Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

HIW Hospital Inspection Report (Unannounced)

Emergency Department, Ysbyty Glan Clwyd

Betsi Cadwaladr University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department (ED) at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board on 03, 04 and 05 May 2022.

Our team for the inspection comprised of four HIW Inspectors, three clinical peer reviewers and one lay reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

At the time of our inspection we found that the ED, as the front door to a wider system, was experiencing a period of unrelenting demand on services. We acknowledged that this was a very stressful environment for some staff, who were working above and beyond in challenging conditions.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the healthcare setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patients were generally happy with the way that staff interacted with them and the care provided. However, patients were critical of waiting times and during the inspection we found that some patients had been waiting to be seen by a doctor for over eight hours.

We saw staff speaking with patients and their relatives in a polite, professional and dignified manner.

We found that the dignity of some patients was affected by either lengthy waits within the department or as a result of where and how patients had been accommodated whilst awaiting further review or treatment. The ambulatory care area, which consisted of a room containing four chairs and no privacy screens between the chairs, was of particular concern due to the lack of privacy and dignity afforded to patients. However, staff made active efforts to move patients to more appropriate areas of the department where possible.

This is what we recommend the service can improve:

- The health board must review the use of the ambulatory care area to ensure that patient dignity and privacy is promoted and maintained
- The health board must ensure that waiting times are displayed in a prominent position within the waiting area
- The health board must ensure that health promotion information is provided in both Welsh and English.

This is what the service did well:

- Red Cross volunteers providing support to patients with food and drink.

Safe and Effective Care

Overall summary:

We found the main areas within the ED to be generally clean and tidy and that high throughput areas and touchpoints, including toilets and door handles, were being

cleaned regularly and to a good standard. However, we found that infection prevention and control measures were not sufficiently robust in clinic and treatment rooms.

We found that health and safety risks were not appropriately managed within the department.

There was an inconsistent approach to the completion of pressure damage risk and falls risk assessments.

Immediate assurances:

HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff. Please note this list is not exhaustive and full details are contained in Appendix B:

- Not all risks to health and safety within the ED were managed appropriately. For example, we found that:
    - The security of the department was insufficient and meant there were opportunities for members of the public to access all areas unchallenged
    - Metal trolley cages, a wooden pallet, construction materials and a rodent trap were seen in the utility area, all of which could present a risk of harm to patients
    - The swipe access door leading from the minors area into the paediatric area was open. This meant that members of the public and adult patients could access this area unchallenged. The mental health assessment room was also located within the minors area and within close proximity to the entrance into the paediatric area. This meant that members of the public and adult patients could access the paediatric area unchallenged. This placed children at serious risk of harm
    - An adult patient was accommodated within the paediatric area when a child was receiving care in the same area. This placed children at serious risk of harm
    - The majority of cupboards in the minors area were unlocked. These cupboards contained items which could be used for self-harm or to harm others. These included prescription only medicines, scalpels, needles and other surgical equipment. This presented a significant risk to patients, staff and visitors
    - An unlabelled urine sample and super absorbent powder sachets were seen placed on the worktop within the dirty utility room.

Absorbent powder sachets are highly dangerous if ingested and present a choking hazard.

- Not all aspects of care were being delivered in a safe and effective manner. For example, we found that:

  - the arrangements for assessing, monitoring, observing and escalating unwell or deteriorating patients were not robust or effective and the quality of the nursing documentation within patient notes was poor, and in most cases, absent
  - There was a healthcare assistant based in the waiting room and one qualified nurse allocated to this area. However, basic observations and checks on patients were not being conducted on a regular basis
  - We checked twelve records on the evening of 3 May 2022, relating to patients in the waiting areas who had been triaged and categorised as yellow or orange (meaning they had a potential to deteriorate) and waiting longer than four hours. In ten cases, other than triage information, no other nursing documentation had been completed.
  - This included a complete absence of risk assessments and progress notes. The longest wait to be seen by a doctor at the time was eight hours and 22 minutes
  - In the cases of two patients, where a significant head injury was reported, there was no record within the patient notes of observations being carried out within the required frequency nor were there any details of neurological observations being undertaken
  - Patients with complex conditions, who were susceptible to deterioration, were not monitored at the required frequency. This included a patient presenting with stroke symptoms who did not receive repeat observations over a five hour period
  - Nursing staff in triage were not alerting the nurse in charge to high risk patients. The nurse in charge had no oversight of the waiting room and was unaware of the acuity level in this area. Consequently, they had not escalated these patients to the doctor or consultant in charge. Senior doctors told us that this was a recurring issue and that they would often 'come across' these high risk patients rather than being alerted to them in a formal and timely way.

- The process for checking the equipment stored within the resuscitation trolleys was not sufficiently robust and safe. Daily checks were not being completed and some equipment was out of date that day with no staff member having oversight of this

- The quality of records management was not sufficiently robust. We found that a number of offices within the ED were left unlocked with patient notes left unsecured on desks and accessible to the public

- Medication management processes were not sufficiently robust and safe

- Infection prevention and control measures were not sufficiently robust.

In addition to the Immediate Assurance issues above, this is what the service must improve:

- The health board must ensure that pressure area risk assessments are completed accurately and consistently
- The health board must ensure that falls risk assessments are completed accurately and consistently
- The health board must ensure that staff use and dispose of PPE appropriately
- The health board must ensure that everyone attending the ED is screened for COVID-19 and that the staff member allocated this responsibility is appropriately supported and able to take breaks when necessary. In addition, the health board must ensure that there are adequate security arrangements in place at the entrance to the department in order to ensure the safety of patients and staff
- The health board must ensure that the risk of accommodating COVID-19 positive and negative patients in the same area is properly managed to reduce the risk of cross infection. In addition, appropriate signage must be provided to clearly identify where COVID-19 positive patients are accommodated
- The health board must ensure that patients have easy access to food, given the lengthy waiting times that some patients have to endure before being seen by a doctor or nurse
- The health board must ensure that fluid intake is appropriately and consistently recorded
- The health board must ensure that discontinued and discarded medication is accurately recorded on one document and that staff are aware of this process
- The health board must ensure that the temperature of the medication storage fridges are monitored and recorded on a regular basis
- The health board must ensure that there are robust processes in place to manage, record and report incidents when children leave the department without being assessed or those who leave against medical advice

- The health board must ensure that patients presenting with mental health care needs are assessed and treated in a timely way by staff who have the appropriate qualifications and training

- The health board must ensure that pain assessments are undertaken to ensure that patients receive appropriate and timely pain relief and treatment

- The health board must ensure that the electronic records management system is effectively meeting the needs of staff and patients, and that staff feel confident and supported in using the system. This applies particularly to temporary staff who may be unfamiliar with the system

- The health board must ensure that patient records are easy to navigate, clear and unambiguous.

This is what the service did well:

- Two hourly safety huddles were undertaken with the aim of providing the nurse in charge and medical team leader with an overview of all areas of the ED to improve flow through the unit. However, we found that multi-disciplinary attendance at these huddles was sporadic and often they did not result in positive and effective action being taken in response to risks. On the occasions where the huddles were attended by all expected attendees the actions taken were appropriate and has the potential to improve the quality of patient care and patient safety within the department.

Quality of Management and Leadership

Overall summary:

We spoke with a cross-section of staff working in the ED with many telling us that they were unhappy and struggling to cope with their workload. Staff also told us that they did not feel supported by the senior managers within the hospital.

We were concerned that senior managers were unaware of some of the very serious issues that we found during the inspection.

We were not assured that there was a supportive culture in place which promoted accountability and safe patient care and that the management and leadership was sufficiently focused and robust.

Immediate assurances:

HIW was not assured that there was a supportive culture in place which promoted accountability and safe patient care, and that the management and leadership was sufficiently focused and robust. We highlighted the following serious issues, which required immediate action by the health board to prevent significant harm to patients, members of the public and staff:

  - There had been little progress on the areas of improvement noted during the Quality Check of March 2022. This was despite the health board providing an action plan and assurances that matters had improved. Key areas which had not only not improved included:
  - Quality of nursing documentation
  - Management of patients in the waiting room
  - Identification and management of high risk patients and monitoring of patients susceptible to deterioration
  - Discharge arrangements.

- There was a significant disconnect between 'ward and board'. This had led to lack of progress in actioning the issues raised during the recent Quality Check

- There was a culture within the department which did not promote or encourage staff to deliver evidence based, safe care, with poor accountability for individual actions. Some staff failed to understand and accept the seriousness of the issues present and remedial actions required. Some staff also lacked insight into their own accountability as registered professionals in ensuring patients were safe and documenting any interventions

- The arrangements for leadership and governance were not always effective or supportive. This meant that staff felt unsupported and not listened to

- Auditing processes were not sufficiently robust in order to highlight deficiencies in record keeping and safety and identify ways of addressing the issues

- Staff were not fully consulted before changes were implemented within the ED. This had resulted in the impact of change on clinical aspects of the service not being taken into consideration and staff feeling detached from the decision-making process

- Staff were unfamiliar with some of the senior managers outside of the ED and were unclear as to the roles and responsibilities of some members of the senior management team.

In addition to the Immediate Assurance issues above, this is what the service must improve:

- The health board must ensure that all staff complete all elements of mandatory training.

