Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Emergency Department (and Assessment Areas), Morriston Hospital, Swansea Bay 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 at Morriston Hospital, Swansea Bay University Health Board on the 5, 6 and 7 September 2022. We also inspected a number of the assessment areas during the course of this inspection. The following areas were reviewed:

- Emergency Department (ED)
- Children's Emergency Unit (CEU)
- Surgical Decision Making Unit (SDMU)
- Rapid Assessment Unit (RAU)

We also spoke with staff in the Older Persons Assessment Service (OPAS), but did not visit Ward D (Medical Assessment Unit) during this inspection.

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

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

This (full) report 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.

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 not always receiving the experience that they should expect. This is because of a lack of timely care and treatment, despite constant efforts demonstrated by the health board to increase patient flow. However, patients were generally happy with the care provided by staff once they were seen.

We found that the environment was not conducive to the maintenance of patient privacy and dignity due to the number of patients accessing the service. We observed staff making efforts to maintain this, despite the limited space available.

This is what we recommend the service can improve:

- Review the use and availability of suitable seating
- Patient privacy and dignity.

This is what the service did well:

- We observed staff speaking with patients in a polite, professional and dignified manner
- Patients expressed the view that they were generally happy with the way staff interacted with them.

Safe and Effective Care

Overall summary:
Patients were generally receiving a safe service, but this was negatively impacted upon by the lack of timely care and treatment at times due to poor patient flow within the department and wider hospital.

Aspects of infection prevention and control (IPC) need to be reviewed to ensure that risks to staff, patients and visitors are eliminated or minimised.

We had a number of concerns in relation to nutrition within the ED which must be reviewed due to the periods of time patients remain in the department and wider hospital.

Immediate assurances:

- We found that patients were not always triaged, reviewed, or treated in a timely manner.

  Our concerns were escalated through our immediate assurance process. Details of this can be found in Appendix B.

This is what we recommend the service can improve:

- Paediatric nurse staffing levels
- Aspects of infection prevention and control
- Patient nutrition
- Aspects of record keeping.

This is what the service did well:

- Link Nurse initiatives, for example bereavement and safeguarding specialists
- Certain patient pathways, e.g. Older Persons Assessment Service (OPAS).

Quality of Management and Leadership

Overall summary:
Overall we found that staff in all roles were committed to providing a good level of care despite the pressures. Clinical and non-clinical management teams made efforts to provide appropriate support and to maintain effective running of the ED and assessment areas.

Staff responses to the HIW questionnaire were mixed and the health board is strongly encouraged to ensure that staff have appropriate channels of communication in which to provide feedback.

This is what we recommend the service can improve:

- Staffing shortfalls and skill mix
- Aspects of staff training and development.

This is what the service did well:

- ED staff expressed positive views regarding Band 7 leadership and immediate line manager support.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used questionnaires to obtain views and feedback from patients and carers. A total of 8 were completed. Patient comments included the following:

> *"Very good service in RAU and staff were marvellous. However ED service was very poor. On admission, first few days in A&E were very stressful, in pain, lacking sleep and sitting in a chair…"*
>
> *"No food offered in ED"*
>
> *"Keep the patient informed. I had been assessed as needing IV antibiotics at 9am and at 14.40 I was still waiting"*
>
> *"If we hadn't phoned the surgeons secretary, my daughter would probably still be waiting. The whole system needs a shake-up"*
>
> *"Initially triaged and then returned to waiting area. Then I had a facial droop and was rushed into resus. Two recent admissions and I have been sent home both times."*

We also spoke to several patients and their relatives / carers during the inspection to help us form a view on quality of patient experience.

Staying Healthy

Health Protection and Improvement
We found some health promotion and support information displayed around the ED and assessment areas. Staff explained that much of the hard copy material had been removed due to COVID-19. The health board should consider re-introducing relevant material in accessible areas for patients and their relatives.

Dignified care

Dignified care

All but two patients who completed a HIW questionnaire agreed that staff treated them with dignity and respect. We observed staff speaking with patients in a polite, professional, and dignified manner at all times.

We found limited opportunity to maintain patient privacy and dignity in the ED waiting areas. These areas were frequently crowded during the inspection and patients were generally seated in these areas for excessive periods of time. This included patients sat in hard plastic type chairs overnight in some instances

We also found a number of examples in which patient privacy and dignity was not fully maintained within the ED or Assessment Areas:

- During our tour of the waiting area, we found one patient lying on the corridor floor and were told by the relative that they had returned home to collect their own pillow due to the heightened discomfort experienced by the patient. We asked the nurse in charge to review this patient at the time

- Within the Minors area, we observed an older patient sleeping on inappropriate seating overnight without a blanket or pillow being provided

- Within the SDMU, the waiting area did not meet patient needs for similar reasons. Whilst efforts were made to avoid patients waiting in this area overnight, we noted there were occasions where patients slept on similar inappropriate hard, plastic seating

- Patients who arrived by ambulance were cared for by both ambulance service and hospital staff whilst they were waiting to be admitted. We observed patient dignity being maintained as far as possible, but we noted the limitations of this due to poor patient flow within the wider hospital. Despite this, we noted that there was a good system in place between ED staff and ambulance service staff to ensure that fundamentals of care, such as pain relief, were delivered when required

- We noted that on two occasions in the Majors area, that patients on trolleys had been positioned in between patient bays. Whilst staff told us that mobile screens were available, these were not in use and the placement of patients in this manner does not promote adequate privacy and dignity for those patients and others within the vicinity.

The health board must review the use and availability of suitable seating within the department. The health board must also ensure sufficient availability of pillows and blankets.

The health board must also ensure that the placement of patients within the department is reviewed to promote privacy and dignity.

We found that dignity was generally maintained in other areas of the department, and we saw that efforts had been made to consider the needs of certain patient groups. For example, designated quieter bays for patients requiring enhanced supervision, a dedicated paediatric emergency unit and direct pathways, such as the older persons assessment service, to avoid the main ED footprint.

We found that there was a notable bereavement service provided by nursing staff within the ED to help support relatives of patients who have sadly died. We were provided with many positive examples of how support is extended in both the immediate aftermath and short term following the death of a loved one.

Communicating effectively and Patient information

We observed staff speaking with patients in a polite, professional, and dignified manner at all times during the inspection. However, some patients in the main ED told us that they would have appreciated being given more time for explanations about their care and treatment. Despite this, most patients told us that they felt listened to by staff.

We observed that some staff working within the ED wore a 'Iaith Gwaith' badge to indicate that they could communicate bilingually (Welsh/English) and main signage displayed throughout the department was overall bilingual. We observed one patient who was unable to speak English and who was being supported by a family member to interpret details of their care and treatment.

The health board should ensure that staff are aware of official translation services that are available to ensure an appropriate flow of information between the patient and healthcare professional.

Patient waiting times in the ED were not displayed and patients would be required to speak to staff should they wish for an update.

Appropriate bilingual signage was on display throughout the ED and in the Assessment Areas.

