Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Dignity and Essential Care Inspection (unannounced)

Aneurin Bevan University Health Board: Nevill Hall, Accident and Emergency Department

3 and 4 December 2014

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care Inspection at the Accident and Emergency (A&E) department Nevill Hall Hospital, part of Aneurin Bevan University Health Board on the 3 and 4 December 2014.

Our inspection considers the following issues:

- Quality of the patient experience
- Delivery of the fundamentals of care
- Quality of staffing, management and leadership
- Delivery of a safe and effective service

2. Methodology

HIW's dignity and essential care inspections review the way patients' dignity is maintained within a hospital ward/unit/department and the fundamental, basic nursing care that patients receive.

We review documentation and information from a number of sources including:

- Information held by HIW
- Conversations with patients, relatives and interviews with staff
- Discussions with senior management within the health board
- Examination of a sample of patient medical records
- Completed HIW questionnaires
- Scrutiny of policies and procedures which underpin patient care
- General observation of the environment of care and care practice

These inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues about the quality and safety of essential care and dignity.

3. Context

Aneurin Bevan University Health Board was established on the 1 October 2009 and covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

Nevill Hall district general hospital was opened in 1969 and provides inpatient, day case and outpatient services together with a complete range of investigations. Nevill Hall is situated on the western outskirts of Abergavenny on the A40 Brecon road and serves a geographical population covering Torfaen, Monmouthshire, Blaenau Gwent and Powys. The hospital is a designated major trauma centre with an Accident and Emergency (A&E) department. Approximately 50,000 new patients attend A&E annually.

At the time of our inspection the A&E department was separated into four main areas where patients were treated:

- Majors area (eight beds) – where staff treated patients requiring the most urgent medical attention.
- Minors area (six beds) – where staff treated patients with minor injuries. There were two additional 'see and treat' cubicles in this area.
- Clinical Decision Unit (CDU) (eight beds) – where staff assessed and treated patients, making decisions about their ongoing care and treatment. This area catered for patients with surgical, medical, and/or psychosocial needs. Patients within this area tended to stay in the department the longest, between 24-48 hours.
- Resuscitation rooms (two) – there were two fully equipped resuscitation bays in the department where patients were admitted, often by ambulance, for resuscitation.

In addition there were two other distinct patient areas within the department:

- Reception and waiting room – where patients referred themselves to the department and waited for triage and treatment
- Corridors – these areas were used as holdings areas for patients to wait on A&E trolleys, (mainly for patients who were admitted to the department from ambulances). The corridor area had a staff team who triaged patients according to their needs.

4. Summary

Overall patients told us they were very satisfied with the quality of care they had received and in particular with the staff who treated them. We saw staff being polite and courteous to patients and treating them with respect, without exception. The waiting area environment and facilities could be improved in order to enhance the quality of the patient experience.

We saw a staff team committed to delivering the fundamentals of care to a high standard. Staff were significantly challenged in doing so by both the physical environment and demand on the service and we found some occasions when this had impacted on patient care. The most challenging area for staff to deliver a high standard of care was in the corridors.

We saw staff communicating with patients admitted onto the department in a kind and patient way, explaining their treatment to them. However there was a lack of communication and information available to patients in the waiting area both before and after triage.

We saw staff treating all patients with respect and kindness. However, staff were unable to protect the privacy of patients in corridors. This meant that these patients' rights to privacy and dignity were seriously compromised. The corridors were an unacceptable environment for treatment and care intervention.

We saw staff encouraging patients' independence as far as possible. The physical environment was not conducive to promoting patients' independence.

Many patients presented at the department with relatives/carers and we saw staff encouraged the presence of these individuals. The limited space available in the corridors meant there were challenges in accommodating these patients' loved ones.

Apart from those patients on trolleys in corridors we found all other areas were being run with consideration to try to allow patients to rest as much as possible within a busy A&E environment. Staff and patients told us there were times the department ran out of linen and pillows which impacted on patient comfort.

Most patients told us they received pain relief quickly. We found one case where this had not happened and therefore could not be assured this happened consistently. Patients' pain scores were recorded but we found they were not always re-evaluated and recorded on an ongoing basis to ensure appropriate pain management over time.