Details of the concerns regarding patient safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we spoke with patients and used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 15 questionnaires were completed. Patients were generally happy with staff interaction and the care provided. However, patients were critical of waiting times. Patient comments included the following:

> *"The staff are very kind and helpful so despite the waiting times they make it worth the wait."*
> *"The nurses are friendly and very helpful."*
> *"More staff to reduce waiting time."*

Dignified care

Dignified care
We observed staff speaking with patients and their relatives in a polite, professional and dignified manner. All but one of the patients who completed HIW questionnaire agreed that staff treated them with dignity and respect.

We found that the dignity of some patients was affected by either lengthy waits within the department or as a result of where patients had been accommodated whilst awaiting further assessment or treatment. During the inspection we found that some patients had been waiting to be seen by a doctor for over eight hours.

The ambulatory care area, which consisted of a room containing four chairs and no privacy screens between the chairs, was of particular concern due to the lack of privacy and dignity afforded to patients. However, staff made active efforts to

move patients to more appropriate areas of the department where possible. The health board must review the use of the ambulatory care area to ensure that patient dignity and privacy is promoted and maintained.

We found areas of the department were well decorated and appropriate for their intended use, for example the artwork within the paediatric area and the décor of the bereavement room.

Communicating effectively
Throughout the inspection we saw staff talking to patients and each other in a respectful manner.

We were also told that some staff working within the ED were bilingual (Welsh/English) and that translation services were available for patients who wished to communicate in other languages.

Patient information
Waiting times were displayed, in both Welsh and English, on a white board within the waiting area. However, the white board was not in a prominent position within the waiting area for all patients to see. The health board must ensure that waiting times are displayed in a prominent position within the waiting area.

There was a flow diagram posted withing the waiting area showing the patient journey through the department. In addition, there was information about the use of minor injuries units and the NHS 111 online service, where appropriate, to reduce the pressure on the ED.

There was also information about smoking cessation within the waiting area. However, this was only available in English. The health board must ensure that health promotion information is provided in both Welsh and English.

Timely care

Timely Access
We found the ED waiting area to be overcrowded throughout the course of inspection. Despite this, other areas of the ED were found to be relatively calm, despite the high number of patients accommodated within these areas.

On the evening of our arrival, we reviewed the care records of 12 patients who had been triaged and were awaiting further assessment, treatment or intervention. We found significant issues relating to the timely provision of medical and nursing care for these patients and the on-going assessment, monitoring, observation and escalation of those who were either unwell or at risk of becoming unwell. For

example, we noted a patient with chest pain and ECG abnormalities was placed in waiting area for five hours with no further escalation and another patient who, despite having been recorded by a doctor as possibly having had a stroke, was placed in the waiting room for over 17 hours with infrequent observations and no documented checks until 12 hours after arrival. This presents a risk of harm to patients.

This issue was dealt with under HIW's immediate assurance process and is referred to Appendix B of this report.

In addition to the 12 patient care records we viewed during our evening visit, we viewed another 10 patient care records during the following two days on-site and undertook a desk top review of a further 10 patient care records off-site. We found the quality of record keeping by the nursing staff to be poor across the majority of the care files seen. In contrast, the quality of the record keeping by the medical staff was generally good. However, in one case we found that the summary report was extremely difficult to navigate and confusing. The health board must ensure that patient records are easy to navigate, clear and unambiguous.

On the evening of our arrival, we found three ambulances outside of the ED who were waiting to offload patients. We confirmed that clinical staff were aware of the condition of these patients and appropriate escalation arrangements were in place. This remained a similar pattern throughout the course of the inspection, and some ambulance staff told us that, on occasions, offload times could be excessive.

We noted that there was a designated member of staff who was responsible for co-ordinating ambulance waits and who contributes to the ED safety huddles. It was positive to note that there was a concerted effort being made to further reduce ambulance waiting times.

Just under half of the patients who completed the HIW questionnaire told us that they were assessed by healthcare staff within 30 minutes of their arrival and just over half of the respondents agreed that staff checked on them whilst they were waiting.

Individual care

Planning care to promote independence

We found that there were multidisciplinary 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 were striving to provide care in a way that promoted and protected people's rights.

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.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We found that health and safety risks were not appropriately managed at all times within the department. This presented a risk to patients, members of the public and staff. These issues included:

- The security of the department was insufficient and meant there were opportunities for members of the public to access all areas unchallenged
- A door within a corridor in the main department, leading to a utility area adjacent to the main entrance into the ED, was propped open and the security swipe lock was not operational. This allowed unchallenged access to the department and also allowed patients to leave without staff knowing
- Large clinical waste bins were located within this area next to a security fence and gate which enclosed a metal staircase leading on to a roof. Patients could potentially use the waste bins to climb over the security fence and gain access to the roof. This presented a significant risk of harm
- Metal trolley cages, a wooden pallet, construction materials and a rodent trap were also seen within this area, all of which could present a risk of harm to patients

- The majority of cupboards in the minors area were unlocked. These cupboards contained items which could be used for self-harm or to harm others. These included prescription only medicines, scalpels, needles and other surgical equipment. This presented a significant risk to patients, staff and visitors

- A trolley, containing cleaning materials such as bleach and other hazardous chemicals, was left unattended in the corridor outside the entrance to the paediatric area. This presented a significant risk to patients

- An unlabelled urine sample and super absorbent powder sachets were seen placed on the worktop within the dirty utility room. Absorbent powder sachets are highly dangerous if ingested and present a choking hazard.

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

Preventing pressure and tissue damage

We found that pressure damage risk assessments were available to staff to complete using a recently implemented patient records management system. However, we found an inconsistent approach towards the completion of these risk assessments. This presents a risk to patients who may be susceptible to tissue damage, particularly patients who may be waiting in the department for extended periods of time. The health board must ensure that pressure area risk assessments are completed accurately and consistently.

Falls prevention

We found that falls risk assessments were available to staff to complete using a recently implemented patient records management system. However, we found an inconsistent approach towards the completion of these risk assessments. This presents a risk to patients who may be susceptible to falls, particularly in a busy ED environment. The health board must ensure that falls risk assessments are completed accurately and consistently.

Infection prevention and control

We found the main areas within the ED to be generally clean and tidy. Cleaning staff were visible within the department throughout the course of the inspection and, on discussion, demonstrated pride in their work. We observed high throughput areas and touchpoints, including toilets and door handles, to be cleaned regularly and to a good standard.

However, we found that infection prevention and control measures were not sufficiently robust in clinic and treatment rooms, which presented a significant risk to staff and patients. These issues included:

- Numerous items of equipment used for invasive treatments found to be out of date and in some cases perished. This included some equipment which fell out of date in 2017
- Treatment rooms had visibly dirty equipment stored in cupboards. This included used tissues which were stained with red and brown fluids and thermometer probe covers stained with ear wax
- Some of the nursing stations were cluttered and littered with used cups and other items
- A pack containing wipes for cleansing skin was left open and visibly soiled
- Patients' clothing, including soiled underwear, was found in cupboard within one of the treatment rooms. The cupboard also contained clinical equipment
- Waste bin lids were stuck in the open position within two treatment rooms
- An equipment bag within the ear, nose and throat room contained tissues which were used and stained
- Used nasal cream tube with no lid observed in one treatment room
- Items in sterile packaging which had been opened and repackaged.

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

We observed how staff within the ED managed patients and the risk associated with COVID-19. We found that staff understood the need to maintain good infection control measures. This included the need to remain bare below the elbow and changing in and out of their uniforms at the beginning and end of their shifts.

However, we found that, whilst personal protective equipment (PPE) was largely being used appropriately, there were occasions where we saw that PPE was not being disposed of and / or replaced at the appropriate time. The health board must ensure that staff use and dispose of PPE appropriately.

We observed attendees to the ED being screened for COVID-19 symptoms before they were allowed to enter the ED. Whilst the staff member responsible for screening attendees worked hard to fulfil their role, the lack of support available to this member of staff meant that attendees to the department could potentially bypass the screening process if the staff member was called away, as was the case when we arrived on site.

In the Quality Check that HIW undertook in March 2022, we were told that security staff would also be present at the entrance to the department. However, no security staff were present until the second day of the inspection. The health board must ensure that everyone attending the ED is screened for COVID-19 symptoms and that the staff member allocated this responsibility is appropriately supported and able to take breaks when necessary. In addition, the health board must ensure that there are adequate security arrangements in place at the entrance to the department in order to ensure the safety of patients and staff.

We were told that patients who were displaying symptoms or who had tested positive for COVID-19 would be directed to, and treated in, a separate area of the ED. However, we did not observe a separate COVID-19 area within the ED in use and saw that COVID-19 positive patients were accommodated in all areas of the department. Whilst single cubicles had been provided to mitigate the risk of accommodating COVID-19 positive and negative patients within the same area, doors to cubicles were not always closed and signage relating to the status of positive patients was not clear. The health board must ensure that the risk of accommodating COVID-19 positive and negative patients in the same area is properly managed to reduce the risk of cross infection. In addition, appropriate signage must be provided to clearly identify where COVID-19 positive patients are accommodated.

Nutrition and hydration

We found that the nutrition and hydration needs of patients were generally met within the department. Patients in the ED were able to access food and drink. This included patients who were being held on ambulances outside of the ED. Patients who required assistance were seen to be supported by staff and the Red Cross volunteers.

Access to food and drink in the waiting was more limited. Throughout the course of the inspection, we saw that patients had access to water. However, access to food was limited to the vending machine or hospital canteen. Patients told us that the vending machine did not always work. The health board must ensure that patients have easy access to food, given the lengthy waiting times that some patients have to endure before being seen by a doctor or nurse.