Timely care

Timely Access

The ED remained over capacity during the course of the inspection which affected timely access to care. There was significant pressure on the ED 'front door', namely the walk-in waiting areas and ambulance arrival bay. There were up to nine

ambulance vehicles outside the department at any one time, but this fluctuated as patients were handed over to the department.

We found the ED waiting areas to be overcrowded throughout the course of the inspection. However, other areas of the department remained relatively calm despite the high number of patients accommodated within these areas.

Staff we spoke with and who completed a HIW questionnaire told us the issues associated with patient flow within the wider hospital and system had been long standing. We were told that the number of patients attending the ED and the inability to discharge medically fit patients was causing significant delays in the ability to see and treat patients in a timely manner.

Staff told us in response to suggestions on how the ED could improve to better meet patient needs:

> *"Better availability of community services to enable easier/appropriate timely discharge from ED (and wards so more beds were then available to ED patients that actually need them)."*
>
> *"Appropriate assessment facilities to avoid seeing patients in waiting areas/ trolleys."*
>
> *"Develop official discharge and redirection from triage policies. Most discharges at triage rely on the experience of triage nurses and their confidence to send someone away…"*
>
> *"All specialities to have an assessment area of their own for referred patients to go to instead of coming to ED… Clear contact details for who is looking after speciality patients who have been in the department for days."*

We attended various site management, patient flow and handover meetings. We found that all teams were working hard to reduce the impact of poor patient flow on patients. This included a nurse patient flow co-ordinator and experienced triage nursing staff.

All nursing and medical staff were working hard to ensure that timely access to care was delivered. However, HIW was not assured that all aspects of care within the main ED were being delivered in a timely and effective manner due to the numbers of patients presenting at the ED and issues of patient flow. We reviewed six ED patient records and highlighted serious issues, which required immediate action by the health board. Examples included:

- We observed delays beyond national guidelines in both triage and medical review of patients presenting with chest pains and associated myocardial infarction symptoms. In one record we reviewed, the length of wait between arrival and triage was two hours

- We found that another patient had been lying on a spinal board for a significant period beyond national guidelines and that there was a delay in providing appropriate interventions, including an MRI, despite a neurological deficit being recorded

- We found that an older frail patient had been lying on an unsuitable surface (ambulance trolley) for over 11 hours and had complained of being in pain during this time.

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

It was positive to note that paediatric patients within the CEU were triaged within appropriate timeframes and compliance with treatment targets was overall good. We were also informed that nurse-led initiatives are actively underway within the department to review the waiting and triage areas.

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 patients and their relatives/carers were involved in decisions about their care needs. However, two questionnaire respondents disagreed that they felt sufficiently involved in decisions about their care.

People's rights
We observed staff working hard to provide care that promoted and protected people's rights. We found evidence that patient information related to their personal, cultural and spiritual wishes was recorded and shared appropriately.

We found that patients in the main ED waiting area could have one relative to accompany them in this area. Within the assessment areas, visiting was permitted during designated hours, but we were told that there is flexibility dependent upon patient needs.

Within the assessment areas, we were told that patients would be accommodated in a cubicle if they were very unwell and that there would be provision for relatives to stay overnight. However, we were told that this was not always achievable, and we noted that two patients had sadly died in a larger multi-bedded bay, although with their families present.

There was a small but functional relatives room which could be used in the event of needing a quiet space to talk with relatives.

Listening and learning from feedback

We noted that there were opportunities for patients to provide feedback, suggestions, and formal complaints. This included speaking to the nurse in charge, contacting the health board Patient Advice and Liaison Service (PALS) or by accessing details online. However, we observed limited information displayed in all areas that we visited during the inspection, including a lack of reference to the Putting Things Right scheme.

The health board must ensure that sufficient information on how to provide feedback or complaints is visible in key locations around the department.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We found that the ED and assessment areas were generally accessible to all patients and visitors. However, we saw that these areas, with the exception of the CEU, were generally overcrowded and cluttered, which could present trip hazards to patients, staff and visitors. For example, in the SDMU, we saw that patients had their belongings on the floor in several bed areas and overnight in the SDMU triage / waiting areas.

General overcrowding in these areas contributed to a lack of space for patients and for staff to deliver care and treatments. We asked staff if the facilities within the ED were appropriate for them to carry out their tasks, 12 agreed and 21 disagreed. Staff commented:

> *"As the ED is constantly overcrowded then managing the assessment and treatment of new patients, even acutely unwell patients is quite challenging."*
>
> *"… not enough rooms to triage in a timely manner."*
>
> *"Limited space available during busy times to see and treat patients appropriately. Temporary REACT not an appropriate space as no privacy for patients & no heating facilities."*
>
> *"Department now not fit for purpose, sluice too small, limited toilets, decontamination room currently used as a surge area."*
>
> *"Lack of workspace to prepare … documentation etc. 'Minors' area too small and always over capacity. 'Minors' area inappropriate for mental health patients but usually the only place to sit these patients. REACT is not fit for purpose, it is too cramped to work in and does not allow for patient privacy and dignity."*

During the inspection senior management described plans to us that have been approved for a large scale new acute medical assessment department at Morriston Hospital. We were told this will provide an improved environment for patients and staff, whilst aiming to minimise referrals and admissions to the ED.

In the interim, the health board must ensure the areas described are free from clutter to reduce the risk of trip hazards.

Despite the above, we found the environment to be generally clean and housekeeping staff were diligent and respectful when completing tasks in clinical and patient waiting areas. Utility rooms were found however to be unlocked and open in the assessment areas. **The health board must ensure that utility room doors are locked when not in use to prevent unauthorised access.**

We found that access to clinical areas of the ED were secure and access to staff only areas, such as medication rooms, were locked. We were told that there was a dedicated security team to provide support if required.

In the assessment areas, namely the RAU, we found that persons could access these areas without the need to be permitted entry by staff. We were told that a patient was seen trying to leave the ward on one occasion during the inspection and was escorted back to their bedside. This is also referenced in the context of Deprivation of Liberty Safeguards (DoLS) on page 19. **The health board must consider ward security given the patient groups being cared for in these areas.**

We found that there was a suitable process for reporting faults and other maintenance issues, but some staff told us:

> *"Needs to be a better working environment. No clean utility for nurses to draw up drugs or prepare IV medication. Estates do not attend in a timely manner to carry out repairs…"*
>
> *"We need more equipment and broken equipment need to be fixed quicker. There is a massive lack of equipment for the number of patients we have."*

The health board must ensure that maintenance issues are given appropriate priority and should reflect on the staff comments provided in this section of the report.

Preventing pressure and tissue damage

Within both the ED and assessment areas, we found that initial pressure ulcer risk assessments had been completed promptly and appropriate skin assessments were completed where required. In the assessment areas, we found documentation completed to a good standard and with on-going monitoring of patients who were deemed high risk.

Falls prevention

Within both the ED and assessment areas, we found that initial falls risk assessments had been completed promptly and comprehensively where required.

ED staff told us that additional support, such as from Occupational Therapists or Physiotherapists, for patients assessed at risk of falling was available, but that support was not always immediately accessible. However, staff in the assessment

areas told us that equipment is provided in a timely manner if required and following an individual assessment.