We saw staff supporting patients with their personal care needs where they could. The installation of further washing facilities were planned to assist patients to maintain their personal care routines.

We saw that patients were able to access hot meals and snacks. We found there were not always sufficient staff assisting at meal times due to the overall workload and other treatment priorities at the time in the department. Food and fluid charts for those patients at risk were not consistently updated. There were appropriate and sufficient oral health supplies available on the department. Oral health assessments should be carried out for those patients staying longer on the department.

In general we saw staff assisting patients with their toilet needs in a timely way. Systems were in place to assess patients' risk of developing pressure sores and to access equipment such as pressure relieving mattresses where required. We could not be assured these systems were consistently implemented for all patients. Patients sometimes had long waits on trolleys which increased their risk of developing pressure sores.

The A&E department was managing a high volume of patients with a staff team made up of a high proportion of newly qualified nurses. This placed additional pressures on existing staff within an already challenging environment. Management staff were working to try to improve the situation but this was not always communicated to staff on the ground. Staff experienced serious difficulties in keeping up to date with training and professional development. We asked the health board, through an immediate assurance letter, to review arrangements for the assessment of patients in corridors. At the time of this report, the health board had provided HIW with sufficient assurance that all issues had been addressed.

There were systems in place to report incidents and monitor areas of patient care and we saw some examples of how the results had been used to improve patient care. It was not apparent how learning from these systems was communicated to the staff team on an ongoing basis to ensure support and consistency. We found the staff team were excellent at clinical prioritisation and ensuring clinical pathways were followed. We also saw good practice in managing the treatment of vulnerable patients, for example, planning the ongoing treatment of one adult with mental health needs. The A&E environment was not suitable for safeguarding children and vulnerable adults and we found that not all medicines or equipment were stored securely to prevent access by unauthorised persons. We asked the health board, through an immediate assurance letter, to address concerns with medicines and equipment. At the time of this report, the health board had provided HIW with sufficient assurance that all issues had been addressed.

5. Findings

Quality of the Patient Experience

Overall patients told us they were very satisfied with the quality of care they had received and in particular with the staff who treated them. We saw staff being polite and courteous to patients and treating them with respect, without exception. The waiting area environment and facilities could be improved in order to enhance the quality of the patient experience.

During the course of our inspection, patients were invited to complete our questionnaires to tell us about their experiences in the A&E department. These were completed via face to face interviews or returned to us in the post. Ten patients completed questionnaires. We also held informal discussions with a number of patients and on the second day we spoke with 21 patients in this way, in every area of the department.

Patients and their relatives were generally very complimentary about the staff who treated them, across all areas of the department.

Comments we received about staff included:

'*Reception staff were very helpful'.* (Two patients in waiting area).

'Staff always kind'. (Patient in waiting area).

'Some staff are very friendly. Others do not address patient directly'. (Carer talking about the treatment of their disabled child, in waiting area).

'The staff here are brilliant'. (This patient was in CDU and a wheelchair user who indicated that staff had spoken with them directly).

'Staff are competent, nice and very helpful. Nothing is too much trouble for them'. (Patient in CDU).

'Although staff were pleasant, they were not considerate for (my) needs, i.e. waking up at 1am and 2am to place medical bands on when I arrived in department at 6pm the previous night'. (Patient in waiting area).

'I don't remember it being this busy before (but) staff are very helpful'. (Relative in Minors).

'The staff are brilliant with children. I wouldn't go to another hospital with kids. Staff are very nice. They listen. They're caring'. (Relative in Minors).

'Staff are always excellent'. (Carer supporting patient in corridors who was then transferred to Majors).

We saw staff being polite and courteous to patients and their visitors. We saw staff interacting with patients in a kind and caring way without exception despite staff being very busy.

Patients told us they felt the waiting area facilities were unsatisfactory. On the first day of the inspection the designated ladies toilet was not working. One family also told us they had to attend to their disabled child's toilet needs in the car because the waiting area toilets were not wheelchair accessible. On investigation, there was a disabled toilet within the A&E department, close to the locked door separating off the reception area, but the family had not been made aware of this.

Recommendation

The health board is advised to review the waiting area environment and facilities to ensure they are in working order and relevant patient information is available and communicated to patients and the public.