We found that the recording of fluid intake was inconsistent and varied between an electronic and paper system, depending on how the patient arrived at the ED. The health board must ensure that fluid intake is appropriately and consistently recorded at all times.

Medicines management

We were not assured that medication management processes were sufficiently robust and safe in all areas, which presented a significant risk of harm to patients. These issues included:

- Intravenous fluids left out within in areas accessible to the public
- Medication intended for single patient use were being reused. This included nasal ointment
- Medication fridge temperatures in the 'see and treat' area within the ED were only checked seven times during April 2022, rather than daily, and, in some cases, temperatures were noted as being outside of normal parameters with no remedial action taken
- Lactulose solution was left on work surface. The medication was prescribed for a patient who was no longer in the department and had not been for some time
- Urinalysis test strips that expired in June 2017
- Salbutamol nebuliser pods left on work surface in a cubicle accessible to the public
- Multiple syringes that had expired between 2017 and 2021, found in cubicles and treatment rooms. Some of these were perished and yellowed
- Cannulae with an expiry date of 2017 found in a treatment room
- Blood transfusion giving sets with expiry date of 2019 found in a blood transfusion bag
- Intravenous antibiotics found in an open cupboard in an area accessible to the public
- Cupboards in the eye treatment room unlocked and containing prescription only eye drops and other medication accessible to the public
- Oxygen cylinders, located under trolleys, were found to empty in the case of two out of the three checked.

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

We found that there was a dedicated pharmacist within the department and that support was available out of hours if required. This included suitable arrangements for accessing medicines.

We observed drug charts to be generally completed correctly by the nursing staff responsible for administering the medication. However, we noted that discontinued medication was recorded either on the medication administration chart or on the electronic records management system. This presented a risk of patients not receiving medication or being administered medication no longer prescribed. The health board must ensure that discontinued and discarded medication is accurately recorded on one document and that staff are aware of this process.

We found that the need for pain relief was identified and administered appropriately, with the exception of one patient. We found that a delay in the patient receiving a medical review resulted in the patient having only received oral pain relief for a fractured neck of femur. The patient was described as being comfortable in their notes, but was also described as presenting in a confused state. We could not be assured that timely and appropriate pain relief was provided. The health board must ensure that pain assessments are undertaken to ensure that patients receive appropriate and timely pain relief and treatment.

We requested evidence that medication storage fridge temperatures were checked and recorded on a regular basis. However, we were not provided with any evidence to confirm that checks were being completed and logged as required. We therefore could not be assured that temperature sensitive medication was being stored in appropriate conditions nor that there was a robust system in place to flag any discrepancies. The health board must ensure that the temperature of the medication storage fridges are monitored and recorded on a regular basis.

Safeguarding children and safeguarding adults at risk
The staff we spoke to demonstrated a satisfactory knowledge of matters relating to safeguarding, deprivation of liberty safeguards and mental capacity.

However, we were not assured that all steps were being taken to appropriately safeguard children within the department. This is because:

- An adult patient was accommodated within the paediatric area when a child was receiving care in the same area. This placed children at potentially serious risk of harm

- The door leading from the minors area into the paediatric area was frequently propped open and left unlocked. This meant that members of the public and adult patients could access this area unchallenged. It also meant children could potentially leave the area. The mental health assessment room was also located within the minors area and within close proximity to the entrance into the paediatric area. This meant that members of the public and adult patients could access the paediatric area unchallenged. This also meant that children could potentially have access to harmful areas. This placed children at potentially serious risk of harm

- The door leading into the dirty utility room, located adjacent to the paediatric area, was left unlocked with the cupboards located within this room also unlocked. The cupboards contained hazardous substances such as bleach. This presented a significant risk to patients.

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

In the patient records we reviewed, we saw evidence of children who had presented to the ED, but had either left the department before being seen or who had been discharged against medical advice. We saw no evidence to suggest that issues relating to safeguarding or follow up had been considered to ensure the welfare of the child. The health board must ensure that there are robust processes in place to manage, record and report incidents when children leave the department without being assessed or those who leave against medical advice.

Whilst we were informed that paediatric staff have been identified for deployment in the department, we were concerned to find that there were no paediatric trained nurses staffing the paediatric area of the ED at the time of the inspection. We found that staff from the minors area were required to also cover this area, and that support, when requested from the Children's Ward from the wider hospital, was not always effective. The health board must ensure that staff working within the paediatric area are appropriately trained and competent in their roles and that they are effectively supported by specialist staff from other areas of the hospital when required.

Staff also spoke to us regarding liaison support with mental health and learning disability staff and spoke of their frustration and concern regarding the treatment and discharge of patients who require psychiatric input. We observed staff having difficulty in obtaining a timely mental health assessment for one patient and there was a suggestion that the patient could be discharged without a psychiatric assessment having been completed. The health board must ensure that patients presenting with mental health care needs are assessed and treated in a timely way by staff who have the appropriate qualification and training.

Medical devices, equipment and diagnostic systems

We reviewed the arrangements for checking the emergency resuscitation trollies within the department. We found an electronic system was used for staff to confirm and log regular checks. However, staff told us that the app used to log the checks did not always work. We noted that there was a back-up system in place, but we found numerous gaps in these records. For example, we found that there was only one entry logged for the entirety of December 2021. We could therefore not be assured that there was a robust system in place to ensure that resuscitation equipment was available, within date and ready for use in a medical emergency.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Effective care

Safe and clinically effective care

We found evidence of good medical leadership in the ED and the medical notes that we reviewed were generally of a good standard. We spoke to a number of clinical staff across the department and all demonstrated a desire to provide patients with a good standard of care.

However, we were not assured that all aspects of care were being delivered in a safe and effective manner within the ED to prevent significant harm to patients.

We found that nursing and medical staff, both within the ED and specialist wards within the wider hospital, were failing to appropriately respond to the needs of acutely unwell and deteriorating high risk patients. In a number of cases, the HIW inspection team intervened to escalate patients to clinicians in charge of the ED.

We found that the arrangements for assessing, monitoring, observing and escalating unwell or deteriorating patients were not robust or effective and the quality of the nursing documentation within patient notes was, in most cases, absent. Some of the issues identified included:

- There was a healthcare assistant based in the waiting room and one qualified nurse allocated to this area. However, basic observations and checks on patients were not being conducted on a regular basis
- In 10 out of 12 records reviewed on the first evening, relating to patients within the waiting area who had been triaged and categorised as yellow or orange (meaning they had a potential to deteriorate) and waiting longer than four hours, apart from triage information, no other nursing documentation had been completed. This included a complete absence

of risk assessments and progress notes. The longest wait to be seen by a doctor at the time was eight hours and 22 minutes

- In line with Royal College of Emergency Medicine guidelines, observations should have been repeated within 30 minutes, then minimally two to four hourly. However, these observations had not been recorded on any of the patient notes reviewed

- Patients with complex conditions, who were susceptible to deterioration, were not monitored at the required frequency. This included a patient presenting with stroke symptoms who did not receive repeat observations over a five hour period, a patient presenting with vascular concerns, a patient presenting with chest pain and ECG abnormalities, and a patient assessed as a suicide risk

- In the cases of two patients, where a significant head injury was reported, there was no record within the patient notes of observations being carried out within the required frequency nor were there any details of neurological observations being undertaken

- In two out of two cases where sepsis screening should have occurred, there was no record within the patient notes of this taking place

- Repeat observations had not been conducted on a patient with a significant clinical history for a seven hour period. This was despite them having abnormal vital signs and being commenced on anticoagulant therapy. No nursing progress notes had been completed for this patient and there were no risk assessments in place

- Nursing staff in triage were not alerting the nurse in charge to high risk patients. The nurse in charge had no oversight of the waiting room and was unaware of the acuity level in this area. Consequently, they had not escalated these patients to the doctor or consultant in charge. Senior doctors told us that this was a recurring issue and that they would often 'come across' these high-risk patients rather than being alerted to them in a formal and timely way.

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

We immediately fed back the above concerns to the health board senior managers during the course the inspection and requested assurances relating to the safety of the ED prior to the forthcoming weekend. This was in addition to the immediate assurance process noted above. Senior leaders were receptive to our findings and provided us with assurance that plans had immediately been implemented to ensure that the triage and associated monitoring, observation and escalation of patients was effective to maintain patient safety.

Information governance and communications technology
We found that the ED had recently implemented an electronic patient management and records system. Some staff commented positively on the system and we acknowledge the benefits that an electronic system can have.

However, there were multiple occasions where staff were unable to access the system in a timely manner or were unable to locate essential records within the system when asked to do so by members of the inspection team. The health board must ensure that the system is effectively meeting the needs of staff and patients, and that staff feel confident and supported in using the system. This applies particularly to temporary staff who may be unfamiliar with the system.

It was positive to note that electronic board round monitors were in used in the ED to help support the efficient care and treatment of patients.

Record keeping
As previously mentioned, we found that record keeping was generally poor across all 32 patient care records that we reviewed, most notably the nursing documentation. It was particularly concerning to find poor and, in some cases, complete lack of nursing documentation relating to patients accommodated within the ED waiting area. However, in contrast, we found medical record keeping to be generally good.

As highlighted in the above section, the implementation of the new patient management and record system led to staff being unable access essential sections of the system in an efficient and effective manner.

We also found that a number of offices within the ED were left unlocked with patient notes left unsecured on desks and accessible to public.