In the ED, we found that OPAS maintained effective links with the department and were able to accept direct admissions with the intention of avoiding a prolonged stay within the ED, thereby reducing the risk of inpatient falls. It was positive to note that examples of learning from falls incidents was often reported and shared via OPAS.

We noted that there was a designated area of the ED for patents who required enhanced supervision and that call bells were within reach of patients.

Infection prevention and control (IPC)
We found generally satisfactory compliance with IPC procedures in all areas that we inspected. Staff we spoke with were generally knowledgeable and were able to describe how they maintained good IPC practices relevant to their roles and responsibilities. Staff were well presented in clean uniforms and were always bare below the elbow.

The areas inspected were supported by IPC nursing staff who work across the hospital site. This team is supported a lead IPC nurse who engaged well with the inspection team. We noted that there was a programme of IPC and cleaning related audits which were completed on a consistent monthly basis.

However, in all areas, we observed persistent missed opportunities for hand washing. There was also poor practice in the use of gloves. We observed nursing and medical staff not changing gloves in between attending to patients and switching between clinical and non-clinical tasks. This included one occasion where a patient was examined by staff in full personal protective equipment (PPE) due to their infection risk, who then went on to use touch points, including the telephone and computer, in contaminated PPE. **The health board must ensure that all staff groups are reminded of the importance of good hand hygiene and appropriate glove use in accordance with health board policy.**

In the assessment areas, we observed medical devices not being wiped in between patient use. Staff we spoke with confirmed that this was not always done. **The health board must ensure that re-usable devices are cleaned in between patient use.**

Mandatory training completion rates for IPC within the ED need to be strengthened. Combined staffing group completion rate was 57.7% at the time of the inspection. **The Health Board must ensure that mandatory training is completed in a timely manner by all staff.**

Nutrition and hydration
Improvements are required to ensure that patient nutrition and hydration needs are fully met.

Within the ED and assessment areas, we found that access to water was generally provided, with water supplied in the waiting areas, accessible within arm's reach on bedside tables and from trolleys which were catered for by Red Cross volunteers.

However, in the ED, we found there to be a lack of emphasis on ensuring that nutritional needs are met. This is because:

- Patients who were in the department for excessive lengths of time were not offered food
- Sufficient food was not regularly delivered to the department
- Ambulance staff told us that they are usually only able to access water
- One patient told us that she was offered sugary snacks despite being diabetic and was not offered an alternative
- We were informed by staff that there is no budget for additional food within the department
- Recent health and care standards audit outcomes showed that care planning and record keeping in relation to fluid intake and patients with swallowing difficulties needs to be improved.

Due to the lengths of time in which patients may be in the department, **the health board must ensure that nutritional needs are fully assessed, documented, and food provision increased.**

Within the assessment areas, we found that the All Wales nutrition pathway was in use and that regular meals were provided to patients throughout the day. No patients were required as needing assistance to eat during the inspection, but staff assured us that staff would be available to assist if required. We noted that the Patient Status at a Glance (PSAG) board highlighted any patients who were nil by mouth, but special dietary requirements were not recorded. **The health board should ensure that dietary requirements, including allergies, are sufficiently visible to all staff.**

Medicines management
We found that there was a written medicines management policy in place and that staff were aware of how to access this if needed.

Overall, we found medicines security to be good in all areas that we inspected. However, in the SDMU we found the outer room door and drugs cupboards to be open and unlocked when not in use. **The Health Board must ensure that access to medicine rooms are secure at all times.**

We reviewed aspects of controlled drugs security and found that controlled drugs had been administered and logged correctly. We confirmed that controlled drugs were checked and logged daily and that audits of this are routinely completed by pharmacy colleagues. Fridge temperatures were checked and logged daily to ensure the integrity of medicines held inside.

We noted that there was no protected drug administration time or red tabard system in place for the administration of medicines in the assessment areas we reviewed. **The health board should consider if this is necessary to ensure a safe and calm administration of medicines.**

In the SDMU, we found that there were some gaps in the prescription of oxygen and target saturations on two of the drugs charts that we reviewed. In one record, there was also no nursing documentation in relation to oxygen requirements and saturations, despite being recorded on the NEWS chart. Additionally, we noted gaps in relation to the completion of fluid balance charts. **The health board must ensure that nursing entries and completion of charts in relation to medicines management are appropriately completed.**

Safeguarding children and safeguarding adults at risk

There were clear health board policies and procedures in place for staff to follow in the event of a safeguarding concern. All staff that we spoke to were aware the process for reporting any concerns and would feel comfortable to do so.

It was positive to see that there was a safeguarding lead within the department who takes a proactive role in providing informal training and awareness for staff, as well as reviewing specific cases. We noted that training on the completion of violence prevention referral and sexual exploitation risk documents was also provided, and staff were aware of the contents.

Within CEU, we observed that any children or young person in crisis would be provided with one to one nursing care. Staff described good working relations with children and adolescent mental health services (CAMHS) and were knowledgeable of issues pertaining to children's rights.

Completion rates of relevant mandatory training areas within the ED included:

- Safeguarding (children): 60.3%
- Safeguarding (adult): 70.9%
- Dementia awareness: 82.4%
- Violence against women, domestic abuse, and sexual violence: 51.9%

The health board must ensure that mandatory training is completed in a timely manner by all staff, particularly amongst medical staff where figures were notably lower in some topics.

In the RAU, we found that there were two patients who required an enhanced level of care, but no additional nursing support or Deprivation of Liberty (DoLS) process had been considered. Staff we spoke to in the RAU and wider assessment areas were aware of DoLS and safeguarding processes but felt that they would need support in completing formal documentation and would benefit from additional training.

The Health Board must ensure that staff in the assessment areas are confident in relevant safeguarding and DoLS processes to ensure that patient rights are upheld.

Medical devices, equipment and diagnostic systems

In all areas, we found medical devices and equipment to be in date and in working order. All devices we observed had a label to indicate when they had last been serviced and staff were clear regarding the reporting of faulty equipment.

Staff told us that they had sufficient equipment in support of patient care. However, RAU staff expressed the view that sit-down weighing scales would be beneficial for certain patient groups within their care.

Effective care

Safe and clinically effective care

We found that staff were knowledgeable of procedures in relation to the identification and management of suspected sepsis cases. Appropriate sepsis care documentation and NEWS scores were completed where appropriate and sepsis trollies were available in the ED and assessment areas. Staff in the SDMU told us that they aim to triage patients in a fifteen-minute timeframe which further helps to ensure early recognition of sepsis.

We considered OPAS to be a notable and effective pathway as an alternative admission route for certain older patients. The service provides an Advance Nurse Practitioner led service focused on the specific care and treatment needs of older adults, which aims to discharge patients in a timely manner without the need of admission to a ward. We noted that the service is currently only open during the

weekday and not evening or weekends. **The health board may wish to review the availability of this service as a further means of reducing admissions**.

Quality improvement, research and innovation
Despite the system wide pressures, we found that the Health Board and senior staff within the ED were keen to develop new initiatives in support of developing the service and in support of patient care.

We saw that there was continued contact and engagement with the Welsh Ambulance Service to tackle the challenges associated with patient flow. Efforts were made to also provide services through the Red Cross to support the patient experience.

