, including children, patients with learning disabilities, dementia or mental ill-health, palliative care patients and patients with substance or alcohol addictions.

We were told that the department has good communication with nurses specialising in all these groups and if someone came in with complex needs, they would contact the relevant nurse lead to ensure prompt review of the patient and to seek advice on managing the patient in the most appropriate way.

In the event patients are waiting for long periods of time in either the waiting area or main department, staff reported that they have regular help and input from the Red Cross volunteers who assist in ensuring the food trolley also goes round both areas three times a day to provide food and drink for patients.

We were informed medical leaders within the department were effective and supportive in their management of junior doctors. They had worked hard to ensure a culture of learning for staff and support them in their roles. Assessment and treatment from doctors were documented clearly and robustly in most of the 20 cases we checked. The medical plans of care and management advice was evidence based in most cases.

We were informed medical leaders supported junior doctors in their development and learning and ensured protected time for training. They had also made efforts to engage with other departments across the health board to foster learning and collaborative working.

The following areas for improvement were identified:

We reviewed the discharge policy and concluded it was not sufficiently specific to ensure safe discharge of patients from the emergency department. During the quality check call, staff also confirmed that there is currently no internal discharge process in place to help staff discharge patients safely. There was a checklist available for staff to complete. However, through reviewing records and speaking to senior staff we ascertained this was not used consistently.

HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of, and are trained in this process, to ensure the safe discharge of patients from this department.

In all 14 records reviewed where the patient was discharged, none contained a completed copy of the department's discharge checklist. In three out of four cases where a patient left against medical advice, the discharge against medical advice form was either not fully completed or absent. In 12 out of 14 cases there was no information recorded by nursing staff relating to the discharge arrangements, checks and safety netting.

This improvement was raised as an issue requiring immediate assurance from the health board.

Arrangements for tracking and monitoring where patients were located within the department were not robust. Records routinely lacked information on where the patient was accommodated. We saw several examples where patient locations were not kept up to date. This had led to confusion and delays in vital care and treatment being provided to patients. Examples included patients who were unwell being placed in the waiting room and staff not being aware they were waiting. In other cases we found that patients had left the department without being seen and were not noted as having left for a number of hours. This exposed patients to risk of harm.

This improvement was raised as an issue requiring immediate assurance from the health board.

Systems for flagging at risk and vulnerable patients were not adequate and meant that staff were not always able to identify where high risk patients were located within the department. This included patients with mental health issues and those at risk of falls.

Through reviews of patient records we identified cases where patients who were vulnerable were placed in areas where they could leave, unseen. In some cases this had occurred and staff were not aware of the absence for long periods. These cases included patients with significant mental health issues and children.

Staff were routinely unaware of the cohort of patients waiting in the waiting room. There was little oversight of this area and patients were not subject to routine or ad hoc checks of their condition and welfare.

This improvement was raised as an issue requiring immediate assurance from the health board.

As part of our quality check, we also asked staff a number of questions around patient flow. We were informed by staff that when they escalated the acuity/status of the department this was not always acted on or was overlooked, as it is regularly noted that the department runs on reduced bed capacity.

The health board should ensure that proactive action is commenced when the bed status/acuity of the department is being escalated.

We were informed by staff that there can be lengthy delays in patients being seen by ED doctors and specialty doctors. Staff told us that communication around this could also be problematic.

The length of time taken for a patient to be reviewed by a doctor was excessive in most cases. This exceeded the time suggested by the assigned triage category in most cases reviewed. In some cases this delay was significant, including in one case where a patient should have been seen within 10 minutes and waited over six hours to see a doctor. This patient subsequently became more unwell. In 14 out of 20 cases, patients were not seen within the recommended time for their triage category.

The health board should ensure that proactive action is commenced when a patient requires urgent assessment by a doctor. This improvement was raised as an issue requiring immediate assurance from the health board.

We were further informed by staff that patients requiring specialty review often encountered delays in being seen by specialty clinicians. For some cases we reviewed the wait was more than 12 hours. The health board should ensure that there is an appropriate pathway of escalation if a patient is not seen within a reasonable timescale by a specialty clinician.

We saw evidence of the observation documentation used within the department. We also saw evidence from a review of clinical records of inconsistencies in recording of physiological observations and NEWS[6] scoring.

In 15 out of 16 cases where physiological observations were indicated, they were not undertaken at a frequency to identify changes or deterioration in the patient's condition and allow for early identification of deterioration. In some of these cases, observations showed a deterioration when rechecked after a significant period of time. This posed a risk that patients could deteriorate unnoticed and not receive time critical interventions.

In some cases observations were not repeated before the patient left the department. This meant there was no accurate record of their clinical condition prior to leaving.

This improvement was raised as an issue requiring immediate assurance from the health board.

We identified that there is a lack of documentation to evidence that there were sufficient processes and arrangements in place to monitor and observe patients presenting with mental health issues.

We observed that there was no consideration given to the high risk nature of these patients and the very specific risks associated with their presentation. This included patients who presented with suicidal ideations and attempts being placed in areas which were not visible to staff.

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

In some cases these patients left the department unnoticed and in some cases no attempts were made to locate the patient. Risk assessments and tools for the assessments of patients presenting with mental health conditions were not routinely used.

Arrangements for assessing which patients may require one to one support were also insufficient and inconsistent. This presented a risk to patient safety. This improvement was raised as an issue requiring immediate assurance from the health board.