These issues were dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Quality of Management and Leadership

Governance, Leadership and Accountability

We found that there were formal auditing, reporting and escalation processes in place within the ED. However, as evidenced during the course of the inspection, these processes were not sufficiently robust and were not effective in highlighting and addressing issues of concern. We were concerned that senior managers were unaware of some of the very significant issues that we found during the inspection.

We spoke with a cross-section of staff working in the ED, with many telling us that they were unhappy and struggling to cope with their workload. Staff also told us that they did not feel supported by the senior managers within the hospital. However, staff spoke positively about the support that they received from the ED Matron.

We were not assured that there was a supportive culture in place which promoted accountability and safe patient care and that the management and leadership was sufficiently focused and robust. We highlighted the following serious issues, which require immediate action by the health board to prevent significant harm to patients, members of the public and staff:

- There had been little progress on the areas of improvement noted during the previous quality check of March 2022. This was despite the health board providing an action plan and assurances that matters had improved. Key areas which had not improved included:
    - Quality of nursing documentation
    - Management of patients in the waiting room
    - Identification and management of high risk patients and monitoring of patients susceptible to deterioration
    - Discharge arrangements.
- There was a significant disconnect between 'ward and board'. This had resulted in senior leaders taking assurance from audits and measures in place which in practice were either not taking place or not capturing the severity of the issues present in the department
- There was a culture within the department which did not promote or encourage staff to deliver evidence based, safe care, with poor accountability for individual actions. Some staff failed to understand and accept the seriousness of the issues present and remedial actions required. Some staff also lacked insight into their own accountability as registered professionals in ensuring patients were safe and documenting any interventions
- The arrangements for leadership and governance were not always effective or supportive. This meant that staff felt unsupported and not listened to
- Auditing processes were not sufficiently robust in order to highlight deficiencies in record keeping and safety and identify ways of addressing the issues

- Staff were not fully consulted before changes were implemented within the ED. This had resulted in the impact of change on clinical aspects of the service not being taken into consideration and staff feeling detached from the decision making process

- Staff were unfamiliar with some of the senior managers outside of the ED and were unclear as to the roles and responsibilities of some members of the senior management team.

These issues were dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Workforce

We found that there was generally sufficient staff on duty across the department. However, we were told that staff recruitment and retention was challenging and that the service was heavily reliant on agency and bank staff to meet the level of staffing. We were also told that the situation is made worse by the number of staff on sick leave. Efforts were being made to secure the same agency staff where possible in order to maintain continuity of care and ensure that the staff members were familiar with the environment. The health board must continue with its efforts to recruit permanent staff.

In addition to holding face to face discussions with staff, HIW issued an online survey to obtain staff views on the Emergency Department at Ysbyty Glan Clwyd. In total, we received 24 responses.

Responses and comments from staff were generally negative, with the following issues being raised:

- Inappropriate use of the Emergency Department, due to patient inability to obtain GP appointments and inappropriate referrals, leading to increased footfall

- Lack of space, due to increased footfall, shared waiting rooms and poor patient flow

- Inadequate staffing levels, skill mix and experience to meet demand/manage footfall, due to high staff turnover, redeployment of staff to wards and lack of development opportunities

- Inadequate facilities and equipment to enable appropriate and dignified patient care

- Poor relationship between senior management and staff and a perception of 'blame culture'

- Poor staff morale

- Lack of training and development opportunities.

Staff comments included:

> ***"All rooms occupied, staff overwhelmed and unsure where or who the patients are."***
>
> ***"ED is usually 90% full, no breathing time, patients are on beds, on occasions it is working like a ward and not an ED. Patients in the wrong area."***
>
> ***"Lack of space for doctors to review patients in the waiting rooms. Insufficient bed spaces for unwell adults with long medical bed waits."***
>
> ***"I feel the department is overwhelmed by patients and is struggling to cope with the increased footfall and demand."***
>
> ***"Due to poor staff retention there is a significant gap between newly qualified nurses and experienced nurses on shift, the support provided to new starters and newly qualified nurses is lacking and inconsistent creating further discrepancies [in] skill levels, despite the length of time qualified."***
>
> ***"At times there is lack of senior skilled staff."***
>
> ***"When the department is at capacity … things get missed as there [are] not enough staff to give safe quality care and you are just trying to keep the area as safe as you can. When patients requiring close observation or one-to-one, due to high falls risk, are admitted, which is frequently due to the demographics of the area, this proves challenging as you not only have to keep that patient safe but also try to look after other patients that you are allocated and this compromises safety and quality care."***
>
> ***"The staffing rota can often be poor, unsafe staffing levels and skill mix. Also as a result staff are being expected to work shift patterns that do not contribute to a good work-life balance and when we are here, we are under extreme stress and pressure."***
>
> ***"Limited amount of equipment, takes time to find equipment to carry out job role."***
>
> ***"Patients put in inappropriate rooms for care, due to lack of capacity."***
>
> ***"More support to resolve issues instead of management criticising without any means to find ways of solving issues."***
>
> ***"Senior Directors should at least once a month come to the ED to show support and speak to staff at ground level."***
>
> ***"The nursing staff and HCSW are at breaking point, staff morale is at an all-time low. We are being expected to take on additional work which is leaving the staff on the floor at risk of burnout."***

The staff training information that we looked at showed that there was considerable variance in mandatory training completion rates across staff disciplines. The health board must ensure that all staff complete all elements of mandatory training. Staff also provided the following comments in relation to the training:

"Training is not protected and often gets cancelled last minute, creating inconsistencies and unfair balance between skill mix and responsibilities on shift."

"More study days set aside and protected … i.e. sepsis study day, trauma, cardiology, ECG reading, etc."

"Managing patients with peg tubes and how to use them, airway management with tracheostomy patients and how to manage them."

"… it's important to ensure all staff are confident and able to perform even simple ED minor injury management tasks, like applying dressings, back-slabbing, and applying braces and splints, so that patients aren't waiting longer than necessary for this to be done by others."

"… ED specific training, as many of the drugs and treatments used within the department are unique to the area, such as the route administered, time sensitive drugs and investigations."

"More places on Advanced Life Support (ALS), Paediatric Advanced Life Support (EPLS/EPALS), Advanced Trauma Life Support (ATLS)."

On a positive note, around two-thirds of staff who responded told us that they were generally satisfied with the quality of care they give to patients, would recommend their organisation as a place to work and would be happy with the standard of care provided by this hospital if a friend or relative needed support.

In addition, most staff told us that they had received an appraisal, annual review or development review of their work within the last 12 months. This was reflected in the staff appraisal information that we looked at during the inspection.

The majority felt able to make suggestions to improve the work of their team. The majority of staff also believed that patients are adequately informed and are involved in decisions about their care.

Staff also commented positively on the support that they received from the ED matron. Comments included:

"I personally feel our matron is the best we've had since I've worked in the department. She is supportive and will come on to the floor to help when she can."

"Our matron has been fantastic in driving our development but we are working in a system that is ultimately failing."

The health board must reflect on the less favourable staff responses to some of the questions in the HIW online survey, as noted in the Quality of Management and Leadership section of this report and take action to address the issues highlighted.

4. Next steps

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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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
During the evening visit to the ED we found that nursing and medical staff, both within the ED and specialist wards within the wider hospital, were failing to appropriately respond to the needs of acutely unwell and deteriorating high risk patients. We also found that the arrangements for assessing, monitoring, observing and escalating unwell or deteriorating patients were not robust or effective and the quality of the nursing documentation within	The issues highlighted presented a serious risk of harm to patients.	We brought our concerns to the attention of the hospital site manager on duty and the clinician in charge of the ED and requested assurances related to the safety of the ED prior to the forthcoming weekend.	Senior managers were receptive to our findings and provided us with assurance that plans had been immediately implemented to ensure that the triage and associated monitoring, observation and escalation of patients was effective to ensure patient safety. However, on review we found this had not been actioned in all cases. These issues were subsequently dealt with through the immediate assurance process.

patient notes was, in most cases, absent.			

Appendix B - Immediate improvement plan

Service: Emergency Department, Ysbyty Glan Clwyd

Date of inspection: 03, 04 and 05 May 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
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.	**Standard 2.1** Managing Risk and Promoting Health and Safety	2 hourly huddles are in place across the 24 hour day, 7 days a week, to provide the Nurse in Charge and Medical Team Leader with an overview of all areas of the Emergency Department (including the waiting room and ambulance queue) including patients of concern.	**Clinical Director, EQ & Head of Nursing, EQ**	**13th May 2022 (Complete)**
		Electronic data capture of the huddles, including completion of the escalation risk matrix, has commenced, and effectiveness / compliance will be monitored weekly by the EQ Leadership Team and HMT and any gaps will be addressed.	**General Manager, EQ**	**20th May 2022**

	When the safety huddle identifies 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 for action. Out of hours, escalation is via the management on call rota. As a consequence of this consistent approach to escalation via the use of an agreed escalation tool, patients at clinical risk of deterioration will receive the appropriate input and be transferred to the appropriate care setting.	**Head of Site Management**	**20th May 2022**
	In between the 2 hourly safety huddles, senior hourly board rounds will take place. This will include the Clinical Site Manager allocated to the emergency floor.	**Clinical Director, EQ & Head of Nursing, EQ**	**30th May 2022**
	Escalation at all other times will be to the ED Nurse in Charge, then as needed to the senior Consultant and Clinical Site Manager / On Call Manager.	**Matron & Clinical Lead, ED**	**13th May 2022 (Complete)**