Patients told us and our observations confirmed that patients did not wait long to be triaged. After triage, and before the next stage of treatment, the waiting times increased and on the second day, (in the morning), we spoke to patients who had been waiting up to 2hours 45minutes so far and still had not been seen further. Some patients we spoke with did not understand fully where they were in the process between admission to A&E, treatment and then either admission to a ward or discharge home. We noted that staff were extremely busy and spent as much time as possible with individual patients, however sometimes there were long periods when they were dealing with other patients and not available to give updates on care.

Reception staff told us they had received training to identify whether a patient should be seen as an emergency and how to escalate an individual to a triage nurse if they saw a patient deteriorating. The layout of the waiting area however did not enable reception staff or clinical staff to easily monitor patients for signs of deterioration. We therefore could not be assured that staff would identify patients deteriorating within the waiting area of such a busy department.

Recommendation

The health board is advised to consider whether staffing levels are appropriate to ensure patients are seen as soon as possible after triage and how to keep patients up to date on the progress of treatment.

The health board is advised to consider how patients who are waiting to be seen in the reception area can be monitored sufficiently to identify any deterioration in their conditions.

Delivery of the Fundamentals of Care

We saw a staff team committed to delivering the fundamentals of care to a high standard. Staff were significantly challenged in doing so by both the physical A&E environment and demand on the service, which on some occasions impacted negatively on patient care. The most challenging area for staff to deliver a high standard of care was in the corridors.

Communication and information

People must receive full information about their care in a language and manner sensitive to their needs

We saw staff communicating with patients admitted onto the department in a kind and patient way, explaining their treatment to them. However there was a lack of communication and information available to patients in the waiting area both before and after triage.

There was a lack of relevant, up to date information in the waiting area. We saw that some information leaflets were kept on a stand but these were limited. Patients did not have access to any information in the waiting area about the A&E department, how the process worked or the facilities available. One family for example, were not aware that they could access disabled toilets on the other side of the locked door from reception.

Some patients we spoke with in the waiting area did not understand where they were in the process of being triaged, being treated and referred onto a ward or discharged home. Some patients told us they had been seen, asked to wait in the waiting area and were not clear about what would happen next. Once on the department, however, we saw staff explaining to patients about their treatment and discharge. On the second day of the inspection the automated update board to advise patients of waiting times in the waiting area was not in use. This meant that, apart from asking reception staff, patients had no other way to access information about the process or how long they might be waiting.

Recommendation

The health board should provide relevant, up to date patient information in waiting areas. The health board is also advised to consider how patients in the waiting area can be kept up to date on their treatment plan and waiting times.

There was a hearing loop in place on reception so staff could communicate with patients with hearing difficulties. There were a number of staff who were able to

speak with patients in English and Welsh. Staff also told us they could access a wider range of interpreters when required. This meant there were systems in place to assist staff with communicating with people with additional needs.

Patients and relatives told us they would ask staff about the process of how to make a complaint, should they wish to do so. We did not see the complaints procedure displayed in patient waiting areas or a supply of complaints forms available. This meant patients did not have easy access to complaints information.

Recommendation

The health board should make complaints information easily accessible to patients.

Respecting people

Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

We saw staff treating all patients with respect and kindness. However, staff were unable to protect the privacy of patients in corridors. This meant that these patients' rights to privacy and dignity were seriously compromised. The corridors were an unacceptable environment for treatment and care intervention.

Staff introduced themselves and called patients by their preferred names. We observed staff being kind and compassionate to patients without exception. For example, we saw staff assisting one confused patient in a particularly sensitive manner.

We observed staff being discreet in their interactions with patients and when communicating personal information between team members during handover. Staff protected the privacy and dignity of patients when providing assistance with personal care or carrying out intimate examinations in bay areas by closing curtains around bed areas.

However, staff struggled to maintain patients' privacy and dignity when caring for patients in corridor areas due to the challenges of seeing them in this kind of physical environment. For example, the triage team in this area had to ask patients for personal details while other patients were waiting to be seen close by and staff and visitors used the corridors as a means of getting to other areas within the department. We saw some patients on corridors were very unwell and some relatives were distressed; and these moments, when patients were at

their most vulnerable, had to be managed on a corridor where numerous people were waiting or passing through.