Matrons within the ED encouraged staff to take on improvement projects. We observed a number of notable senior nurse-led initiatives and services within the department relating to safeguarding, bereavement, triage and frequent attendees. It was positive to see that staff have been given appropriate time to develop these services in a meaningful and patient focused manner.

Senior management also provided an overview of the Acute Medical Services Redesign programme and the various associated projects being developed in relation to improving the health board's emergency and acute medicine services. This is due to be implemented in November 2022 on the Morriston site.

Information governance and communications technology
We found suitable ICT systems in place to enable staff to complete their tasks in support of patient care.

The majority staff who completed a HIW questionnaire agreed they can access ICT systems they need to provide good care and support for patients

Record keeping
We found an acceptable standard of record keeping in the ED. However, some records contained fewer than expected entries despite patients having been present in the department for a sustained period. We confirmed that relevant observations had generally taken place, but **the health board must ensure that records are updated in a contemporaneous manner**.

We found an acceptable standard of record keeping in the assessment areas. There was clear accountability and evidence of how decisions related to patient care were made. All entries were dated, signed and legible.

However, we noted in the SDU and RAU that nursing entries into patient notes were only made once per day. To ensure that entries are comprehensive and contemporaneous, **the health board must consider the effectiveness of this practice.**

Record keeping in the CEU was observed to be maintained to a good standard.

Quality of Management and Leadership

Governance, Leadership and Accountability

We confirmed that there was an appropriate management structure within the ED and assessment areas that we inspected. Staff were clear on who their managers were and how to escalate any issues.

In the ED and CEU, all but two staff who responded to this question in the HIW questionnaire agreed that their immediate manager can be counted on to help with a difficult task at work. In the assessment areas, all but one staff member agreed.

There were a number of positive number of comments from staff in the ED in relation to their immediate line manager. These included:

> *"… the morale of the ED department has lifted since [names] have stepped in, the support they give the staff is outstanding and we all know they are there for us through thick and thin…"*
>
> *"I have seen great improvement is staff morale since … has taken post, They are hugely supportive and are always seen within the department… constantly asking the team for opinions on how we can improve the department and wellbeing of staff…"*
>
> *"Excellent support from [manager] over last few weeks, I feel like their presence has boosted the morale within the department, even during the difficult times that we've been experiencing…"*

In the ED and CEU, all staff agreed that they know who the senior managers are and all but three agreed that they are visible. In the assessment areas, just over half of staff agreed that senior managers are visible.

In the ED and CEU, only two thirds of staff agreed that communication between senior management is effective, and that staff feedback is acted upon. In the assessment areas, two thirds of staff agreed that communication is effective but only half felt that staff feedback is acted upon.

All areas undertook a breadth of audit activity and this was reported through an appropriate framework of local and directorate wide governance meetings. It was positive to note that the ED had committed to undertaking an audit in light HIW findings in other Health Boards. **Given some of the findings in this report, the Health Board should consider increasing oversight of aspects of auditable activity.**

Throughout the course of the inspection, management and staff made themselves available to the inspection team and were open and engaging.

Workforce

We found committed staff in all roles and areas working hard to provide patients with a positive experience and good levels of care despite extreme pressures.

Senior staff confirmed that there are medical and nursing vacancies across the areas that we inspected. However, we noted in ED that there were a number of new nursing staff who were going through the recruitment and appointment process. During the course of the inspection, we found that ED nurse staffing was generally at the required levels, but we noted a heavy reliance on agency nurses. We confirmed that the majority of the agency staff were known to and familiar with the department. There were shortfalls in staffing across other roles in the department, but efforts had been made to provide some cover where possible.

When asked whether there are enough staff to enable them to do their job properly, the majority of staff who responded to the HIW questionnaire disagreed. More than half of staff also disagreed that there is an adequate skill mix within the ED. Comments included:

> *"Review medical staffing rotas to ensure staff numbers meet patient demand…"*
>
> *"Currently relying heavily on agency workers to fill our safe staffing numbers. Department has taken on more staff recently; however, it will be some time before they are fully skilled…"*
>
> *"we are losing our experienced staff due to the growing high pressures of the department and also being able to get more money for less stress somewhere else."*
>
> *"We often have days where there seems to be a few newly qualified that are left to deal with situations beyond their control."*

Similarly, in the assessment areas that we inspected, we found shortfalls in staffing across all roles. We noted that efforts are made to provide sufficient cover, but this was not always achieved. Staff told us that this caused issues when patients required enhanced observation or levels of care.

In the CEU, we noted that the unit maintained staffing of two registered nurses, with at least one paediatric nurse on each shift. We were told that ED nurses would provide rotational cover and that a recruitment process is underway to provide the unit with sufficient paediatric nursing cover five days of the week.

Whilst we note the difficulties in recruiting paediatric nurses, this is an issue that was raised in our June 2021 quality check of the CEU. **The health board must review this in a robust and sustainable manner since the Unit is a 24/7 emergency service.**

Staff Feedback

During the course of the inspection, we distributed online questionnaire to obtain views and feedback from staff. We received 55 in total. These responses have been included within the relevant sections of this report and additional responses and comments are included below.

Responses and comments from staff working in the **Emergency Department**:

When asked whether the ED environment is appropriate in ensuring patients receive the care they require at their 'point of attendance', the majority of staff disagreed. Staff comments included:

> *"The environment is often not safe due to high volume of patients attending ED and shortage of beds in the hospital."*
>
> *"Overcrowding is a chronic problem within our department. Patients are often left sat in chairs for 50 hours+…"*
>
> *"No beds for sick patients, lack of flow through the hospital. Too many patients attend ED when they don't need to."*
>
> *"The department is physically big enough for the ED service but unable to run it as it hosts a ward instead."*

Two thirds of staff agreed they are satisfied with the quality of care they give to patients.

When asked whether their hospital encourages teamwork, the majority of staff agreed. However, only just over half of staff agreed that partnership working with other departments is effective.

When asked whether their job is detrimental to their health, half of the staff who answered stated that it is. However, the majority agreed their organisation takes positive action on health and wellbeing.

When asked whether they had seen errors, near misses or incidents that could have hurt staff or patients just over half of staff who answered stated they had. However, the majority agreed that the Health Board takes action to ensure that they do not happen again.

In relation to professional development, the majority of staff agreed they have had full training on all areas within the department. However, comments included:

> *"Despite being a major ED … nurses in the department typically only get to attend ALS courses once in our career and don't get to re-certify. I think that it should be a minimum standard that all ED nurses have a current ALS qualification."*
>
> *"There also aren't enough Paeds ILS courses to train everyone let alone recertify."*
>
> *"… most ED nurses are no longer exposed to minor injuries and former 'bread and butter' skills are lost to current generations of ED nurses."*
>
> *"Unsure if have received the full ED training such as the trauma course. Not been on ALS."*

We reviewed completion rate for Advance Life Support (ALS) trained staff in the ED and found low completion rates. Whilst efforts had been made to ensure that Band 6 nursing staff had completed this course, **the health board must ensure enough staff within ED are ALS trained to provide sufficient coverage.**

We asked if there was any other training staff would find useful. Staff told us:

> *"NIV training"*
>
> *"More management-based training but, due to staffing levels, unable to take time for it."*
>
> *"ALS, trauma, minor injuries (more in depth), experience [in] the minor injury unit"*
>
> *"Training involving anaesthetics."*
>
> *"Psychotherapy training…"*

When asked whether training, learning and development helped them to do their job more effectively the majority of staff agreed.