Evidence based pathways, risk assessments and guidelines were not being used consistently. Examples of guidelines not being used included those issued by NICE[7], RCEM[8] and RCS[9]. This posed a risk to patient safety. In all cases reviewed, standard risk assessments were either not completed fully or absent. These included risk assessments on self harm and suicide, falls risk and pressure damage.

HIW is not assured that there are sufficient risk assessment processes in place to protect patients from avoidable harm. This improvement was raised as an issue requiring immediate assurance from the health board.

In one case it was deemed that a patient who had presented with a potentially lethal overdose of paracetamol was not managed effectively in the department. Our peer reviewer noted that blood results were not documented (paracetamol level, liver function tests and INR[10]) and the clinical peer reviewer was unable to determine if the medical assessment was reasonable. The documentation lacked any detail of the patient's mental capacity or mental state. The patient discharged themselves against medical advice and the form to facilitate this discharge was not completed fully. This was not in line with local or national guidelines. Furthermore, there was no evidence that a paracetamol leaflet was provided as follow up advice.

Important aspects of investigation and checks of patient conditions were either not undertaken or not documented in most cases. This included a patient presenting with a very high heart rate and staff not undertaking an important investigation to check their heart (ECG). In another case a patient presented with abnormal blood test results and these were not noted or actioned by the department.

Patient mental capacity was not considered or documented in 13 of 20 cases reviewed. In these records there was no record of findings that suggested that the patient may lack capacity or that a mental capacity assessment has been carried out in line with RCEM and MCA guidance.

[7] The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for providing national guidance and advice on promoting good health and preventing and treating ill health.
[8] RCEM- The Royal College of Emergency Medicine. The College is established to advance education and research in Emergency Medicine
[9] The royal college of surgeons- A Professional Body Working To Advance Surgical Practice & Patient Care
[10] An INR (**international normalized ratio**) is a type of calculation based on PT test results. Prothrombin is a protein made by the liver. It is one of several substances known as clotting (coagulation) factors.

None of the 20 cases were assessed under the Mental Health Act. This was further evidenced in the RCEM audit undertaken 2019/20 'Assessing Cognitive Impairment in older people'. The audit identified that in 131 eligible patients only 1 had been considered for cognitive assessment.

Safeguarding arrangements were not robust and documentation for the assessment of safeguarding risks was not routinely considered. Safeguarding checklists and prompts were not completed in 18 out of 20 cases.

This improvement was raised as an issue requiring immediate assurance from the health board.

The risk of sepsis was not routinely considered and despite the department having sepsis screening tools, these were not utilised in any cases we reviewed. In some cases, patients showed significant signs of infection and possible sepsis, and in all cases they were not screened or treated in line with the health board's or national guidelines on the assessment and management of sepsis.

Further evidence was provided in the form of Severe Sepsis and Septic Shock 2016/17 audit, which identified that the department fell below the national standard that states that Respiratory Rate, Oxygen Saturations (SaO2), Supplemental Oxygen Requirement, Temperature, Blood Pressure, Heart Rate, Level of Consciousness (AVPU or GCS) and Capillary Blood Glucose should be recorded on arrival. This posed a risk that patients may not receive time critical interventions when required.

This improvement was raised as an issue requiring immediate assurance from the health board.

The management of patients presenting with possible or confirmed alcohol withdrawal was not in line with health board policy or national guidelines. The issues predominantly related to the assessment and monitoring of this group of patients by nursing staff. The Clinical Institute Withdrawal Assessment (CIWA)[11] scoring was not routinely undertaken or monitored. Observation of these patients while waiting to see a doctor did not meet the required standards in all cases reviewed. This included lack of scoring, lack of documented observation and lack of escalation. This posed a risk, as this group of patients have the potential to become very unwell, quickly.

This improvement was raised as an issue requiring immediate assurance from the health board.

[11] The Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) is an instrument used by medical professionals to assess and diagnose the severity of alcohol withdrawal.

Patients presenting with mental health issues and self harm were not routinely assessed for their risk of further harm. This had resulted in several patients leaving the department without being seen and in some cases returning after further self harming.

HIW was not assured that staff were recording and documenting the care and treatment they provide. This was further illustrated by evidence provided of RCEM Mental Health (self-harm) QIP 2019/20 audit, which identified that improvements should be undertaken in relation to close observations of patients in the department who are deemed medium or high risk of suicide. In addition a clinician reviewing a patient presenting with self-harm or a primary mental health problem, should have a recorded brief risk assessment of suicide or further self-harm. There should also be written evidence that patients have had an assessment for cognitive impairment during their visit to the department using a validated nationally or locally developed tool.

This improvement was raised as an issue requiring immediate assurance from the health board.

In all cases reviewed, the standard of nursing documentation fell far below the expected standard and did not include significant information required. This included the complete absence of documentation in some instances. This was despite some patients being present in the department for in excess of eight hours and requiring nursing care.

The documentation in all cases was missing important information and assessments. This included documentation of checks and monitoring, risk assessment, general condition updates, communication and specific needs such as food and drink.

This improvement was raised as an issue requiring immediate assurance from the health board.