Patients on the corridor could not always be properly assessed because staff were unable to undress patients, due to lack of privacy. Although staff told us that when needed, they found a private space to assess patients, there were not always spaces free. This meant that staff may not always be able to identify and fully visualise pressure areas, wounds, deformities or swellings. In one instance we saw a blood pressure check being performed with the cuff placed over the patient's thick jumper which could produce an inaccurate reading.

Recommendation

The health board should review the treatment of patients in corridors to consider how patients' privacy and dignity can be upheld within this environment.

The health board should ensure that staff are able to undertake full and accurate patient assessments, undressing patients where needed.

Promoting independence

The care provided must respect the person's choices in making the most of their ability and desire to care for themselves.

We saw staff encouraging patients' independence as far as possible. The physical environment was not conducive to promoting patients' independence.

We saw staff encouraging patients to be as independent as possible, as far as their condition would allow. Corridors and bays areas were cluttered with equipment, supplies and trolleys due to a lack of storage on the department. Patients waiting on trolleys meant that corridors were filled and busy. This was not conducive to allowing patients to mobilise independently and safely.

Recommendation

The health board is advised to review the environment to consider where suitable storage areas can be made available.

We saw a dementia display which explained a scheme whereby staff used a flower symbol on patient beds to indicate that a patient was confused (and may require additional staff time and support). During our time on the department we did not see this implemented with any patients. Although we saw staff assisting confused patients and re-orientating them in a kind and caring way, the

environment had not been set up to be accessible to patients with confusion or dementia.

Recommendation

The health board should consider how to make the environment as accessible as possible to those patients with dementia and/or confusion.

Specialist equipment was available for patient use, for example, we saw some air mattresses in use. There was however, limited choice for patients about where they could wait or be seen, as the department areas were all small with little space in between each patient area/cubicle.

Relationships

People must be encouraged to maintain their involvement with their family and friends and develop relationships with others according to their wishes.

Many patients presented at the department with relatives/carers and we saw staff encouraged the presence of those individuals. The limited space available in the corridors meant there were challenges in accommodating these patients' loved ones.

We saw that staff encouraged the presence of accompanying relatives/carers, respecting and appreciating the help they could give. For example, we saw relatives assisting their loved ones with eating and drinking.

The assessment of patients on trolleys in the corridors provided challenges around patients maintaining their relationships with loved ones, due to the limited amount of space available. We saw that relatives often had to stand in the corridors for long periods of time as there were limited chairs available. We saw staff trying to accommodate relatives as much as possible within a very challenging environment.

Recommendation

The health board is advised to review how patients' loved ones can be appropriately accommodated when patients are waiting to be seen on trolleys.

There were two relatives' rooms available, one which was adjacent to the resuscitation room and area where deceased persons could be seen by relatives. These rooms provided good, private areas for relatives to use, had soft furnishings and telephones available to make phone calls.

Rest, sleep and activity

Consideration is given to people's environment and comfort so that they may rest and sleep.

Apart from those patients on trolleys in corridors we found all other areas were being run with consideration to try to allow patients to rest as much as possible within a busy A&E environment. Staff and patients told us there were times when the department ran out of linen and pillows which impacted on patient comfort.

The nature of an A&E department means that areas are not set up to be conducive to allowing patients to rest and sleep. This was particularly evident with patients waiting for treatment on trolleys who were not able to rest due to activities happening alongside them on corridors. Staff told us wherever possible, when patients on trolleys stayed overnight, they wheeled them into spaces available off the corridors to allow them to rest. One patient told us however, that they stayed overnight on a trolley in the corridor. This was due to the shortage of space, patient demand and challenges of a small environment.

We observed patients within both CDU and the Majors area resting. Although these areas were busy, teams were organised and calm and noise was kept to a minimum.

During our inspection we found linen cupboards to be well stocked. However, several patients and staff commented that there were times they ran out of linen and most often, pillows. One patient told us they had requested an extra blanket and this had not been provided.

Recommendation

The health board is advised to ensure that linen cupboards are well stocked at all times to ensure patients' comfort and encourage rest.