Responses and comments from staff working in the **assessment areas**:

All staff agreed that patients and their relatives are involved in decisions about their care and that sufficient information is provided to patients.

When asked whether they are satisfied with the quality of care they give to patients two thirds of staff who answered agreed.

When asked whether their hospital encourages teamwork two thirds of staff agreed. However, only a little over half agreed that partnership working with other departments is effective.

When asked whether their job is detrimental to their health a little under half of staff who answered stated that their job is. However, a little over half of staff agreed their organisation takes positive action on health and wellbeing.

When asked whether they had seen errors, near misses or incidents that could have hurt staff or patients, a little under half of staff said they had. However, the majority agreed that the Health Board takes action to ensure that they do not happen again.

When asked whether they felt they had appropriate training to undertake their role over third thirds of staff agreed. Comments on further training needs included:

> *"Palliative / end of life"*
>
> *"CVC lines as we have a lot of patients with these."*
>
> *"Pressure ulcer training as a lot can be graded wrong"*
>
> *"ABG machines and training on taking group and save samples"*
>
> *"Catheterisation"*
>
> *"Regular updates for the MDT on current referral routes and processes would be beneficial to ensure timely and safe discharge planning"*

The majority of staff who answered agreed their training, learning and development helped them do their job more effectively.

Due to the number and breadth of comments received, it has not been possible to include all comments within this report. **The health board is encouraged to ensure that staff have appropriate and on-going channels of communication in which to provide feedback.**

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 summaries 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
No concerns were resolved during the inspection			

Appendix B – Immediate improvement plan

Service: Emergency Department, Morriston Hospital

Date of inspection: 5-7 September 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
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 triage, review, and intervention. This extends to ambulatory patients and those arriving via ambulance. HIW was not assured that all aspects of care were being delivered in a timely and effective manner within the ED.	Standard 3.1 / 4.1 / 5.1	• Ensure Staff on ED Reception understand and comply with the priority patient flow process (Red Dot process) Seek immediate assurance through an audit process that this is being utilised appropriately and is then undertaken as part of the routine audit programme of the department. • Development and implementation of internal professional standards with clear roles and responsibilities for staff with regards to time sensitive presentations which includes: alerting staff to patients at risk; time to triage and associated triage activities and documentation; escalation actions for patients exceeding prescribed	**ED Matron** **Emergency Department CD**	**16/09/22** **24.09.22** **07/10/22**

We reviewed a sample of patient records and highlighted serious issues, which require immediate action by the health board to prevent harm to patients. Examples included: • We observed delays beyond national guidelines in both triage and medical review of patients presenting with chest pains and associated myocardial infarction symptoms. In one record we reviewed, the length of wait between arrival and triage was two hours • We found that another patient had been lying on a spinal board for a significant period beyond national guidelines and that there was a delay in providing appropriate interventions, including an MRI, despite a		standards within each of the triage categories post medical assessment. • Undertake a walkthrough of environment to increase capacity to allow for timely triage assessment. • Finalise and implement alternative pathways for expected patients to avoid attendance at the ED. • Ring-fence the current allocated REACT spaces. • Review COVID pathways within the ED with the possibility of utilising areas differently to provide additional capacity for REACT • Review chest pain pathway within the emergency department to identify any potential shortfalls. Recommendations for any required changes to be implemented by the end of October 2022.	**Deputy Head of Nursing** **ASGD Specialised Surgical Service Group.** **Service group director** **Emergency Department CD** **ED Consultant/ Deputy Head of Nursing**	**16.09.22** **30.09.22** **14.09.22** **26.09.22**

neurological deficit being recorded • We found that an older frail patient had been lying on an unsuitable surface (ambulance trolley) for over 11 hours and had complained of being in pain during this time. As discussed at the feedback session, HIW recognises the extreme system pressures that Emergency Department staff are experiencing currently.	• Liaise with WAST to introduce repose mattresses for patients who are unable to be offloaded from WAST trolley. • Review the practice of Intentional rounding within the ED/SDMU to provide assurance of timely delivery against agreed clinical standards. • Review of operational standards for diagnostic access within the ED/Assessment areas. Implement any identified shortfalls by end of October 2022. • Accelerate the further development of admission avoidance and length of stay reduction plans to support the reduction in exit block from the ED aligned to the AMSR programme. Implementation of identified admission and length of stay plans associated with AMSR will be delivered during quarter 3 2022. Areas of focus detailed below: Admission avoidance include: ○ WAST stack review ○ Virtual wards – in reach ○ OPAS ○ Expansion of Hot clinics	**Executive Nurse Director** **Deputy Head of Nursing.** **Radiology CD** **Service group director, Morriston** **Service Group Director, Morriston** **Clinical Lead SDEC; AMD**	**29.09.22** **30.09.22** **30.09.22** **30.09.22** **21.9.22**

		○ Home visiting service ○ NHS Elect – extension ambulatory sensitive conditions Length of Stay reduction at Morriston: ○ On-going review of clinically optimised process with reinforced senior review of patients within the downstream wards and healthboard wide escalation; ○ SAFER bundle: on-going work with Improvement Cymru regarding board rounds and real-time data; ○ Roll out of digital solutions to support effective flow management – Safety dashboard; Signal 3; ○ Review of SDMU and associated capacity to support effective flow for surgical emergency admissions; ○ Repatriation policy review with DSU for non-MTC patients; ○ Realignment of bed capacity to meet specialty demand and update of site management	**Interim Director of Nursing, Morriston** **Interim Director of Nursing, Morriston** **Deputy Service Group Director, Morriston** **ASGD-ISSG**	**End Quarter 3 2022 against AMSR plan**

		policies to support effective flow management • LOS reduction plan across the healthboard to support effective flow through the system. This includes: ○ Community team In-reach to support admission avoidance at the front door. ○ Commissioning additional transition beds to support patients who are waiting for ongoing PoC. ○ Extension of virtual wards and home first capacity. ○ Commissioning review of community demand and capacity to align resources across the healthboard to meet demand. ○ Expansion of rapid response services to support admission avoidance and SDEC. ○ Establishment of senior weekly stranded review meetings to unblock challenges to discharge. ○ Expansion of ESD services for stroke, frailty and orthopaedics to support patients rehabilitation at home rather than in-hospita	**Service Group Director Morriston** **Service Group Triumverates**

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: **K Hannam**

Name (print):

Job role: **Interim Service Group Director, Morriston Hospital**

Date: **14 September 2022**

Appendix C - Improvement plan

Service: Emergency Department and Assessment Areas (per page 5), Morriston Hospital