In one instance it was evident from the records review that there was a failure to provide complete records and recognise unscheduled re-attendance requiring Consultant Sign-Off in line with June 2016 - RCEM - Quality in Emergency Care Committee Standard. We saw further evidence of this in the RCEM audits provided which was undertaken in 2016/17, this audit identified that only 14% of patients were identified as reviewed by consultants under this standard. Further to this, there was one instance from the records review that also identified a patient who was brought into the department in police custody was not assessed in line with RCEM Best Practice Guideline - Emergency Department Patients in Police Custody - June 2016 and was discharged at triage.

Governance & Staffing

HIW was not assured that there was a supportive culture which promoted accountability and safe patient care. We found that senior nursing staff had raised concerns with middle management and these concerns had not been acted on. Senior staff told us that they were

aware of a number of the issues identified but could not tell us what they had done to remedy these and safeguard patients.

We were told by staff that senior operational and nursing leadership was inconsistent and did not always support the staff within the department to deliver safe and effective care.

This improvement was raised as an issue requiring immediate assurance from the health board.

We found that the culture within the department lacked accountability and did not encourage nursing staff to deliver evidence based, safe care. The department was routinely operating at a high level of escalation. We found that due to this, staff were not always escalating their concerns, or reporting patient safety issues and incidents. This meant key lessons were not always learned and posed a risk of reoccurrence.

This improvement was raised as an issue requiring immediate assurance from the health board.

It was accepted by managers that the department operated at a very high occupancy /acuity level. As a result staff within the ED and senior leaders were not following the health board escalation policy fully. This led to the approach to managing patient flow becoming sometimes chaotic and ineffective at all levels.

This improvement was raised as an issue requiring immediate assurance from the health board.

Medical staff appeared to be well supported and did attempt to hold staff to account. The medical leadership within the department was effective and supportive for junior doctors. However, we found that due to the deficits in the nursing care, documentation and escalated nature of the department this presented significant barriers to medical staff being able to undertake their roles effectively.

This improvement was raised as an issue requiring immediate assurance from the health board.

We found that there had been an unstable senior nursing leadership situation for a number of months in the more senior lines of leadership and management. This had resulted in several interim positions and a feeling of instability and change fatigue within the department and management structure. Leaders within the department were not aware of some of the issues identified, and where they were aware, had not recognised the gravity and seriousness of the issues.

Leaders for the department had attempted to raise concerns about several issues of patient safety. However, these had not been listened to or acted on. Leaders acknowledged that

significant cultural change was required to make the department a safe and effective environment for patients and staff.

This improvement was raised as an issue requiring immediate assurance from the health board.

The management of incident investigations was not robust and failed to identify key safety issues and ensure robust remedial action was taken. This meant that patients were exposed to risk of harm. In one example we found that key issues around patient triage had not been identified and addressed.

This improvement was raised as an issue requiring immediate assurance from the health board.

We found that repeated issues were present in several of the make it safe reviews we reviewed. This included lack of risk assessment, lack of observations and poor documentation. Despite these issues persisting throughout several incidents over a period of months, senior staff could not tell us what had been done to escalate these risks and address them at a senior level.

This improvement was raised as an issue requiring immediate assurance from the health board.

We were told by staff that learning from incidents is not something which is regularly shared across Betsi Cadwaladr University Health Board hospital sites. The health board should ensure that there are robust mechanisms in place to share learning from incidents.

This improvement was raised as an issue requiring immediate assurance from the health board.

What next?

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

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

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

- Ensure that the areas for improvements are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