Ensuring comfort, alleviating pain

People must be helped to be as comfortable and pain free as their circumstances allow

Most patients told us they received pain relief quickly. We found one case where this had not happened and therefore could not be assured this happened consistently. Patients' pain scores were recorded but we found they were not always re-evaluated and recorded on an ongoing basis to ensure appropriate pain management over time.

We found that staff were responsive to those patients in a high level of pain and treated them with appropriate medication. However, we found one person had been assessed as being in moderate pain at triage but waited over an hour for analgesia from a doctor. Patient Group Directions in place at triage meant nurses had the authority to be able to administer pain relief but this had not been done in this case. We could therefore not be assured that all patients were able to consistently access pain relief quickly.

Recommendation

The health board should ensure nurses and doctors respond to patients' pain scoring at triage, administer pain relief where required and evaluate the effectiveness of pain relief for patients.

Through looking at documentation we found that staff recorded patients' pain scores during triage to assess the appropriate treatment. We did not see notes in documentation to show patient's pain scores were reassessed or re-evaluated for effectiveness and ongoing treatment.

Recommendation

Staff should evaluate and record patients' ongoing pain scores to ensure pain management plans are in place where required and they treat patients' pain appropriately and effectively over time. This is particularly important for those patients who stay on the department for significant periods of time.

Personal hygiene, appearance and foot care

People must be supported to be as independent as possible in taking care of their personal hygiene, appearance and feet.

We saw staff supporting patients with their personal care needs where they could. The installation of further washing facilities were planned to assist patients to maintain their personal care routines.

We saw that where possible, staff assisted patients with personal care needs but prioritised patients' urgent care and treatment needs over this. This was as to be expected within an A&E department, where patients attended for short periods of time only.

We saw that patients on CDU were wearing either their own clothes or hospital gowns and appeared clean and well cared for. We saw a stock of soap and towels was available for patients to use.

There was a shower available within the Majors area. Staff explained that due to an increase in the number of long stay patients, the installation of a shower was planned in CDU in order to assist in meeting patients' personal care needs.

Recommendation

The health board should ensure that patients have access to suitable facilities to assist with their personal care needs, particularly those patients who are now staying on the department for longer periods of time.

Eating and drinking

People must be offered a choice of food and drink that meets their nutritional and personal requirements and provided with any assistance that they need to eat and drink.

We saw that patients were able to access hot meals and snacks. We found there were not always sufficient staff assisting at meal times due to the overall workload and other treatment priorities at the time in the department. Food and fluid charts for those patients at risk were not consistently updated.

We learned that the department had adapted to the increasing lengths of time patients spent in the A&E before admission to wards and had made changes based on a nutritional audit. There was a small staff room kitchen on the department where hot drinks could be made and a food trolley was now used each mealtime for serving patient meals. Patients were offered hot meals, sandwiches and snacks.

Staff explained that water jugs were replenished on every shift and those patients who did not want water were offered an alternative. Textured diets for patients with swallowing difficulties could be ordered on request and we saw that meals were suitable for diabetic patients. Fortified drink supplements were also available upon request.

Patients told us that they were pleased to be offered hot meals within the A&E department, although some patients commented that their meal had been cold. We observed a meal time and saw that there were limited staff available to assist patients to eat and drink. One staff member in CDU gave out meals and also assisted patients to eat. Therefore, on the occasion we observed, they had to leave the trolley for a significant amount of time to assist one person to eat their meal. This meant that although food was kept on the hot trolley, there was time in which food could become cold. We also saw another patient struggling

to eat their meal on the corridor and staff were not available to assist during our observations.

Although most staff giving out meals wore appropriate protective clothing we observed one staff member not wearing any protective clothing. Two patients told us and we also observed that they were not offered wipes to wash their hands before eating.

Recommendation

The health board should ensure that where patients require assistance with eating and drinking, this is identified and there are sufficient staff to assist. Staff assisting with meals should wear appropriate protective clothing and ensure patients are offered wipes to wash their hands before eating.

We saw that nutritional risk assessments were in place for several patients who were staying on the CDU but recordings were inconsistent. For example where patients were identified as at risk and had food and fluid charts in place, entries were not consistently updated.