Date of inspection: 5-7 September 2022

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

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
1.In the ED and SDMU, the Health Board must review the use and availability of suitable seating within the department for patients who are admitted overnight and must ensure sufficient availability of pillows and blankets.		Bid for national funding to support improvement in ED Waiting areas have been submitted	Directorate Manager – ED	COMPLETED – Funding has been confirmed and includes monies to refurbish Staff Areas
		Additional stock of pillows ordered (60 per wk.) and will be available in ED Linen Rm.	Morriston Quality & Safety Matron	COMPLETED
		Information to be displayed on ED and SDMU Linen Rms. to remind staff that additional blankets are available in Central Linen Rm. 24/7	Morriston Quality & Safety Matron	COMPLETED
		Pillows to be made clearly identifiable as an “ED pillow” so	Interim Matron – ED	31/01/2022 - solution needs to be IPC

		that they can be collected and repatriated to ED		compliant, in discussion with suppliers
		Meeting with WAST (locality managers) including discussion on the supply and return of linen to/from WAST crews whilst on site.	Deputy Head of Nursing – ED	COMPLETED – a 1for1 policy has been agreed and implemented
		Review opportunities for increasing the number of more comfortable seating in the SDMU waiting room.	Interim Head of Nursing – ISSG/ Matron ISSG	COMPLETED Additional two recliner chairs secured
2.In the ED, the Health Board must ensure that the placement of patients within the department is reviewed to promote privacy and dignity.		Twice daily ED Safety Huddle to be updated to include risk assessment of privacy & dignity factors in addition to clinical considerations.	Deputy Head of Nursing - ED	COMPLETED
3.In the ED, the Health Board should ensure that staff are aware of official translation services that are available to ensure an appropriate flow of information between the patient and healthcare professional.		Revised SOP for ED Reception Staff to support identification of high risk patients to include requirement for translation service	Directorate Manager – ED	COMPLETED
		Review the REACT process to ensure that communication/	Deputy Head of Nursing - ED	

		language for those patients arriving by ambulance is assessed and where required there is a clear process to procure translation support		COMPLETED –part of risk assessment process
4.In the ED, the Health Board must ensure that sufficient information on how to provide feedback or complaints is visible in key locations around the department.		Review of public notice boards to inform visitors to the ED on how to make a complaint and provide feedback and ensure that appropriate public information is available – Display "QR Code" posters in ED to enable patients to provide electronic feedback via mobile phone devises Undertake a deep-dive (desk-top) review of patient experience feedback to ED, to focus in on key causative and contributory factors which are influencing both positive and negative experience *(The ED has received approx. 2800 electronic surveys into the*	Morriston Quality & Safety Matron / Morriston PALS Team Directorate Manager – ED Morriston Quality & Safety Matron / Morriston PALS Team	COMPLETED – monthly routine PALS check re-established COMPLETED By 31/12/2022 – to be shared at Jan 2023, Divisional Meetings and Morriston Q&S meeting and Feb 2023 HB Patient & Stakeholder Experience Group

		Health Board's Civica system since January 2022)		
5.In all areas, notably the SDMU, the Health Board must ensure the areas described are free from clutter to reduce the risk of trip hazards.		Feedback and Lessons Learnt from HIW visit to ED and Assessment Areas provided to all Divisional Heads of Nursing	Divisional Heads of Nursing	COMPLETED
		Draft HIW Report: ED and Assessment Areas shared at Health Board's Quality & Safety Group	HB Head of Quality & Safety	COMPLETED – agenda item 15/11/2022
		HIW Report: ED and Assessment Areas shared at Health Nursing and Midwifery Board	Corporate Head of Nursing (Health Board)	Next Available Meeting (Dec 2022)
		Review of environment/security risks form part of monthly Matron Audit process.		
		Monthly Matron Audit of SDMU/RAU to specifically focus on environment/security risks as part of the November 2022 review	Head of Nursing – Medicine/Head of Nursing ISSG	COMPLETED
		Spot-check announced walk-around on SDMU	Matron - ISSG	COMPLETED – 10/11/2022

		Risk Awareness Training Session to support Matrons in the identification of risk	Deputy Head of Legal & Risk Services	COMPLETED (Morriston Matrons Meeting – Oct2022)
		Implementation of Director Led "15 Step" Process at Morriston	Interim Nurse Director – Morriston	Implementation Delayed – revised date by 01/12/2022
		Weekly multi-disciplinary site corridor walkaround involving site team, estates, domestics and portering	Deputy Head of Nursing – Hospital Operations	COMPLETED – weekly on a Friday, immediate actions taken
		Development of clear labelling and storage for equipment which has been condemned to be removed from corridors	Deputy Head of Nursing – Hospital Operations /Head of Portering	31/12/2022 – SOP under development pending sign-off from all parties involved
		Routine "Equipment Amnesty" – twice annually	Interim Nurse Director – Morriston	By 31/03/2023 (last event 31/08/ & 01/09/2022)
6.In the RAU and SDMU, the Health Board must ensure that utility room		During safety huddles and nurse meetings awareness has been	Matron- ISSG Matron- Medicine	COMPLETED

doors are locked when not in use to prevent unauthorised access.		raised around security and utility rooms being locked. Signage used on doors to remind staff about the requirement to lock the doors.		
7.In the Assessment areas, notably RAU, the Health Board must consider ward security given the patient groups being cared for in these areas.		**Please see actions and updates provided in Points 5&6 above** **The following is available to ALL location on the Morriston Hospital Site** Health Board on-site Security available 24/7 at Morriston Hospital Dedicated on-site presence of South Wales Police	Health Board Deputy Head of Support Services Hospital Operations Directorate Manager-Morriston	COMPLETED – security staff appropriately trained to detain individuals pending police arrive. Body cameras worn. COMPLETED (dedicated Officer on-site currently located with the Hospital Security Team)

8.In all areas, the Health Board must ensure that maintenance issues are given appropriate priority and should reflect on the staff comments provided in this section of the report.		Routine Emergency Department walk-around with Estates to highlight areas of work required. Escalation of environmental /infrastructure risks at Morriston Hospital via monthly Risk Escalation Process, for November 2022 *It is acknowledged that staff in their feedback have highlighted their frustration at delay and lack of response from Estates* Snr ED Staff to actively update staff on Estates issues at routine monthly Team Meetings	Deputy Head of Nursing – ED Group Head of Quality, Safety & Patient Experience Deputy Head of Nursing – ED/ Interim Matron- ED	COMPLETED – see Point 5 above for site wide actions COMPLETED Snag List in place COMPLETED Updates as part of Relaunched Staff Meeting Structure (see Point 25 Below)
9.In all areas, the Health Board must ensure that all staff groups are reminded of the importance of good hand hygiene and appropriate glove use in accordance with health board policy.		Regular and routine monitoring of Hand Hygiene is in place and forms a part of all routine IPC monitoring at Morriston SG	Group Interim Nurse Director	COMPLETED