	A START (Senior Triage, Assessment & Rapid Treatment) model has commenced (not yet fully embedded) to provide earlier senior clinician review and provision of Point of Care Testing. It is envisaged this will speed up decision making, reduce congestion via the rapid discharge of appropriate patients to alternative pathways, identify patients suitable to transfer to Same Day Emergency Care (SDEC) and identify patients of concern not already picked up via the initial triage. This will quickly identify patients at risk of deterioration. The START area utilises the previous Ambulatory Care footprint which has been decommissioned.	**Clinical Director, EQ & Head of Nursing, EQ**	**13th May 2022 (Complete)**
	A SOP to be finalised to be discussed with all staff working with a START safety huddle prior to each shift	**Clinical Director, EQ & Head of Nursing, EQ**	**24 May 2022**
	This registrant will be located next to the reception desk and will initially triage all patients and identify any patients who require immediate escalation	**Head of Nursing, EQ**	**20 May 2022**

	Patient Leaflets to be produced (English & Welsh) to explain how the START model works.	**General Manager, EQ**	**30th June 2022**
	A protocol to review patients on the back of ambulances is in place, including speciality review if required. This includes the ability to bring the patient in to the hospital for X-ray and other diagnostic tests. Spot checks will be undertaken to ensure this is consistently adhered to.	**Medical Director, YGC**	**13th May 2022** **(Complete)**
	Staffing rotas will be signed off by the clinical leaders (Head of Nursing and Clinical Director). Whilst vacancies and the level of absence remain challenging and reliance on agency staff continues, we will ensure that a minimum of 50% coverage of rotas at all times is achieved via substantive BCU staff to ensure awareness of departmental systems and processes and support for agency staff where the risk is inherently	**Clinical Director, EQ & Head of Nursing, EQ**	**20th May 2022**

	higher. The skill mix will also be reviewed as part of this process.		
	Agency staff will be block booked 3 months ahead to cover known vacancies and planned leave, including the use of "off framework" agencies if regular arrangements cannot cover to the staffing levels required. Additional agency will be organised to cover any short notice absences.	**Head of Nursing EQ & Director of Nursing, YGC**	**13th May 2022 (Complete)**
	Internal professional standards will be relaunched with all speciality teams to be explicit with regard to expectations for timely patient review (Registrar or above) following referral to speciality.	**Acute Care Director, YGC**	**23rd May 2022**
	Discussion will take place to review patient pathways and expectations about level and speed of response with teams outside the hospital setting, including Mental Health / Liaison.	**Medical Director, YGC**	**30th June 2022**
	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	**Medical Director, YGC**	**6th June 2022**

	maximum of one hour, at which point it will be escalated to the directorate team and HMT.		
	Staff general awareness training with regard to the need for Datix submission for real time data capture of safety incidents or near misses will be completed.	**General Manager, EQ**	**23rd June 2022**
	Daily review of all Datix submissions from the EQ Directorate undertaken by HMT, and where appropriate timely Make It Safe + (MIS+) meetings organised to identify actions required.	**Director of Nursing, YGC**	**13th May 2022 (Complete)**
	The 2 hourly safety huddles will review any actual or potential patient safety risks that require immediate attention and ensure that real-time Datix submission occurs.	**Clinical Director, EQ & Head of Nursing, EQ**	**13th May 2022 (Complete)**
	A Registered General Nurse will responsibility for oversight of the ED waiting room is in place 24/7.	**Director of Nursing, YGC**	**13th May 2022 (Complete)**
	The Red Cross service commissioned by the Health Board has been further extended and staff provide reviews of	**General Manager, EQ**	**13th May 2022 (Complete)**

		the waiting room to proactively offer food and drink to patients where appropriate.		
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.	**Standard 5.1** Timely Access	All registered staff have been reminded of the BCU Observation Policy, and the requirements of their role in relation to this.	**Director of Nursing, YGC**	**13th May 2022 (Complete)**
		Compliance with this policy will be audited via the Symphony system on a daily basis by the Nurse in Charge or nominated delegate, with spot checks undertaken by the Director of Nursing	**Matron, ED & Director of Nursing, YGC**	**23rd May 2022**
		A Registered Nurse is assigned to the Waiting Room 24 hours a day, 7 days a week, and all staff who form part of the Nurse in Charge rota have been reminded that this staff member must not, under any circumstances, be deployed elsewhere. Any staffing risk in relation to this will be escalated to HMT. This registrant will be located next to the reception desk and will initially triage all patients and identify	**Head of Nursing, EQ**	**13th May 2022 (Complete)**
			Head of Nursing, EQ	**20 May 2022**

	any patients who require immediate escalation.		
	Roster management will be revised to prospectively identify the individuals on each shift responsible for being the Nurse in Charge, triage nurse, waiting room nurse and paediatric competent nurse.	**Head of Nursing EQ & Director of Nursing YGC**	**20th May 2022**
	There will be a Registered Nurse working within the paediatric footprint of ED that has completed paediatric competencies.	**Director of Nursing, YGC**	**20th May 2022**
	An options appraisal will be undertaken to assess the clinical need for a Paediatric ED service overnight.	**Director of Operations, YGC**	**20th June 2022**
	Safety huddles to check the frequency of observations across all areas of ED in line with policy and appropriate to the patient based on NEWS score.	**Matron & Clinical Lead, ED**	**13th May 2022 (Complete)**
	Each member of staff will be competency assessed with regard to the monitoring and recording of observations, physiological observations and NEWS scoring, with records	**Matron, EQ**	**6th June 2022**

	maintained of the results and the cycle repeated monthly for six months. This will be undertaken by the Practice Development Nurse or their nominated deputy		
	If there is a need for remedial action, additional training will be provided, based on individual competency gaps.	**Head of Nursing, EQ**	**20th June 2022**
	A comprehensive induction programme will be provided for all new staff.	**Matron, ED**	**27th June 2022**
	Daily senior leadership (Acute Care Director, Site Operations Director, Ste Medical Director, Site Director of Nursing) presence on the shop floor to act as a point of escalation and support, and to spot check patient records (Symphony) to monitor standards of documentation and frequency of observations.	**Hospital Management Team**	**13th May 2022 (Complete)**
	Any repeated issues identified relating to individual staff members to be addressed through line management process and appropriate escalation.	**Head of Nursing & Clinical Director, EQ**	**13th May 2022 (Complete)**

The health board must provide HIW with details of the action taken to ensure that those patients considered high risk due to their presenting conditions are escalated so that they receive appropriate and timely intervention.		The recently commenced START (Senior Triage, Assessment & Rapid Treatment) system will continue to be embedded to run on a 24/7 basis to provide early senior input for all patients, in order to ensure that patients requiring urgent and timely intervention are identified and managed.	**Head of Nursing & Clinical Director, EQ**	**13th May 2022 (Complete)**
		START to act as a means of identifying appropriate patients for alternative (external) pathways and to direct appropriate patients to the Same Day Emergency Care (SDEC) unit during opening hours. This is anticipated have the positive impact of decompressing overall numbers in ED to ensure that the staff:patient ratio improves with fewer patients held in the waiting room. Key metrics will be developed to monitor progress.	**General Manager, Head of Nursing & Clinical Director, EQ**	**27th May 2022**
		The HMT is working to extend the hours of SDEC to support a 7 day service, which will provide exit routes from ED and enable START to function without becoming blocked.	**Director of Nursing & Director of Operations, YGC**	**20th June 2022**

		Staffing for START (medical and nursing) will be protected to enable the model to succeed and to embed new processes – all staff who are part of the Nurse in Charge rota instructed that staff rostered for START must not be moved.	**Head of Nursing & Clinical Director, EQ**	**20th May 2022**
		"High risk" conditions to be identified and action cards produced for staff clarifying best practice pathways as part of START.	**Clinical Director & General Manager, EQ**	**27th May 2022**
		SDEC staffing will be increased to maximise the volume of patients who can be appropriately diverted from ED each day following review in START. This will include the majority of "GP expected" patients and will significantly decompress ED.	**Matron Assessment Units & Director of Nursing, YGC**	**23rd May 2022**
		Two aligned bays have been ring-fenced in SAU to enable the SDEC to continue to turn over when there are patients requiring a longer period of observation / treatment, including those who may need an overnight stay for review and discharge the next morning.	**Matron Assessment Units & Head of Site Management**	**13th May 2022 (Complete)**

		Symphony will be configured to identify the volume of patients waiting to be seen as part of START and their waiting time. The START model will be broadened to incorporate all ambulance arrivals with the exception of pre-alerted calls. This will then enable initial triage to be fully integrated in to the START model. This is reliant on a drop curb and traffic management plan being completed (lead time 4-6 weeks).	**General Manager, EQ** **Director of Operations, YGC**	**27th May 2022** **27th June 2022**
The health board must provide HIW with details of how it will ensure that medication is stored in line with regulations, national and local guide lines, standards and policies, and that there is a robust process in place to check expiry dates of medication and medication administration equipment such as syringes and IV administration sets.	**Standard 2.6** Medicines Management	All medications removed from clinic rooms and cupboard locks repaired. Medication no longer stored in consultation rooms that do not have formal stock governance processes in place. Formal stock locations (Mediwell) benefit from regular pharmacy and electronic expiry date checking and stock rotation.	**Head of Nursing, EQ** **Director of Nursing & Lead Pharmacist YGC**	**13th May 2022 (Complete)** **13th May 2022 (Complete)**