Recommendation

Where patients are identified as at risk in relation to their nutritional needs, documentation should be consistently implemented and food and fluid charts updated to ensure their nutritional needs are being met.

Oral health and hygiene

People must be supported to maintain healthy, comfortable mouths and pain free teeth and gums, enabling them to eat well and prevent related problems.

There were appropriate and sufficient oral health supplies available on the department. Oral health assessments should be carried out for those patients staying longer on the department.

We saw supplies of toothpaste, toothbrushes and denture pots on the ward and staff distributed them to patients where needed. We saw staff assisting patients with oral care at the same time as offering assistance with personal care.

Care plans to keep patients' mouths healthy and comfortable were not in place due to the short nature of patients' stays. However, we found that some patients were staying on the department for increasing lengths of time, particularly on CDU.

Recommendation

Appropriate oral health assessments should be introduced, particularly for those patients staying on the department for periods of time up to and above 24hours to ensure their oral health care needs are met.

Toilet needs

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

In general we saw staff assisting patients with their toilet needs in a timely way.

One patient told us they had to wait for assistance with their toilet needs, stating *"(I) asked for the toilet, waited over 30 minutes, then was brought a bed pan".* In general however, patients told us and we observed staff responding promptly to assist patients to the toilet.

Patients in the resuscitation area (where appropriate), major injuries and minor injuries areas did not have any continence assessments completed, as these are not part of the A&E nursing documentation. However, nursing staff were undertaking continence assessments for patients in the CDU if it was anticipated that they would be admitted onto inpatient wards.

We saw there were ample incontinence supplies for patient use. The commodes we saw in use were clean. However, we saw that there was no system in place to indicate that they had been cleaned and ready for use, (for example, through the application of green tape).

Recommendation

A system should be put in place so that staff are able to easily see which commodes have been cleaned and are ready for use.

Preventing pressure sores

People must be helped to look after their skin and every effort made to prevent them developing pressure sores.

Systems were in place to assess patients' risk of developing pressure sores and to access equipment such as pressure relieving mattresses where required. We could not be assured these systems were consistently implemented for all patients. Patients sometimes had long waits on trolleys which increased their risk of developing pressure sores.

We saw that staff carried out waterlow scoring (which gives an estimated risk associated with the development of a pressure sore in a given patient) on triage. Staff implemented individualised risk assessments for those patients staying for longer periods of time, for example patients in CDU and we saw these in use.

We saw that staff had assessed those most at need and where they could, had found them full sized beds and air mattresses instead of A&E trolleys. We saw that within CDU mainly air mattresses were provided as a matter of routine, with profiling beds to reduce patient risk of developing pressure sores.

We found one instance however, where a patient had been assessed as having a moderate risk of developing a pressure sore and had been nursed on an A&E trolley overnight. We also found instances where records relating to turning patients had not been updated. This meant that we could not be assured that all patients consistently received appropriate care and attention in relation to their pressure needs or that documentation was consistently implemented and updated.

Recommendation

The health board must ensure that patients can be made as comfortable as possible on beds if they are required to wait in A&E for a length of time before admission. The health board must ensure that where patients are identified as at risk of developing pressure sores, staff undertake appropriate assessments, which are updated and appropriate care, attention and treatment is provided.

Quality of Staffing, Management and Leadership

The A&E department was managing a high volume of patients with a staff team made up of a high proportion of newly qualified nurses. This placed additional pressures on existing staff within an already challenging environment. Management staff were working to try to improve the situation but this was not always communicated to staff on the ground. Staff experienced serious difficulties in keeping up to date with training and professional development. We asked the health board, through an immediate assurance letter, to review arrangements for the assessment of patients in corridors. At the time of this report, the health board had provided HIW with sufficient assurance that all issues had been addressed.

Staffing levels and skill mix and professional accountability

During the inspection, we were well supported by the site management team. During our inspection the Ward Sister was on annual leave but we were well supported by the Band six and Band seven nurses (nurses with management experience) who were coordinating shifts.