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

Immediate improvement plan

Service:	Ysbyty Glan Clwyd
Area:	Emergency Department
Date of Inspection:	8th – 10th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Healthcare Inspectorate Wales (HIW) undertook an announced remote quality check of the Emergency Department at Ysbyty Glan Clwyd from 8th -10th March 2022. A clinical review of 16 case records was undertaken and the following immediate assurances were found. **HIW is not assured that the current arrangements for discharging vulnerable patients from the emergency department are safe and robust, to prevent risk of harm.** • Increasingly staff working within the emergency department are discharging patients with complex and varied needs. We observed this through our review of records and through staff dialogue. Therefore, it is of utmost importance that staff working within the department consider all aspects of discharge to ensure patients are safe when leaving the department • Within our review of records we found several records which indicated that discharges were not being undertaken consistently, and basic checks were not documented as being undertaken in all cases. These checks included making sure vulnerable patients had access to their property and were haemodynamically stable prior to discharge • There were significant gaps in the documentation of discharge arrangements. This meant in some cases it was not possible to identify what happened to the patient or where they went • In all 14 records reviewed where the patient was discharged, none contained a completed copy of the departments discharge checklist				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• In three out of four cases where a patient left against medical advice, the discharge against medical advice form was either not fully completed or absent • In 12 out of 14 cases there was no information recorded by nursing staff relating to the discharge arrangements, checks and safety netting • In one case, although there were some notes on discharge, these were not sufficient and did not take account of all factors to facilitate a safe and effective discharge, placing patients at significant risk of harm. **HIW is not assured that the arrangements for monitoring, observing and tracking patients throughout the department are sufficient to protect patients from avoidable harm.** **Waiting areas** • The arrangements for monitoring patients within the adult waiting areas were insufficient and meant patients were placed at risk of avoidable harm. Patients with 'major' presentations (patients who would require a trolley in the Majors area if available) were routinely accommodated in the waiting room while waiting to be seen. These patients were not subject to any consistent or ongoing checks or monitoring of their condition, potentially leading to deterioration of their condition by the time they were seen by a doctor. This included patients with infections, mental health problems and significant head injuries • In one significant case a patient was placed in the waiting room with a suspected bowel perforation. They were later transferred to intensive care and sadly died the waiting room is not a suitable placement for a patient who has the potential to deteriorate rapidly and catastrophically. • The lack of oversight of the waiting area meant that high risk patients were able to leave the waiting area unnoticed. In several cases their absence was not noted until many hours later, at which point the patient may have been exposed to significant risk. Examples included a child who had attempted suicide, patients who had attempted self-harm and suicide, and patients who had signs of alcohol withdrawal and abnormal physiological observations • In some cases observations were not repeated before the patient left the department. This meant there was no accurate record of their clinical condition prior to leaving • There were no clear lines of accountability and responsibility for the waiting areas, with arrangements for checking the area adhoc and inadequate • In 14 out of 16 cases, patients were not seen within the recommended time for their triage category.				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• The length of time to review by a doctor was excessive in most cases. This exceeded the time suggested by the assigned triage category. In some cases this delay was significant including in one case where a patient should have been seen within 10 minutes and waited over six hours to see a doctor. This patient subsequently became critically ill • There were insufficient processes and arrangements to monitor and observe patients presenting with mental health issues. We observed that there was no consideration given to the high risk nature of these patients and the very specific risks associated with their presentation • Arrangements for assessing which patients may require one to one support were insufficient and inconsistent. **All areas of the department** • Physiological observations and visual checks of patients throughout the department were not undertaken consistently or at a frequency to enable effective identification of deterioration or changes to a patient's condition and we found an inconsistent approach to the monitoring and recording of observations and early warning scores • In 15 out of 16 cases where physiological observations were indicated, they were not undertaken at a frequency to identify changes or deterioration in the patient's condition: o In one example a patient who had suffered a seizure and head injury had infrequent observations and did not include neurological parameters o In one example a patient presented with a significantly raised pulse rate following suspected substance misuse. This parameter was not checked for a number of hours, which is not in line with RCEM guidelines on the observations taking o In another case a patient was noted to be critically ill and requiring urgent surgery. This patient had significant hypotension, but despite this, there is no record of their observations being repeated for a number of hours • Arrangements for tracking and monitoring where patients were located within the department were not robust. Records routinely lacked information as to where the patient was accommodated. We also saw several examples where patient locations were not kept up to date. This had led to confusion and delays in vital care and treatment being provided. In one case it appears to have led to a significant delay in a patient receiving surgical review. The patient sadly continued to deteriorate during the time they were not able to be located, and later required surgery and died • Systems for flagging at risk and vulnerable patients were not adequate and meant that staff were not always able to identify where high risk patients were. This included patients with mental health issues and falls risks				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale

• Despite the department having a system for intentional rounding, this was not routinely undertaken or documented. This included patient groups who may have been at higher risk of developing pressure damage. Consistent rounding or checks were not evident in any of the cases reviewed.
• Evidence based pathways and guidelines were not being used consistently. Examples of guidelines not being used included those issued by NICE, RCEM and RCS. This posed a significant risk to patient safety:
  ○ This included an example where a patient had suffered a head injury with a loss of consciousness. This patient had no documented checks or observations for a six hour period after presentation. This is not in line with guidance from RCEM or NICE on the management of head injuries.
 	