		An additional member of Pharmacy staff working on a daily (7 days) basis has been allocated to ED to enable improved stock control and stock rotation. In addition to the pharmacy audit process, the senior nursing team will undertake spot checks of medication and associated equipment. The Mediwell within the Minors footprint will be relocated to a more secure location away from the paediatric area (end June is first date available).	**Lead Pharmacist YGC** **General Manager EQ & Lead Pharmacist YGC** **General Manager, EQ**	**13th May 2022 (Complete)** **13th May 2022 (Complete)** **27th June 2022**
HIW requires details of how the health board will ensure that the contents of the resuscitation trolleys are checked on a regular basis and that an accurate record of checks is maintained.	**Standard 2.9** Medical Devices, Equipment and Diagnostic Systems	The 8am and 8pm Safety Huddles, 7 days a week, will be responsible for ensuring that the resuscitation trolleys have been checked and that the records have been uploaded via the QR code (which is the new process providing a better audit trail than traditional log book.) This process will also include fridge checks and CD counts following the handover from night to day staff and day to night staff. The electronic	**Matron ED & Head of Nursing, EQ**	**16th May 2022**

		records from these two safety huddle will provide an audit trail that this has been actioned. The Director of Nursing will receive a daily electronic report from the resuscitation team to act as a further check that the record of checks has been updated and is maintained.	**Director of Nursing, YGC**	**16th May 2022**
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	The Nurse In Charge and Medical Team Leader will be responsible for undertaking a spot check on Symphony of a minimum of 5 records per day, covering both nursing and medical staff who are on shift. This will include completion of the discharge checklist and completion of risk assessments where indicated. The results will be collated and fed back to the Head of Nursing / Clinical Director to build a picture of staff who require additional support / training. Because Symphony only became operational at YGC on 30th March 2022, staff are being supported by the IT training team who are available on the shop floor 2 days a week, and at other times through a designated phone line.	**Matron & Clinical Lead, EQ** **General Manager, EQ**	**23rd May 2022** **13th May 2022 (Complete)**

		There will be rapid feedback to staff where the outcome of audits shows that record keeping falls below the standard expected by the Health Board.	**Head of Nursing & Clinical Director, EQ**	**23rd May 2022**
		Additional spot checks will be undertaken as part of Hospital Management Team visibility in ED, and constructive feedback given.	**Hospital Management Team**	**16th May 2022**
		Where there is non-compliance with record keeping, the individual will receive a bespoke training plan within a set time frame	**Director of Nursing, YGC**	**30th May 2022**
HIW requires details of how the health board will ensure that patient's files containing confidential information are kept secure at all times.		Via regular departmental briefings and on an ongoing basis as part of appraisals, staff will be reminded of the requirement to use the lockable notes trolleys that are available in all areas of the department. This will be checked as part of the senior nurse walkabout twice a day and form part of the safety huddle checklist.	**General Manager, EQ**	**16th May 2022**
		All reception staff to be reminded via weekly staff meetings of their responsibilities in relation to storage of notes of patients who have left the department. Bespoke training session for staff on Information Governance to be provided, in addition to IG training	**General Manager, EQ**	**16th May 2022**

		as part of the mandatory training bundle. Improve the provision of administrative support for the scanning of notes, and investigate whether records can be exported from Symphony direct to the scanner (without first being copied) for patients being admitted, in order to reduce the volume of confidential paperwork in the department. Regular spot checks (rota between all hospital Heads of Nursing, Matrons and General Managers will be put in place) to ensure that patient identifiable information is not left inappropriately in the ED.	**General Manager, EQ** **Head of Nursing, EQ**	**30th May 2022** **23rd May 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.	**Governance and Leadership** **Standard 7.1** Workforce	Hospital Management Team and Senior Professional Managers to be visible in the Emergency Department daily, and to spot check the effectiveness of safety huddles as part of this process. All staff meetings (across professions) to be minuted with an action log, with minutes fed upwards to the Directorate leadership team and on to the HMT. Governance Meetings within the EQ Directorate to be restructured to cover	**Hospital Management Team** **Head of Nursing & Clinical Director, EQ**	**16th May 2022** **16th May 2022**

		progress updates / oversight of all improvement areas including monitoring of key metrics. A weekly accountability meeting is in place between the EQ Directorate Team and the HMT, chaired by the Acute Care Director. The focus of this meeting will include oversight of this action plan and identification of any actual or potential issues with delivery. A recruitment programme is active for all disciplines of staff in line with the investment provided through the Health Board.	**Head of Nursing & Clinical Director, EQ** **Acute Care Director, YGC** **Senior HR Manager, YGC. Head of Nursing & Clinical Director, EQ**	**30th May 2022** **13th May 2022 (Complete)** **13th May 2022 (Complete)**
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.		Staffing levels are reviewed on a daily basis with oversight from the Director of Nursing. Block booking of agency staff for known gaps is undertaken 3 months in advance to increase the likelihood of fill and individuals with experience of ED. An additional Matron has been identified and will be staring in post on an interim basis from the end of May.	**Head of Nursing EQ** **Head of Nursing EQ** **Director of Nursing, YGC**	**13th May 2022 (Complete)** **20th May 2022** **30th May 2022**

		The substantive Head of Nursing will undertake a phased return after a period of absence, and this will provide additional senior support alongside the Interim Head of Nursing who will remain in post.	**Director of Nursing, YGC**	**30th May 2022**
		A training needs analysis is being undertaken to establish what the educational gaps are for registered nursing staff across the department.	**Head of Nursing EQ & Director of Nursing, YGC**	**13th June 2022**
		A weekly absence review of all staff will be undertaken between the Matron and Head of Nursing, supported by the HR team.	**Head of Nursing, EQ**	**20th May 2022**
		Exit interviews will undertaken by the HR team on an ongoing basis.	**Senior HR Manager, YGC**	**16th May 2022**
		Facilitated listening events will take place to encourage staff to voice their concerns and put forward ideas.	**Acute Care Director, YGC**	**13th June 2022**
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.		All ED departments across the HB have been made aware of the issues identified within the HIW report and have given assurance that action is in place to rectify any gaps	**Deputy CEO/ EDICS**	**06th May 2022 (Complete)**

		Pharmacy reviews have been carried out across all ED departments The ward accreditation programme has restarted and will be focussing on ED departments and wider clinical areas. The reports will be monitored via the Executive Delivery Group for Quality Triangulation of the information available has led the Health Board to develop a site improvement plan for YGC and use this approach as a template for the wider organisation As part of the revised operating model the executive have recognised a need to have a stronger assurance function which will be housed within the Office of the CEO and managed by the new Associate Director of Governance and the Board Secretary. A proposal will be developed to take this forward.	**Chief Pharmacist** **Executive Director of Nursing** **Deputy CEO/EDICS Executive Director of Transformation and Planning** **Associate Director of Governance/Board Secretary**	**13th May 2022 (Complete)** **13th May 2022 (Complete)** **31st May 2022** **31st May 2022**

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

Service representative:

Name (print): Neil Rogers

Job role: Acute Care Director, YGC

Date: 17 May 2022

Appendix C - Improvement plan

Service: Emergency Department, Ysbyty Glan Clwyd

Date of inspection: 03, 04 and 05 May 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 (Key focus areas)	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must review the use of the ambulatory care area to ensure that patient dignity and privacy is promoted and maintained.	**Standard 4.1** Dignified Care	The ambulatory care area as it existed at the time of the inspection is no longer in place. The space has been remodelled and is now the point of care investigation/ testing area as part of the START model The new model ensures patient dignity and privacy is achieved through the installation of curtains to provide for individual spaces where patients receive the	Directorate General Manager and Head of Nursing on behalf of the Hospital Management Team HMT (Acute Care Director, Medical Director, Director of Nursing and Director of Operations).	The new model environmental and estates work has been completed The new way of working has commenced with staff working to the new Standard Operating

		appropriate investigations, protecting privacy and dignity. In addition to the investigation area, patients are taken into individual consulting rooms for assessment. Corridor seating is available as a temporary waiting area only, and so no assessments/ongoing investigations are undertaken there. Where a clinical risk assessment indicates patients require immediate treatment, this can take place in the START area and staff will work to ensure privacy and dignity is maintained. Through the wider improvement plan for the site, the Senior Leadership Walkabouts (which include attendance of Executive /		Procedure from 7 May 2022. A formal review of the proforma will take place by 15 July 2022 at the Hospital

		Independent Members), have commenced, utilising a structured proforma which will be developed further through feedback. A tiered approach will be taken to Senior Leadership Walkabouts. This approach will ensure regular visibility of senior leaders and will ensure that any deviation from expectations will be identified quickly, root causes and challenges understood, and contemporaneous action taken.		Management Team weekly meeting followed by Executive sign off by the Senior Responsible Officer for the wider Improvement plan in place
The health board must ensure that waiting times are displayed in a prominent position within the waiting area.	**Standard 3.2** Communicating Effectively	Since HIW have inspected, the display monitor in the waiting room is now functioning, however it requires updated hardware to ensure resilience. The function of the monitor is managed by staff in the reception area who have been reminded to update hourly	Directorate General Manager and Emergency Department Matron	The hardware is on order and we envisage that it will be installed by the end of August 2022.

