Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Department, Ysbyty Glan Clwyd
Inspection date: 03, 04 and 05 May 2022
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This summary document provides an overview of the outcome of the inspection

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Introduction

At the time of our inspection we found that the ED, as the front door to the wider hospital, 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.

We found that the health board was not fully compliant with many of the Health and Care Standards and we highlighted significant areas of concern which could present an immediate risk to the safety of patients.

Our main concerns included poor patient experience within the ED with lengthy waiting times and poor management of health and safety risks.

We highlighted significant concerns regarding many aspects of the delivery of safe and effective care. We were not assured that all the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of timely, safe and effective care.

We found that the quality of management and leadership was not sufficiently focused and robust. We also found that the wider leadership and governance arrangements, beyond direct management of the ED, were not having an effective or supportive impact on the ED.

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

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.

This summary version of the report is designed for members of the public.

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

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.

What we found this service did well

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

Where the service could 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.

Patients told us:

“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.”

Delivery of Safe and Effective Care

Overall Summary

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 and falls risk assessments.

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.

What we found this 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. However, we found that multi-disciplinary attendance to 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 had the potential to improve the quality of patient care and patient safety within the department

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 of the full report:

- 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 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
- 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
  - 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 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 public

- Medication management processes were not sufficiently robust and safe

- Infection prevention and control measures were not sufficiently robust.

In addition to the Immediate Assurances 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 qualification and training
- The health board must ensure that pain assessments are undertaken to ensure that patients receive appropriate and timely pain relief
- 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.

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

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. This was despite the health board providing an action plan and assurances that matters had improved. Key areas which had not improved included:
    - Nursing documentation
    - Management of patients in the waiting room
    - Identification and management of high risk patients and monitoring of patients susceptible to deterioration were insufficient
    - 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.

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

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

Staff told us:

"All rooms occupied, staff overwhelmed and unsure where or who the patients are."

"I feel the department is overwhelmed by patients and is struggling to cope with the increased footfall and demand."

"There does not appear to be a plan to get further staff on-board to help the staff and improve patient care. Ultimately patients are suffering due to chronic underfunding and understaffing of a busy department."

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.