HIW is not assured that sufficient risk assessment processes are in place to protect patients from avoidable harm.
• In all 16 reviewed cases, core and relevant risk assessments were absent or incomplete. This included risk assessments on falls, pressure area damage and bed rails. This meant that staff were potentially unsighted on the individual risks for each patient and therefore these risks may not have been mitigated
• Safeguarding checklists and prompts were not completed in 15 out of 16 cases. This included the domestic violence checklist for adults and the safeguarding children's checklist:
  ○ In one case a child had presented with issues which would have prompted a safeguarding referral. Despite this the safeguarding checklist was not completed. A referral to the hospital liaison nurse was completed later, however, no efforts were made to safeguard the child in the immediate term. No contact was made with social services for advice or guidance. This was despite the child self-harming, appearing withdrawn and going missing from the department
• We saw that in some cases the absence of risk assessment and associated mitigations had potentially led to patients suffering harm. In one case a patient attended with a cerebral bleed following a fall. Despite this, no falls risk assessment was completed. The patient suffered two falls and sustained further injuries while in the department
• In another case a patient presented with seizures. Despite this there were no risk assessments present for any risks including bed rails and falls. The patient was subsequently found on the floor following a seizure and sustained further injuries
• Despite the department implementing a safety checklist for all patients, this was consistently missing or not completed. This meant key aspects of patient safety were not considered, identified or managed.
• Patient risk of pressure damage was routinely not assessed in the cases we reviewed				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• We were not assured that risk of sepsis was routinely considered. Despite the department having sepsis screening tools these were not utilised. In some cases patients showed significant signs of infection and possible sepsis and were not screened or treated in line with the health board's, or national, guidelines • The management of patients presenting with alcohol withdrawal was not in line with the health board policy and national guidelines. The issues predominantly related to the assessment and monitoring of this group of patients by nursing staff. Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scoring was not routinely undertaken or monitored and observation of these patients while waiting to see a doctor was inadequate in all cases reviewed. This posed a significant risk as this group of patients have the potential to become very unwell quickly • Patients presenting with mental health issues and having self-harmed were not routinely assessed for their risk of further harm. This had resulted in several patients leaving the department without being seen and in some cases returning after further self-harming. **HIW is not assured that nursing staff are adequately recording and documenting the care and treatment they provide. This poses a significant risk to patient safety.** • In all cases reviewed the standard of documentation fell far below the expected standard and did not include significant information required. Record keeping was consistently poor and lacked significant detail • In 13 out of 16 cases reviewed this include lack of any nursing documentation. This meant it was unclear from the documentation whether the patient had received any nursing care or input • Key areas which were routinely not completed included risk assessments, documentation of care provided, checks and observations and mental capacity assessments • In seven out of nine cases where the patient presented with a history which could indicate dysfunction of the mind, no mental capacity assessment was documented for key decisions. This included patients deciding to leave the department against medical advice • In the other two cases capacity was documented, but did not meet the standard for documentation of this in line with national standards. **HIW was not assured that there is a supportive culture which promoted accountability and safe patient care. Senior operational and nursing leadership was inconsistent and did not always support the staff within the department to deliver safe and effective care.**				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• We found a culture in the department which did not encourage staff to deliver evidence based, safe care, with poor accountability for individual actions. • The department was routinely operating at a high level of escalation. We found that due to this, staff were not always escalating their concerns, or reporting patient safety issues and incidents. This meant key lessons were not always learned and posed a risk of reoccurrence • It was accepted that the department operated at a very high occupancy /acuity level. As a result staff within the ED and senior leaders were not following the health board escalation policy. The led to the approach to managing patient flow becoming sometimes chaotic and ineffective at all levels • We found that there had been an unstable senior leadership position for a number of months in the more senior lines of leadership and management. This had resulted in several interim positions and a feeling of instability and change fatigue within the department and management structure • Leaders within the department were not aware of some of the issues identified, and where they were aware, had not recognised the gravity and seriousness of the issues. • Leaders for the department had attempted to raise concerns about several issues of patient safety. However, we were told that these had not been listened to or acted on • Leaders acknowledged that significant cultural change was required to make the department a safe and effective environment for patients and staff • The management of incident investigations was not robust and failed to identify key safety issues and ensure robust remedial action was taken. This meant that patients were exposed to risk of harm. In one example we found that key issues around the patient triage had not been identified and addressed • We found that repeated issues were present in several of the make it safe reviews we reviewed. This included lack of risk assessment, lack of observations and poor documentation. Despite these issues persisting throughout several incidents over a period of months, senior staff could not tell us what had been done to escalate these risks and address them at a senior level.				
HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process,	**Standard 5.1 Timely Access**	Daily spot checks of the ED Discharge Checklist will be undertaken manually for admitted	Head of Nursing and	Immediate and ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
to ensure the safe discharge of patients from this department. HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.		and non-admitted patients (until the symphony system is embedded, which will enable the automated pull of the information.) The results from this will be extended to include Minor Injuries Units (MIUs) and will be presented to the HMT on a weekly basis to provide oversight of the discharge process. The ED Leadership has requested (through the BCU wide symphony user group) that the Discharge Checklist is made mandatory for all patients. Currently it is only mandatory for patients where a decision to admit has been made. Symphony goes live at YGC on the 30th March 2022 and we are seeking assurance that this programming change is achievable by this date. It has been agreed by ED leads to include extra fields to the mandatory checklist, including safeguarding prompts, concerns and mental capacity. This will be	Clinical Director Directorate Manager ED ED Leadership team	 30th March 2022 30th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		applied to all admitted and non-admitted patients		
HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.		The BCUHB wide Discharge Policy is being reviewed and will include specific ED discharge elements. The policy will be in place from early May 2022 and a roll out process will be implemented with ED staff.	Deputy Chief Executive and Executive Director of Nursing and Midwifery, and Assistant Director of Central Area	Early May 2022
		Whilst awaiting the updated Discharge Policy, all EDs have been instructed to use the BCU wide discharge checklist, and the applicability of the MIUs is being assessed	Deputy Chief Executive and Executive Director of Nursing and Midwifery	Immediate
		Professional accountability is being reinforced via the ED leadership, supported by the HMT (who will personally undertake random spot	Head of Nursing / Clinical Director and HMT	Immediate
HIW requires the health board to have an ED specific discharge process in place and ensure				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.		checks) in relation to the responsibility and accountability when discharging patients from ED by strengthening processes, improving oversight and introducing spot checks, further training and reinforcing professional expectations. Educational sessions regarding professional regulation and record keeping have already commenced for all registered nursing staff. The importance of quality checks will feature within this, including safeguarding, pressure ulcers, falls and identification of infection risk and sepsis. This will be extended to all clinical and support staff. Prior to the next version of the rota, we will ensure an experienced Band 6 is available to lead on all shifts 24/7, if there is not a Band 7 not already rostered. A band 7 senior leadership meeting has been undertaken (16th March	Head of Nursing / AHP Lead / Clinical Director Head of Nursing / Matron Head of Nursing / Matron	Commenced 10th March, due for completion by 24th April 2022 in YGC 16th March 2022 8th May 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		2022) to feedback the key findings from the HIW report. It has been agreed that there will be a band 7 on duty 24/7 to ensure senior oversight of the department. This will take effect from the next version of the rota, which is from 8th May. ED Safety Huddles will be undertaken every 2 hours to provide oversight of any patient safety, quality, experience and concerns, and the safety of the department. Key areas will include managing a deteriorating patient, as well as managing associated risk. An SOP describing this approach (incorporating the roles and responsibilities of the HMT, the senior doctor and nurse on duty at every shift) in order to manage whole site and system risk will be rolled out for implementation by 25th March 2022.	Head of Nursing / Matron HMT Head of Nursing/ Head	16th March 2022 25th March 2022 22nd March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A series of steps have been agreed around roles and responsibilities that will enhance oversight of patient safety and quality, whilst ensuring that the ED nurse in charge can be entirely focused on patient safety quality and experience. These steps are commencing on the 22nd March and include: i) A further CSM based within the EQ throughout the daytime ii) Move from EQ based huddles to ED safety huddles with a defined SOP on the key areas of focus iii) The flow responsibilities that currently sit within the Nurse in charge role will move to an ED Clinical Flow co-ordinator. Volunteers will be requested to focus on ensuring patients are offered food and drinks and that contact with families/friends and	of Site / Directorate Manager / Matron Head of Nursing/ Head of Site / Directorate Manager / Matron	25th March 2022 1st April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		carers can be maintained, escalating as appropriate Discharge planning will commence from the point of arrival. All patients of any age or with any type of vulnerability to be raised at ED safety huddle prior to discharge, to ensure that relevant risk assessments have been undertaken.	Head of Nursing/ Head of Site / Directorate Manager / Matron	
HIW requires details of how the health board will ensure that all staff are aware of their duty to maintain accurate, up-to-date, complete and contemporaneous records at all times.	**Standard 3.5 Record Keeping**	Educational sessions regarding professional regulation and record keeping have commenced for registered nurses and support staff, and will be rolled out to include medical and AHPs. This will be augmented by clinical audit support from corporate teams, which will be part of a broader cycle of audits undertaken. This will also include the implementation of CIWA guidelines The HIW report has been shared with the senior nursing and medical	Head of Nursing / Clinical Director / ED Practice Development Nurse / Corporate Education Team Clinical Director / ED	Commenced 10th March 2022/ ongoing Commenced 16th March