		and to ensure the sound on the tanoy is not turned down. There is a Registered Nurse and a Health Care Support Worker in the waiting room who will ensure the display monitor is up to date and support communication with patients.	Emergency Department Matron	Health Roster (electronic rostering) is in place and will ensure that a Registered Nurse and Health Care Support Worker are assigned to the area for each shift
		Any issues or incidents that occur in between safety huddles, a dynamic risk assessment and clinical judgement is be made to mitigate the risk, dependent on clinical need and acuity of the department.	Operational Lead Manager, Emergency Care	Safety huddle, occurs every two hours
		The Nurse in Charge completes a shift log throughout the day and at each huddle, the risks and issues from the previous	Nurse in Charge	The shift log is paper based and the safety huddle stores information electronically via the

		huddle are reviewed and actioned for example escalation to speciality review i.e. medicine, surgery etc. The Patient Advice and Liaison Service (PALS) will conduct a weekly check of the department waiting area which will include consideration of displayed waiting times.	 Patient and Carer Experience Team	safety huddle digital application Monitored monthly through patient experience feedback mechanisms.
The health board must ensure that health promotion information is provided in both Welsh and English.		Patient information leaflets are available within the department for common presentations and ailments for example head injuries, minor burns or lower limb injuries. Due to COVID-19 restrictions the availability of displayed patient information limited. We are currently reviewing how we can effectively display and signpost, patients and	Emergency Quadrant Clinical Leads and Matron	Monitored monthly through patient experience feedback mechanisms (PALS). August 2022

		carers to request bilingual information/advice relevant to their personal situation. In addition, the Health Board subscribes to EIDO Healthcare (supported by Welsh Risk Pool), which produces a wide range of patient information leaflets. These leaflets can be printed off and given to patients regarding various health conditions and related treatment options in Welsh, English and some international languages. The Patient Advice and Liaison Service (PALS) offer patients an opportunity to Care to Share interviews with patients which is a mechanism to provide feedback, and part of the standard template for this approach is 'understanding	Patient Carer and Experience Team	The Health Economy is looking to set up a Patient and Carer Experience Group who will review and monitor these mechanisms, proposed timescale of September 2022. As detailed above

		and involvement in care', which includes patient information.		
The health board must ensure that pressure area risk assessments are completed accurately and consistently.	**Standard 2.2** Preventing Pressure and Tissue damage	Risk assessments are recorded in the Symphony system. The falls and pressure area risk assessment facility is displayed in a prominent position on the system, for staff to complete. In addition, when clinicians come to treat a patient, they can select the 'E-view' functionality which provides a simple overview of all relevant information including any risk assessments undertaken. Furthermore, the Symphony system has an e-audit facility which allows for reviews of falls and pressure area risk assessments. This allows for simple data ranges to be entered which will generate	Ward Manager with support of Emergency Department Matron The Clinical Lead and the Head of Nursing	Ward Managers weekly audit and Matrons monthly audit (via the IRIS and Symphony systems) in place Audit outcomes, including compliance and harms are discussed monthly at accountability meetings and fed up to the Director of Nursing with any

		the appropriate records for audit. The Clinical Lead and the Head of Nursing will sign off an audit programme for the year and incorporate this into the plan. Vulnerable and at risk patients are identified in real time and will be discussed in the two hourly safety huddles to ensure appropriate care is being given Audits of All Wales Risk Assessments shows an improvement in compliance of rate of 64% for May 2022. Risk assessments are recorded in Symphony and individuals at risk are escalated to the Nurse in Charge during the		actions required for assurance. August 2022 with data analysis to commence from September 2022 Two hourly safety huddles are in place. A safety huddle digital application is in place to log risks and actions in order to support follow up reviews at future safety huddles

		two hourly safety huddles, or more urgently as required. At present there are local HARMS meetings within the site that review all HARMS on a weekly basis. A review of the model has been commenced in line with the wider improvement model where a HARMS collaborative has been introduced with initial focus on Falls and Pressure Ulcers with a specific focus on Emergency Departments.		The HARMS collaborative will be rolled out in August 2022
The health board must ensure that falls risk assessments are completed accurately and consistently.	**Standard 2.3** Falls prevention	As detailed above		
The health board must ensure that staff use and disposed of PPE appropriately.	**Standard 2.4** Infection Prevention and Control (IPC) and Decontamination	PPE is used and disposed of in line with Welsh National guidance and BCUHB Policy. PPE posters are widely displayed across the Health Board and within the department.	Ward Manager with support from Matron and Infection Prevention Team	The Electronic Staff Record (ESR) mandatory training compliance is discussed monthly with Workforce

				Monthly IPC Audits undertaken by the IPC team.
		As part of Senior Leadership Walkabouts and observations, any breaches in practice are identified and addressed at the time and will be captured as evidence through the walkabout proforma.	Directorate General Manager and Head of Nursing on behalf of the Hospital Management Team	The YGC Improvement Plan database (Caspio) holds all programme documentation, including walkabout proformas. Completed proformas are being uploaded to the database, with reflections and evidence of intervention when required.
		All staff, inclusive of new and temporary, have been educated with regard to the policy via mandatory training, peer to peer discussions and where appropriate, induction to the area. Current compliance of Infection	Ward Manager with support from Matron and Infection Prevention Team	Monthly IPC Audits undertaken by the IPC team.

		Prevention and Control (IPC) mandatory training is 76%. Adherence to the PPE policy is monitored via the weekly Ward Manager and monthly Matron audits. In addition, IPC conduct unannounced walkabouts throughout the department. IPC audits are undertaken monthly and repeated as required if any issues are identified, the audit is repeated to monitor compliance and improvement. In terms of compliance with IPC audits, the latest environmental audit (takes place annually) was undertaken on 6 July 2022 which the Head of Nursing, Facilities and Estates will review and monitor.	Senior Nursing Team, Facilities, Estates and Infection Prevention Team	

		Hand hygiene audit is at 100% for May and June 2022. Credits for cleaning (C4C) is a national standard practice is undertaken monthly to provide assurance regarding estates, facilities and infection prevention for example cleanliness and well maintained facilities.		Credits for cleaning (C4C) undertaken monthly by IPC jointly with facilities, estates and nursing teams. This is monitored through monthly accountability meetings overseen by Head of Nursing and reported to the Local Infection Prevention Group and reported up through the governance structure.
The health board must ensure that everyone attending the ED is screened for COVID-19 and that the staff member allocated this responsibility is appropriately supported and able to take breaks when necessary. In addition, the health board must ensure that there are adequate security arrangements in place at the entrance to the department in		In relation to COVID-19 screening, national guidance has evolved following the HIW inspection. If a patient presents with COVID 19 symptoms they are isolated in a separate red waiting room / isolation cubicle with correct signage on the cubicle door.	Ward Manager with support from Matron and Infection Prevention Team	Monthly IPC Audits undertaken by the IPC team. Two hourly safety huddles are in place

order to ensure the safety of patients and staff.		In addition to the waiting room Registered Nurse, a nurse is situated at the front door to the department who's main duties are to undertake the COVID-19 screening process which includes temperature. If patients require admission they will then have COVID-19 testing prior to attendance to wards. The department is fully compliant with this standard as demonstrated via our IPC audits. Breaks are covered by a Registered Nurse. The Nurse in Charge has the responsibility for overseeing this for each shift and will allocate breaks to staff ensure the provision of adequate cover for their areas. Staff are supported to take their breaks and where this is challenging due to acuity, staff wellbeing		

		is taken into consideration, and where possible, the senior nursing team will support. In relation to security arrangements, at present there are two security persons in place daily, providing 24 hour cover.		Service Level Agreement in place with external company
The health board must ensure that the risk of accommodating COVID-19 positive and negative patients in the same area is properly managed to reduce the risk of cross infection. In addition, appropriate signage must be provided to clearly identify where COVID-19 positive patients are accommodated.		In relation to COVID-19 screening, national guidance has evolved following the HIW inspection. If a patient presents with COVID 19 symptoms they are isolated in a separate red waiting room / isolation cubicle with correct signage on the cubicle door In relation to reducing the risk of cross infection, staff comply with the current PPE requirements to ensure PPE is used and disposed of in line	Nurse in Charge supported by IPC Ward Manager and Matron supported by IPC	Monthly IPC Audits undertaken by the IPC team. Credits for cleaning (C4C) undertaken monthly, jointly with facilities, estates and nursing teams.

		with Welsh National guidance and BCUHB Policy. The wider YGC Improvement plan brings a system wide approach to addressing the root causes of our challenges. The third work stream is based around Emergency Department medicine and flow and will focus on actions to decompress the Emergency Department, thus facilitating this area of improvement. Staff are educated with regard to the policy via mandatory training and peer to peer discussions. Current compliance of IPC mandatory training is 76%. The safety huddle will monitor patient placements and segregation.	Director of Operations, Hospital Management Team Ward Manager and Matron supported by IPC	ESR Mandatory Training compliance discussed monthly with Workforce Two hourly safety huddles are in place