Staff told us they aimed to have staffing levels in place of nine nursing staff and two healthcare support workers during the day, with eight nurses and two health care support workers at night. Staff rotas and observations confirmed those levels were achieved during the inspection. We found that there were a number of band six and seven senior nursing staff employed to work in the A&E which was positive as these grades indicated clinically confident, experienced staff. However, there were still instances throughout the inspection where we saw staff struggling to meet demand and the fundamentals of care being compromised due to the staffing levels in place.

For example, on the Clinical Decision Unit there was an instance when no staff were present to attend to a patient whose condition deteriorated and their relative had to come out to the main corridor to find a nurse and call for help. We observed one patient on the corridor who had been left with a hot meal and was unable to eat independently. Staff also reported that when they were part of the ‘corridor team’, during breaks they felt particularly vulnerable due to insufficient cover.

We spoke in detail with five members of staff and informally with many more. We saw a unit that was managing high volumes of patients requiring treatment, particularly on the first day we were present. We saw that the physical and environmental resources were not sufficient to manage the intensity of the

work. Staff told us that within the last 18 months staff turnover had been high and although additional staff had been recruited to fill vacancies a high percentage were newly qualified. There was a mentorship and competency programme for newly qualified staff but some existing staff reported that the high number of new starters placed additional pressure upon themselves. The management team met with Band seven staff on the second day to consider how best to support newly qualified staff. This meant that they were working with staff to try to find solutions.

On the first day of our inspection there were two agency staff covering shifts. Staff sickness was below the health board average both for medical and nursing staff. However, nursing staff reported that staff sickness, in addition to the high numbers of newly qualified staff, placed them under a great deal of pressure.

Recommendation

The health board is advised to review staffing levels to ensure appropriate numbers and skill mix are maintained at all times.

The health board is advised to review how it provides support to the high number of newly qualified staff on the department. This is to ensure that both newly qualified and existing staff are supported and patient safety is maintained.

We saw both medical and nursing staff working well together as a coherent team. One medical staff told us that there was good senior medical cover to provide support to the team. Although senior medical staff did not work in the department between midnight and 8am there was an on-call consultant available via telephone for advice on patient management.

We saw a display board in place which celebrated staff achievements, ranging from training to additional responsibilities staff had undertaken. This meant staff achievements were noted and celebrated.

Despite this, we found that staff morale was low. We saw that there was a staff team in place who were committed to the fundamentals of care and who maintained their professional values and conduct despite the significant pressures they were facing. Staff raised particular concerns about staffing levels, triage and observations of patients in corridors. We were told about systems initiated to try to improve staffing in the corridors, such as implementation of a dedicated ‘Rapid Assessment Team’ (one nurse offloading ambulances and triaging, one allocated waiting room nurse and one allocated corridor nurse). Staff told us however, that the third nurse was often newly

qualified and that during break times, patients and staff were left vulnerable in that area.

Recommendation

The health board should review patient assessment in corridors to ensure sufficient staffing. We have asked the health board through an immediate assurance letter, to address concerns around assessment of patients in corridors.

Effective systems for the organisation of clinical care

We saw an electronic system in use to inform the department of incoming patients via ambulance. This was seen to be frequently updated by staff once patients had arrived. We also saw that an electronic system to track patients was in place and effective in allowing staff to see an overview of patients' status at a glance and to help with prioritising patient need. The department had a pod system for quick transportation of blood samples to the testing laboratories.

We observed the site management team actively co-ordinating the hospital, particularly in terms of the escalation procedure. Specifically we discovered that three bed management meetings happened throughout the day to review the current pressures on the department and to assess where wards may be able to free up beds and so improve the flow of patients from A&E. Those meetings were well attended by Senior Nurses from other directorates. We attended two of those meetings during our inspection, one on the first day which indicated a shortage of 19 beds across the hospital. Similarly, on the morning of the second day a bed shortage of 9 was reported. We further found that potential beds were identified at such meetings and management returned to wards to explore whether beds could be made available for patient care and treatment.

An external speaker attended the meeting on the second day to inform the team of a new 'risk based' escalation policy and management advised they would be putting this in place to try to improve the escalation procedure. Staff were advised to make sure they recorded the number of 12 hour waits patients were facing on the A&E information board. This was to ensure an open and transparent culture within the department.