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		teams. A daily spot check of record keeping will be undertaken (incorporating input from HMT) and findings reported to the governance meeting	Matron / ED Nurse in Charge	2022/ ongoing
		The BCU Clinical Executive Directors have indicated to all clinicians the importance of the professional standards, in relation to maintaining appropriate and comprehensive reports.	Clinical Executive Directors	Commenced 17th March 2022
		Following acceptance of this improvement plan by HIW, the report will be shared across the site and the importance of the findings. Once the report has been submitted and approved this will be formally shared through site PSQ, the Clinical Director Forum and other forms. Learning will also be shared across sites through the North Wales Emergency Care Forum.	HMT	Commenced10th March 2022
		We have commenced NMC record keeping and accountability training sessions specifically for ED staff. This is being led by Associate Director of Professional Regulation and Education.	Associate Director of Professional Regulation and Education	End of April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		We are undertaking a review of PADR compliance, preceptorship arrangement for new qualified staff and induction programmes for all registered and support staff (medical and nursing). This will inform any gaps in knowledge and will include contemporary record keeping standards. General training has already commenced. In order to address any gaps in knowledge around record keeping we will implement a tailored training plan based on individual needs.	Head of Nursing/ Clinical Director	25th March 2022
		All registrants will be issued a formal notification with regard to their roles and responsibilities as a registrant. The letter will contain their job description, NMC/GMC code of Professional Conduct and how to mitigate or escalate any actual or potential concerns whilst on shift and beyond. Staff side and HR engagement is already underway with agreement in place.	Clinical Director / Head of Nursing / AHP Lead / Chief Pharmacist	25th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
HIW requires details of how the health board will ensure that there are measures in place to ensure patients accommodated in all areas of the department, including the waiting room, are observed and monitored to ensure their safety.	**Standard 2.1** Managing Risk and Promoting Health and Safety	In order to enhance the current Manchester triage review arrangements, the nurse in charge will ensure that a dynamic risk assessment of the waiting areas, including ambulances will take place every 30 minutes.	ED Nurse in Charge	25th March 2022
HIW requires details of how the health board will ensure that there are measures in place to ensure risks to patient safety are assessed and mitigated.		The nurse in charge will redeploy additional staff when required to mitigate any risks. An SOP is being developed to outline the roles and responsibilities of the registered nurses and HCAs that are accountable for the waiting areas on a shift by shift basis – and this will be in place by 25th March 2022	ED Nurse In Charge and Clinical Flow coordinator	25th March 2022
The health board must provide HIW with details of the action to be taken to ensure consistent monitoring and recording of visual observations, physiological observations and NEWS scoring for all patients.		Reinforcement of Intentional rounding and clinical observations processes will be reflected in the safety huddles and escalated to the nurse in charge where indicated.	ED Nurse In Charge	25th March 2022
		This will be validated on a daily basis and the results reported to HMT on a weekly basis.	Head of Nursing / ED Matron /	25th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
			Matron of the Day	
		HMT to implement Health Board workforce recommendations, ensuring refresh of plans in line with professional standards, ensuring all gaps are in the process of being recruited to.	HMT	Immediate
		Roster compliance will be strengthened to ensure compliance with KPIs. This will be validated for approval by the HoN and Clinical Lead prior to every roster sign off.	Head of Nursing and ED Matron	23rd March 2022
		In addition to the above, real-time staffing levels for the ED are monitored via the Safe Care systems twice daily meeting between the matron of the day and the HoN. Any actual or potential issues are mitigated/escalated via staff movement or bank or agency, or escalated to HMT/silver or gold out of hours	Head of Nursing and ED Matron	23rd March 2022
		Nurse in charge and Clinical Flow Coordinator to ensure that all patients in ED are accounted for at all times. A roll call will take place	Head of Nursing /	15th April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		before every 2 hourly safety huddle and any concerns escalated. Spot checks of the safety huddles will take place to ensure compliance with process. If a patient leaves without being seen, there are clear posters in place stating that they must make the receptionist aware. Where this happens, this will be escalated to the nurse in charge immediately. Safeguarding team are providing training on the process of identifying vulnerable patients/children in ED. This process will also be cross – referenced in the Discharge Policy, which will also include the management of vulnerable patients. All staff have been reminded of their professional responsibilities to escalate concerns. HMT and ED leadership will increase their visibility in clinical areas by undertaking the safety huddles, and undertaking walkabouts, particularly in times of high escalation	Directorate General Manager Safeguarding Deputy Chief Executive/ Executive Director of Nursing HMT	Early May 2022 30th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		This will be underpinned by an escalation plan to be devised that outlines what key actions need to take place as the acuity and volume in the department increases.	Head of Nursing / ED Matron	30th April 2022
		All band 5 and band 6 Registrants will undertake the RCN Emergency Nurse management competencies which include taking observations and how to escalate and manage risks where appropriate	ED Matron	September 2022
		A gap analysis will be undertaken with regard to band 6 and 7 clinical and leadership skills that will lead to generic and bespoke training to meet the clinical and leadership requirements of their roles.	Head of Nursing / Clinical Director	End of April 2022
		KPIs will be set for all roles	Head of Nursing	End of April 2022
		A Foundation for Emergency Nursing Course will be implemented on a rolling basis to include all band 5 RN's.	Head of Nursing	End of April 2022
		Emergency Department Discharge checklist to be amended so that all patients receive a final set of	Head of Nursing /	End of April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		observations prior to transfer out of the department and discharge. This will be aligned with the BCU discharge policy and compliance spot checked on a daily basis and reported to HMT on a weekly basis. Clear identification of Nurse in Charge will be in place by the end of April 2022	Clinical Director Head of Nursing	 End of April 2022
The health board must provide HIW with details of how it will ensure that there are robust and appropriate leadership arrangements in place with robust and effective governance processes and measures. HIW requires assurance from the health board that our findings are not indicative of a systemic failure to provide safe, effective and dignified care across all services. The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients on the ED.	**Governance and Leadership** **Standard 7.1** Workforce	The Health Board will put in a place a process enabling the HMT, Executive Team, and Independent Board members a regular process of gaining visibility and accessibility across service and clinical areas, which will incorporate walkabouts, safety huddles, *Ask the Panel events*, as well as hosting monthly listening events for ED staff. HMT will put in place a process of triangulating information from different sources such as: Incidents, complaints, Speak out safely guardians, risks and monitor this as part of a mechanism to assess effectiveness.	HMT Executive Team and Independent Board Members HMT	Commenced for Board visits 30th March 2022 for HMT 30th April 2022 30th April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.		As part of regular performance review meetings, there will be corporate oversight of this action plan. This will incorporate assurance reports through to the Patient Quality and Safety Group. Interim Head of Nursing in place to ensure cover for long term absence. This role will provide daily Senior visibility and give staff an opportunity to share information and escalate concerns. Staff wellbeing initiatives are in place and will be promoted, and Speak out Safely Guardians have attended the EQ Governance Meeting on 24th February 2022 and all staff were encouraged to raise issues. Following this we will implement a monthly collaborative forum consisting of HMT, Staff Side and SoS Guardians, where the HMT can be appraised of any emerging issues from the SoS Guardians. Management of rosters will be strengthened to ensure compliance with KPIs. This will be validated for	HMT / Executive Team HMT HMT and SoS Guardians Head of Nursing / ED Matron /	Implemented 4th April 2022 7th April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		approval by the HoN and Clinical Lead prior to every roster sign off. In addition to the above real-time staffing levels for the ED footprint are monitored via the Safe Care systems twice daily meeting between the matron of the day and the HoN where any actual or potential issues are mitigated via staff movement or bank or agency. Implement a 'QI Thursday' for senior nursing and medical staff to increase visibility, share good practice and undertake assurance visits. Safety huddle/debrief post shift, which will include review of shift log and documentation. This will link to existing support around TRIM where required. We will extend the use of LEAF (Learning, Education, Alerts and Feedback) across all staff groups and ensure learning from incidents and concerns is implemented into practice.	DoN / HoN DoN / HoN and Medical Director ED leadership team ED leadership team	May 2022 May 2022 May 2022 End April 2022 End April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Build in PADR/appraisal/LEAF process e.g. to include the submission of a piece of reflective practice Bespoke training in Risk Management will be implemented in a prioritised manner, starting with those in key leadership positions in the department across medical, nursing and operational staff. This will focus on 3 key areas risk assessment, risk escalation arrangements and documentation of risk assessments, and will specifically address areas such as seizures, pressure areas, sepsis management, mental health assessments and alcohol withdrawal.	ED leadership team ED leadership team / Interim Board Secretary	End April 2022