The health board must ensure that patients have easy access to food, given the lengthy waiting times that some patients have to endure before being seen by a doctor or nurse.	**Standard 2,5** Nutrition and Hydration	There is a vending machine available in the waiting room to facilitate drinks and snacks. An agreement is in place with our catering services for the provision food and where a patient has a particular need, their requirements are catered for. We will strengthen compliance with the weekly and monthly audit process (IRIS) to monitor delivery of this improvement In addition, where patients are risk assessed as vulnerable, they are actively supported with fluid and nutritional input which is recorded via Symphony and intentional rounding. Daily, within the waiting room the Registered Nurse, Health Care Support Worker (HCA)	Nurse in Charge supported by Matron	External supplier who replenish and maintain in accordance with the contract in place. Ward Managers weekly audit and Matrons monthly audit (via the IRIS and Symphony systems)in place Red Cross Provision is well established and monitored through the Service Level Agreement- contract in place. A monthly report including statistics is provided from Red Cross to the directorate. PALS Engagement Plan in place, attending once weekly

		and facility staff, offer regular fluid and food to all patients. This is supported by the red cross who provide daily support within the Emergency Department. The Patient Advice and Liaison Service (PALS), facilitate Care to Share interviews with patients where they have the opportunity to feedback on access to food during lengthy waiting times. Intentional rounding is also undertaken within all areas of the Emergency Department, so that if a patient requires any food or fluids in between normal meal times, this can be provided. The Senior Leadership Walkabout approach will ensure regular visibility of senior leaders and will ensure that any deviation from		PALS feedback audited weekly and fed back to the Hospital Management Team, with good open communication Intentional rounding is captured on the Symphony system and is audited daily as part of the Nurse in Charge daily checklist.

		expectations will be identified quickly, root causes and challenges understood, and contemporaneous action taken.		
The health board must ensure that fluid intake is appropriately and consistently recorded at all times.		If a patient clinically requires a strict input / output fluid balance chart, this is recorded on symphony. All of these are monitored via the international rounding.	Matron and ward manager	Ward Managers weekly audit and Matrons monthly audit (via the IRIS and Symphony systems) in place
The health board must ensure that discontinued and discarded medication is accurately recorded on one document and that staff are aware of this process.	**Standard 2.6** Medicines Management	Staff return unused medications to the Mediwell system. This is a swipe in and out facility that provides a clear audit trail of medicines that have been returned Where treatments or drugs have been discontinued this is recorded on the symphony system. If medicines can be returned to the Mediwell system they are, however, for medications that have been	Senior Nursing Team with Patient Safety Lead Pharmacist	Ward Managers weekly audit and Matrons monthly audit (via the IRIS and Symphony systems) in place The Pharmacy Department undertake monthly audits

		partially used or need to be destroyed they are disposed via the pharmacy bins Training has been provided by the Emergency Quadrant pharmacist on the Mediwell system and its functions in May 2022. Chapter 10 of the Medicines Management Policy MM01 Return, Disposal and Destruction of Medicines will be circulated to all staff and discussed as part of medicines management training which is to be undertaken by the Pharmacy Team, twice yearly from September 2022.		Medicines management training which is to be undertaken by the Pharmacy Team, twice yearly from September 2022.Commence September 2022
The health board must ensure that the temperature of the medication storage fridges are monitored and recorded on a regular basis.		As per BCUHB policy, the fridge temperature checks are recorded using a daily checklist and recorded on a daily basis.	Nurse in Charge supported by Matron	Daily checklist completed by Nurse in Charge

		Since the HIW inspection, medication storage issues have been addressed and strengthened following the installation of the controlled drugs Mediwell system (ensures stock control), and further training with support of the Emergency Department Pharmacist. Moving forward, twice yearly medicines management training of medicines management training which is to be undertaken by the Pharmacy Team, twice yearly from September 2022.	Pharmacy Team	Pharmacy Team undertake monthly and daily checks
The health board must ensure that there are robust processes in place to manage, record and report incidents when children leave the department without being assessed or those who leave against medical advice.	**Standard 2.7** Safeguarding Children and Safeguarding Adults at Risk	Minors who leave the Emergency Department without being seen have a safeguarding liaison form completed as per BCUHB policy. Staff have undertaken Mental Health and Capacity training	Matron and Emergency Department Clinical Lead	Quarterly audits as per the Standard Operating Procedure

		which includes an understanding of both policies with a compliance of 76% as at July 2022. A Standard Operating Procedure is being prioritised and finalised and ensure a more robust process for minors leaving the department without been seen. This will then be audited for compliance and reported to the Emergency Quadrant Safety meetings.	Head of Nursing and Directorate General Manager	July 2022
The health board must ensure that patients presenting with mental health care needs are assessed and treated in a timely way by staff who have the appropriate qualification and training.	**Standard 5.1** Timely Access	Psychiatric Liaison Nurses are on call 24/7 and based in the Ablett Unit. The current Psychiatric room is accredited and the team work to a breach time of one hour.	Matron and MH lead	Two hourly safety huddles

		Any concerns regarding psychiatric patients will be escalated in line with operational procedures. The safety huddle will report and record the escalation and mitigation.		
The health board must ensure that pain assessments are undertaken to ensure that patients receive appropriate and timely pain relief and treatment.		Pain assessments are completed as part of the initial triage assessment on arrival to the department. The effectiveness of the pain relief is reviewed on an individual basis. Patients are also asked as part of the intentional rounding regarding their requirements for pain relief. The Registered Nurse based in the waiting room will identify any non-verbal/verbal signs of pain and administer pain relief as prescribed and will	Nurse in Charge	Monitored through weekly ward manager audit and matron audit on IRIS Captured on the Symphony system and is audited daily as part of the Nurse in Charge daily checklist.

		document in the Symphony system.		
The health board must ensure that the electronic records management system is effectively meeting the needs of staff and patients, and that staff feel confident and supported in using the system. This applies particularly to temporary staff who may be unfamiliar with the system.	**Standard 3.5** Record Keeping	All substantive medical and nursing staff have been provided with training for use of the symphony system. Additional training in the form of super users has also been provided to ensure all staff feel supported. Temporary staff are given access to the symphony system and have been provided with support from the Nurse in Charge for each area / or super users. A fact sheet has been developed that outlines standards expected and FAQ's. Symphony super users within the department continue to support staff who are not	Head of Nursing and ED Clinical Lead	Dedicated Symphony Administrator for the site who will ensure all new staff are trained and will provide refresher training where applicable Super users in place to support staff

		familiar / require additional support to use the system.		
The health board must ensure that patient records are easy to navigate, clear and unambiguous.		All patient records are stored on the Symphony system which supports clear, contemporaneous and unambiguous record keeping which has been a significant step forward from the previous paper based approach for medical records. Additional support has been provided to upskill individuals that require additional training with regard to the symphony system, including the introduction of super users.	Head of Nursing and Emergency Department Clinical Lead	Ward Managers weekly audit and Matrons monthly audit (via the IRIS and Symphony systems)in place
The health board must continue with its efforts to recruit permanent staff.	**Standard 7.1** Workforce	There has been an active recruitment campaign since the HIW inspection that has	Directorate General Manager , Head of Nursing and ED clinical	For the current posts appointed, we aim to commence

		yielded the following nursing and medical posts: **<u>Nursing</u>** 2 substantive Band 7 Registered Nurses posts 5 substantive Band 5 Registered Nurses posts. Ward Manager, Emergency Department Band 7 4 substantive Housekeepers **<u>Medical</u>** 5 Middle Grade Doctor posts Advert out for substantive Emergency Department Consultant Currently advertising for a full time administrative support for roster co-ordination to free up clinical time	Lead supported by HR colleagues	employment by September 2022. In the interim, we will continue to actively support with temporary staff. For the posts advertised and recruitment campaign, this is ongoing

		As well as an active recruitment campaign, the Senior Nursing team are focusing on a retention plan which includes a review of the Health Roster, exit interviews, and career pathways.		
The health board must ensure that all staff complete all elements of mandatory training.		Nursing are 77% and medical staff 75% compliant with in mandatory training as of July 2022. Clinical Lead and Matron have communicated to all staff and highlighted that there is opportunity to improve compliance with mandatory training and that this needs to be completed by the 30th September 2022 Staff are supported to complete mandatory training with protected time at work	Directorate General Manager , Head of Nursing and ED clinical Lead	Improve compliance with mandatory training September 2022, monitored through the Electronic Staff Record (ESR) and monthly accountability meetings

		or paid for time outside of working hours.		
The health board must reflect on the less favourable staff responses to some of the questions in the HIW online survey, as noted in the Quality of Management and Leadership section of this report and take action to address the issues highlighted.		The stronger together team will be asked to provide initial support organisational development within the department and the Senior Leadership team	Hospital Management Team supported by Directorate General Manager , Head of Nursing and ED clinical Lead working with HR and OD colleagues	September 2022
		All Band 7 Registered Nursing staff have been given an opportunity to feedback following the HIW inspection, and highlight any support they require to fulfil the expectations of their role. This approach has then been cascaded throughout each team.	Matron and Head of Nursing	End of July 2022
		Engagement sessions / senior Hospital Management Team walkabout sessions have been	Hospital Management Team supported by Directorate General	August 2022

		planned and will be undertaken during July and August 2022 "You said We did" boards will be in place within the waiting room to share feedback with all patients, carers, staff and public. There is a refreshed emphasis on education and training and the following external courses have been booked for each Emergency Department team to attend which include: • Assessment & management of head injury (5th August) • Injured & sick child (13th & 14th September.) • The Acute Intervention Team (AIT) are providing a bespoke programme for the Emergency Department team in recognising deteriorating patients,	Manager , Head of Nursing and ED clinical Lead Hospital Management Team and Patient Carer and Experience Team Matron and ED clinical lead.	July 2022 September 2022

		sepsis, respiratory failure and escalation (8th July, 18th July, 22nd July with more dates to follow.)		

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): Neil Rogers

Job role: Acute Care Director

Date: 7 July 2022