		Morriston IPC 8wk Ward Improvement Plan – focusing on improvement in infection prevention awareness & training	Group Interim Nurse Director	COMPLETED (Aug-Sep 2022)
		Confirm SDMU Hand Hygiene Training Compliance	Matron - ISSG	COMPLETED 100% HH Trained 100% HH Audit (as at Oct22)
		Use of gloves to be built, into the Annual Mandatory Training Study Days within ED – including Medical Staff	Mandatory Training Lead – ED	Nursing COMPLETED Medical Staff to be included in Mandatory Training Study Days from January 2023 COMPLETED
		Daily observation	Nurse in Charge - ED	COMPLETED – feedback to ED staff at daily huddles and adhoc feedback to visiting team members in situ
		Feedback on outcome of report to Health Board Infection Prevention & Control Team to consider the inclusion of "Glove	Group Head of Quality, Safety & Patient Experience	COMPLETED Copy of Final Report provided to Health

		Usage" within standard Hand Hygiene Training package		Board Head of Nursing for IPC
10.In all areas, the Health Board must ensure that re-usable devices are cleaned in between patient use.		ALL staff to be reminded of the importance of decontamination of equipment between patients and how to escalate queries or concerns – at next available staff meeting	Divisional Heads of Nursing	COMPLETED
		Daily observation	Nurse in Charge - ED	COMPLETED – feedback to ED staff at daily huddles and adhoc feedback to visiting team members in situ
		Ensure routine and regular IPC audits established and includes review of re-usable devises	Divisional Heads of Nursing	COMPLETED
		Refresh advice on how to ensure that re-useable devises should be cleaned is available and accessible to all staff	Divisional Heads of Nursing	COMPLETED
		Specialist support from the Health Board's Decontamination	Deputy Head of Nursing – ED	By 30/11/2022

		Lead to be requested to review and assess ED equipment. *Decontamination has been identified as a quality priority as part of an over-arching Infection Prevention Goal* Group representation on the Health Board's Decontamination Quality Priority Sub Group (Quarterly) Routine monitoring and reporting of decontamination successes, priorities, opportunities and risks including in Group Quality & Safety Annual Work Programme (quarterly review)	Group Head of Quality, Safety & Patient Experience Group Head of Quality, Safety & Patient Experience	COMPLETED (Group Head of Quality, Safety & Patient Experience) COMPLETED Quarterly reporting in place
11.In the ED, the Health Board must ensure that IPC mandatory training is completed in a timely manner by all staff.		**Please see actions and update under Point 9 Above** Staff in ED provided with dedicated time to complete and maintain ESR based training	Deputy Head of Nursing – ED / Medical Training Lead ED	30/03/2023

		Due to data transfer issues within ESR systems Medical staff on rotational training, who have completed mandatory training in other organisations are NOT being pulled through to their new post Nurse Staff mandatory training compliance monitored at monthly ECHO Board	Deputy Head of Nursing – ED / Medical Training Lead ED	Compliance reported through ESR (Nov 2022) 68% for Nursing and 35% for Medical (against standard 85%) In Place
12.In the ED, the Health Board must ensure that nutritional needs are fully assessed, documented, and food provision increased.		**CURRENT POSITION** *Patients receive breakfast (cold), lunch (hot) and Dinner (cold). Overnight hot drinks and sandwiches are available.* *Bottles of water bottles with disposable cup are available and are periodically offered 24/7* *In addition, there are vending machines available to purchase food*		Current position reflects environmental constraints of an ED – no tables to enable patients to eat and wider food standards requirements to maintain patient safety

		Development of dedicated "hostess" service to support ED	Interim Matron -ED	30/11/2022 VACANCY APPLICATION PENDING APPROVAL (2xwte Staff Members)
		Additional "hot" food option to be added to evening offering	Interim Matron -ED	From 22/11/2022
		Seek agreement from catering services to support exceptional dietary requirements for patients whilst in ED	Interim Matron -ED	COMPLETED – includes cultural and religious requirements
		Review of current Health Board Policy on Nutrition and Hydration to be undertaken to establish whether there is a current baseline for provision of food within the ED	Group Head of Quality, Safety & Patient Experience	COMPLETED (no explicit guidance on expected standards of nutrition & hydration for patients waiting in the ED)
		Benchmark ED against available "best practise" for providing nutrition and hydration in an emergency/assessment area	Interim Matron -ED Head of Nursing –ED / Group Nominated Lead	COMPLETED (no generic standard identified) By 31/01/2023

		Develop a set of formal standards applicable to an emergency/assessment area – for consideration Health Board wide	for Nutrition & Hydration / Deputy Head of Nursing- ED	
13.In the Assessment areas, the Health Board should ensure that dietary requirements, including allergies, are sufficiently visible to all staff.		***RAU*** *currently does not have a dedicated hostess to support the ward, therefore ward staff provide support in serving patients food* *Please note that the new Acute Medical Unit at Morriston Hospital will have dedicated catering services, supported by catering staff (due to open December 2022)* ***SDMU*** *has confirmed that that they have a hostess covering the Unit – however this resource is Mon-Fri daytime.* *All Band7's, Band6's and hostess have been trained in allergen awareness (Mar21 & Apr22)* Confirm allergen awareness information is available on the	Surgical Matron - SDMU	COMPLETED Confirmed via walk-around 10/11/2022

		ward and easily accessible to staff		
14.In the SDMU, the Health Board must ensure that access to medicine rooms are secure at all times.		**Please see actions in Point 5 Above** Unannounced Observational Visit to SDMU	Matron - ISSG	COMPLETED Confirmed door locked via walk-around 10/11/2022
15.In the Assessment areas, the Health Board should consider if protected administration time or a red tabard system is necessary to ensure a safe and calm administration of medicines.		Heads of Nursing to Consider the practicalities of this approach to the management of medicines in an assessment area – including both emergency and short-stay patients	Head of Nursing ISSG / Matron ISSG	COMPLETED Due to the nature of SDMU including Short Stay – it is inherent that patients will require medicines (particularly pain management) at different times during the day due to varying admission times and planned procedure times. A structured timetable for medicine administration (such as in a longer stay ward environment) will carry a risk of poor patient pain management and

				delayed discharge – extending the LOS on the Unit
16.In the SDMU, the Health Board must ensure that nursing entries and completion of charts in relation to medicines management are appropriately completed.		Snr Nursing Review of Medication process in SDMU *The Health Board are in the process of implementing an electronic prescribing and medicines administration system - HEPMA* The HEPMA system is currently being implemented in Medical Specialities but will move into Surgical Specialities in line with the overall project plan	Head of Nursing – ISSG / Matron ISSG Health Board HEPMA Project Lead	COMPLETED Due to the varied times of admissions (including for patients with planned procedures) onto the assessment unit, medication charts are written up for the day at the time of admission - therefore it is possible to have empty boxes on the chart depending on where the patient is on their pathway Planned Project Completion 31/03/2023
17.In the ED, the Health Board must ensure that adult and child safeguarding mandatory training is completed in a timely manner by all		*Due to data transfer issues within ESR systems Medical staff on rotational training, who have*		Current ESR Compliance for Medical Staff

staff, particularly amongst medical staff where figures were notably lower.		*completed mandatory training in other organisations are NOT being pulled through to their new post.* Review and assure the current process for maintaining accurate records of medical staff training in order to: • Establish a current baseline against 85% baseline • Develop a robust process for maintaining training records on long-term basis	Clinical Lead - ED	**Adult = 43%** **Child - 47%** By 28/02/2023
18.In the Assessment areas, the Health Board must ensure that staff in the are confident in relevant safeguarding and DoLS processes to ensure that patient rights are upheld.		Ensure that mandatory training compliance for both Safeguarding (adult & child), DOLs and Dementia Awareness are at an appropriate level and regularly monitored and reviewed against the local target of 85% *Please note that SDMU would not routinely support children who would be managed via the Paediatric Assessment Unit.*	Head of Nursing ISSG	COMPLETED Current compliance with safeguarding training: • SDMU =94% (Adult) • SDMU = 93% (Child)