Ysbyty Glan Clwyd (Emergency Department) Representative:

Name (print):	Neil Rogers
Role:	Acute Site Director
Date:	21 March 2022

Improvement plan

Setting: Ysbyty Glan Clwyd

Ward/Department/Service:
Emergency Department

Date of activity: 8-10th March 2022.

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

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

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board should ensure that proactive action is commenced when the bed status / acuity of the department is being escalated.	**Standard 2.1** Managing Risk and Promoting Health and Safety	Safety huddles are in place every two hours, 24 hours a day 7 days a week. An electronic log is maintained for all safety huddles. All areas of the Emergency Department are reviewed at the safety huddle, including the waiting room and any ambulances queued outside. A risk matrix is completed defining the overall escalation status of ED at that point and what actions have been taken within ED to control and	Director of Nursing, YGC.	16th May 2022

			mitigate any risks. Sufficient clinical capability will be maintained to ensure all patients are actively triaged and observed regardless of location In between the 2 hourly reviews, senior hourly board rounds will take place. Escalation in-between huddles and board rounds will be from clinicians to the ED Nurse in Charge, then as needed to the Senior Consultant, and Clinical Site Manager/On-Call Manager. When the safety huddle triggers any issues in relation to overall capacity / acuity within the department or excessive volumes or delays in patients awaiting transfer out, the Hospital Management Team (HMT) will be alerted. Out of hours, escalation is via the management on call rota. As a consequence of this consistent approach to escalation, patients at clinical risk of deterioration will receive the appropriate input and be transferred to the appropriate care setting. The ED escalation status feeds through in to the overall hospital site escalation plan, with defined roles and responsibilities and	Director of Operations, YGC. Director of Operations, YGC.	16th May 2022 16th May 2022

			timescales to de-escalate the position in the Emergency Department. The plan is reviewed on a dynamic basis, in accordance with the position at the time and will be a formal agenda item for the weekly HMT meetings.		
2	The health board should ensure that all staff are compliant with mandatory training		Staff will be supported to complete all aspects of available mandatory training that are essential to their role. Where there have been issues with regard to face to face / classroom sessions due to social distancing constraints, staff will be rostered and freed up to attend now that these restrictions have eased. This will include the immediate organisation of resuscitation training (ILS levels 2 & 3) for those staff who are not compliant and where compliance has lapsed. Where appropriate, additional training sessions will be convened to take place locally within the Emergency Department to provide bespoke training to drive up compliance levels, including Level 2 and 3 Safeguarding for registrants and Level 1 for all staff. The Hospital Management Team will track performance to maintain	Director of Nursing, YGC. Director of Nursing, YGC. Director of Nursing, YGC. Acute Care Director, YGC	31st July 2022 31st July 2022 31st July 2022 31st July 2022

			mandatory training compliance levels across the Emergency Department with a trajectory to achieve a minimum 85%. Compliance will be a standing agenda item on the weekly Hospital Management Team (HMT) meeting.		
3	It is recommended that the health board ensure a further IPC audit is undertaken and an action plan is completed in order to improve the IPC status in the department		Further audits were undertaken by the Infection Prevention & Control Team. These reports have been reviewed, immediate actions taken and further actions incorporated into the existing action plan. These will be overseen by the site Quality and Safety meeting. A further audit has been forward-planned for week commencing 20th June 2022. This timescale is on the advice of the Health Board's Director of Nursing for Infection Prevention & Decontamination, to formally review and scrutinise progress. An environmental improvement plan is being developed jointly with Estates and Facilities, and will be in place to include additional support to maintain IPC standards.	Director of Nursing, YGC. Director of Nursing, YGC. Acute Care Director, YGC.	Completed - 4th May 2022 20th June 2022 30th June 2022.
4	The health board should ensure that proactive action is commenced when a patient requires specialty review or if	**Standard 5.1 Timely Access**	The Internal Professional Standards (IPS) have been refreshed and issued to all specialities and will	Acute Care Director, YGC.	16th May 2022

	there is a delay in receiving a specialty review.		be shared at all future inductions on an ongoing basis to ensure that expectations are understood and visible. Training sessions will be organised for all specialities to outline IPS requirements and to highlight any gaps in service provision, and that any mitigations required have been put in to place. This will be overseen and monitored by the weekly HMT meeting. The Hospital Management Team will put an expectation in place, following a workshop with all speciality Clinical Directors and Clinical Leads, that speciality response time to ED will be a maximum of 1 hour at which point it will be escalated. On an hourly basis, a board round will be undertaken in ED, identifying any patients of concern where a speciality review is either outstanding, or where a review is required and has not been made. Any patient who is outstanding a speciality review within the 1 hour standard will be highlighted to the ED Nurse in Charge for escalation to the Registrar for the appropriate speciality. Further escalation will be to the Speciality	 Medical Director, YGC Acute Care Director, YGC. Medical Director. YGC Medical Director, YGC	30th June 2022 23rd May 2022. 23rd May 2022 23rd May 2022

			Consultant if a response is not received within 30 minutes of escalation. Delivery against the IPS will be monitored for each speciality and reviewed by the HMT weekly, with further action to be taken if the IPS standards have not been delivered.	Acute Care Director, YGC.	30th May 2022

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

Name: Neil Rogers, Acute Care Director, Ysbyty Glan Clwyd

Date: 12th May 2022.