Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Department, Wrexham Maelor Hospital

Inspection date: 08, 09 and 10 August 2022

Publication date: 03 February 2023

This summary document provides an overview of the outcome of the inspection

Digital ISBN 978-1-80535-392-8

Patients were generally happy with the care provided and the way in which staff interacted with them. However, patients were critical of waiting times.

We found that the majority of patients were being appropriately assess on arrival in the ED and that there were generally effective measures in place for assessing, monitoring, observing and escalating unwell or deteriorating patients. However, we noted some occasions when patients should have been escalated in a more timely way.

Some patients were waiting a long time for triage and to be seen by doctors at times. This presented a risk of further deterioration, as time critical conditions were not being identified in a timely way.

We found friendly and professional staff throughout the department who demonstrated a commitment to providing high quality care to patients.

There was good management and leadership within the department.

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 Wrexham Maelor Hospital, Betsi Cadwaladr University Health Board on 08, 09 and 10 August 2022.

Our team, for the inspection comprised of two 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 care provided and the way that staff interacted with them. However, patients were critical of waiting times and during the morning of 09 August 2022, we found that some patients had been waiting to be seen by a doctor for over 16 hours. This was down to the high volume of patients attending the department and only two doctors on duty over night. However, waiting times rapidly reduced to 5 hours 40 minutes during the course of the morning as more doctors came on duty.

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

What we found this service did well

- Generally positive patient comments
- Positive staff engagement
- General maintenance
- Provision of food and drink
- Red Cross volunteers providing support to patients with food and drink.

Where the service could improve

- Continue to explore strategies to reduce waiting times and patient flow through the hospital
- Move forward with the development plans to increase the footprint of the emergency department
- Ensure that all entrances into the hospital are kept clear of cigarette buts
- Provide up to date informing on waiting times
- Provide Information on how to raise a concern
- Improve the time patients waited for triage
- Ensure that national guidelines for conditions are followed at all times
- Ensure that all children presenting with acute illness receive a Paediatric Early Warning Signs (PEWS) score and that this is acted on appropriately

- Ensure observations are undertaken at a frequency which will pick up any deterioration in a timely way.

Patients told us:

"Not informed re: waiting times. Told would be taken off list if I went home."
"Advised to complain by a nurse as place lost from queue then another 3 hour wait."
"Due to waiting time more staff."
"More doctors and better communication between staff. Lack of information nobody told us it would be such a long wait - 17 hours."
"Get more staff to reduce waiting time."

Delivery of Safe and Effective Care

Overall Summary

We found the main areas within the ED to be clean and tidy and that high throughput areas and touchpoints, including toilets and door handles, were being cleaned regularly and to a good standard. We also found that infection prevention and control measures were robust throughout the department.

We found that health and safety risks were appropriately managed within the department.

There was a consistent approach to the completion of pressure damage risk and falls risk assessments.

What we found this service did well

- Overview and observation of patients in waiting room
- Communication and escalation through regular safety meetings and huddles
- Infection prevention and control
- Concerted efforts to manage flow and improve ambulance offload times
- Staff training

- Staff rest area
- Medication management.

Where the service could improve

- Triage times and timing of important interventions such as ECG
- Frequency and quality of observations and early warning scoring
- Escalation of patients presenting with symptoms of sepsis
- Adherence to national guidelines
- Nursing documentation
- Brief Resolved Unexplained Event protocol
- Paediatric Nurse recruitment
- Ensure that there a paediatric trained nurse is present within the paediatric area at all times
- Blood gas reagent fridge temperature
- Recording of resuscitation trolley checks
- Ensure that the computer screen in paediatric is not overlooked by patients/relatives
- Staff breaks
- CCTV coverage outside the department.

Quality of Management and Leadership

Overall Summary

We found good management and leadership within the department.

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

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

Senior ED managers were visible within the department and often worked within a clinical role in support of staff.

What we found this service did well

- Policies procedures
- Auditing and reporting
- ‘Make it Safe’ reviews
- Focus during safety meetings on what the ED needs to make safe.

Where the service could improve

- Continue efforts to recruit of staff.

Staff told us:

“Not enough space to give safe patient care.”

“Limited space and staff.”

“Busy department with lack of space.”

“More doctors to be able to see patients quicker.”

“The hospital management do not truly understand the challenges faced by our ED.”

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.