		Current compliance with DOLs training in SDMU is 39%. Action will be taken to ensure that compliance with DoLS training achieves the local target of 85% and is monitored thereafter.	Head of Nursing ISSG	28/02/2023
19.The Health Board may wish to review the availability of the Older Persons Assessment Service (OPAS) service as a further means of reducing admissions.		Recommendation acknowledged As part of the Acute Medical Service Redesign, OPAS will form part of the Same Day emergency Care (SDEC) services. Which we have recently increased our ANP workforce for OPAS to cover longer periods of time. Swansea Bay UHB is working with NHS Elect to support the development of SDEC services.	Group Service Director	COMPLETED

20.In the ED, the Health Board must ensure that records are updated in a contemporaneous manner.		Staff are to be reminded as part of the importance of updating patient health information contemporaneously when they have been in the ED for an extended period of time Outcomes from monthly FOC Audit process – related to documentation completion and quality to be reviewed monthly as part of ED Performance KPI's	Deputy Head of Nursing – ED / Interim Matron - ED Interim Matron - ED	COMPLETED – part of twice daily huddle COMPLETED
21.In the Assessment Areas, the Health Board must consider overall effectiveness of making entries into patient notes only once per day.		Snr Nursing Review of Nursing Entry process in SDMU – small scale spot-check audit Roll-out of the Welsh Electronic Nursing Record Follow-up audit of SDMU record keeping – in line with WENR requirements	Head of Nursing – ISSG / Matron ISSG HB WERC Project Lead/ Head of Nursing - ISSG Head of Nursing – ISSG / Matron ISSG	COMPLETED 2xPatient Records reviewed Evidence of contemporaneous notes throughout day COMPLETED – SDMU roll-out complete By 31/12/2022

22.In the CEU, the Health Board must review paediatric nurse staffing levels in a robust and sustainable manner since the Unit is a 24/7 emergency service.		ED Nursing Workforce Plan (including CEU) to be developed The plan includes: 7.0wte registered paediatric nurse (recruited via streamlining)	Head of Nursing – ED Interim Matron - ED	20/12/2022 – for discussion at next Divisional Performance Review RECRUITMENT COMPLETED All nurses to be in post by 28/02/2023 having also fully completed local induction and training Any staff pending their "pin" registration are working in an ETA role within ED
23.In the ED, the Health Board must ensure that enough staff within ED are ALS trained to ensure that there is sufficient coverage.		*The Resuscitation Council UK advocates a 2day face-to-face training programme for ALS with recertification after 4yrs.* *Registered Nurses with +18mths working experience are eligible for this training.*		

		Ensure the **current ALS compliance for Nursing Staff is meeting the criteria for training** Ensure that there is a robust monitoring system in place to maintain the required levels of skill training within the ED *Due to data transfer issues within ESR systems Medical staff on rotational training, who have completed mandatory training in other organisations are NOT being pulled through to their new post.* Ensure local training records for ALS are maintained via	ED Training Co-ordinator / Interim Matron – ED Deputy Head of Nursing – ED / Clinical Lead – ED Clinical Lead - ED	**<u>30/04/2023</u>** Current training compliance for nursing staff = 43% with a further 7% booked in November 2022 training. Please note that the RC UK have not issued training dates for December 2022 onwards at the time of submitting this action plan (November 2022). As soon as the dates are released training will be allocated to staff as appropriate. 30/02/2023

		discussion with rotational medical workforce until ESR system supports the electronic transfer of more robust data on training.		
24.Given some of the findings in this report, the Health Board should consider increasing oversight of relevant audit activity.		Existing Health Board Quality Assurance Framework for unannounced visits, to be revised for use in ED settings	Health Board Head of Quality & Safety	By 31/12/2022 Document due for full sign at Health Board's Patient Safety Group - December 2022
		Monthly monitoring of outcomes from internal Health Board via Health Patient Safety & Compliance Group	Health Board Head of Quality & Safety	COMPLETED Monitoring requirement in Service Group standard reporting template – see update below on development of Template
		Formal update to Health Board's Patient Safety Group on all Assurance Reporting (internal & external)	Health Board Head of Quality & Safety	COMPLETED CONSULTATION CLOSED 17/10/2022

		Health Board Quality Strategy to be developed	Health Board Head of Quality & Safety	To be launched January 2023 COMPLETED
		Review within Morriston Service Group to ensure that there are clear lines of accountability to the Health Board's revised Quality & Safety structure (implemented June 2022)	Group Head of Quality, Safety & Patient Experience	IN WORKING DRAFT FORMAT
		Development of standardised reporting in support of Health Board's Patient Safety & Compliance Group to be established.	Group Head of Quality, Safety & Patient Experience	Pending final sign-off – December 2022 in line with Health Board timescales IN WORKING DRAFT FORMAT
		Development of standardised reporting in support of Health Board's Clinical Outcomes & Effectiveness Group to be established.	Group Head of Quality, Safety & Patient Experience	Pending final sign-off – December 2022 in line with Health Board timescales
25.The Health Board is encouraged to ensure that staff have appropriate and		The following is currently in place and available to staff within the ED	Interim Matron – ED / Matron ISSG	COMPLETED

on-going channels of communication in which to provide feedback.		**OPEN DOOR POLICY** • Snr Nurse involved in every handover • Interim Matron "open invitation" **MENTORSHIP** • "Buddy" Scheme in place in ALL Clinical Areas for new staff or where requested **DEBRIEF** • 30+ Well-Being Champions trained within the ED (across different roles and different grades) • 7 TRiM trained practitioners within ED (across different roles and different grades) **STAFF MEETINGS** • Monthly over-arching Department meeting • Twice mthly Band 7 meetings • Band 6 mthly meeting launched • Band 5 mthly meeting launched • EDA mthly meeting launched		ED meetings structure review and relaunched SDMU meeting structure reviewed

		• Regular BAME meeting launched **NEWSLETTER** • Monthly Departmental Newsletter **WELL-BEING** ED Food Bank – "Mother Hubbard's Cupboard" - to support staff who may be struggling launched The following is currently in place and available to staff within the SDMU **OPEN DOOR POLICY** • Snr Nurse involved in every handover • Interim Matron "open invitation" **UNIT MEETING** • Undertaken using TEAMS to maximise participation **"WHATSAPP"** • Team chat always someone available		

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): Ceri Matthews

Job role: Interim Nurse Director, Morriston Service Group

Date: 17/11/2022