We spoke with staff about escalation procedures and they told us there was a dedicated phone number they used to escalate concerns when patient demand was becoming unmanageable. They told us this was not always staffed by clinical staff who understood the pressures so action was not always taken. Although management were visibly working hard to reduce pressures and told us about initiatives such as the recruitment of patient flow coordinators to try to

help patient flow, staff working within the department were not always aware of this and so did not always feel the pressures were being recognised.

Recommendation

The health board is advised to review escalation procedures and to make improvements where identified to ensure appropriate responses to keep patients and staff safe. The management team should consider how they communicate with staff so that staff feel their concerns are listened to and they are informed of new initiatives that may help to improve their working environment.

Training and development

All staff we spoke with told us they had difficulties in being released from their shifts to access training. One staff member told us their nurse practitioner training had to be abandoned four times due to not being able to access non clinical time to complete training.

We received staff training statistics from the health board which supported our findings. We found that training days were often cancelled. Specifically, the department had seven teams and each team required a minimum of two days of training time just to deliver mandatory and statutory training. This year just four teams had one day and the remaining three teams had no training days. Days were arranged but had to be cancelled due to workload.

Staff had limited knowledge around the Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and how consent and mental capacity issues were managed on the ward. We discovered that DOLS training had never been delivered. Staff told us their training in topics such as Protection of Vulnerable Adults and Child Protection was not up to date. Staff told us they had not received training in dementia/confusion but one member of the team had and there were plans to cascade the training, although no firm dates were planned.

Recommendation

The health board is advised to review the current training needs of staff and prioritise staff receiving the training they require. This is to ensure staff are equipped to carry out their roles, act legally in terms of the Mental Capacity Act and DOLS and also to ensure staff feel valued and are able to develop.

Staff did not receive timely access to performance development reviews (PDRs) and senior management told us the current compliance rate was estimated at 24%. PDRs are an important way to ensure staff have access to formal support and relevant training and performance needs are identified.

Recommendation

The health board should ensure staff had access to timely PDRs.

Handling of complaints and concerns

Staff were aware of the complaints procedure and how they would support patients or relatives to make complaints. During the second day of the inspection we spoke with a family who wished to make a complaint. They were appropriately directed by reception staff and met with a member of the management team to talk through their concerns. It then became apparent that their concerns were around care received on a ward and the staff member advised them of how to raise these concerns with the ward in question. We felt assured that complaints were handled appropriately.

Delivery of a Safe and Effective Service

People's health, safety and welfare must be actively promoted and protected. Risks must be identified, monitored and where possible, reduced or prevented.

There were systems in place to report incidents and monitor areas of patient care and we saw some examples of how the results had been used to improve patient care. It was not apparent how learning from these systems was communicated to the staff team on an ongoing basis to ensure support and consistency. We found the staff team were excellent at clinical prioritisation and ensuring clinical pathways were followed. We also saw good practice in managing the treatment of vulnerable patients, for example, planning the ongoing treatment of one adult with mental health needs. The A&E environment was not suitable for safeguarding children and vulnerable adults and we found that not all medicines or equipment were stored securely to prevent access by unauthorised persons. We asked the health board, through an immediate assurance letter, to address the safe storage of medicines and equipment. At the time of this report, the health board had provided HIW with sufficient assurance that all issues had been addressed.

Risk management

Incidents were reported through the datix system (electronic software for reporting and recording incidents). Staff also told us about separate incident forms implemented by one of the consultants to record near misses and/or any incidents of violence and aggression. This was put in place to try to capture those incidents which may not always require formal reporting but were significant in terms of demonstrating what staff were managing. We felt assured that the staff team supported the reporting of incidents and staff felt able to do so.

We were told that the 'Rapid Assessment Team' had been put in place following an incident, which indicated some learning had happened around this and changes made as a result. Staff told us they did not usually get feedback on incidents they reported and were not aware of any learning that happened on an ongoing basis or trends that had been identified from incidents over time. Staff also commented that when incidents occurred there was not always time to debrief fully.

Recommendation

The health board is advised to reflect on incidents and identify trends to enable learning. The health board is also advised to ensure staff at Department level, including front line staff, are supported following incidents and that any learning around incidents is disseminated through the team.

The A&E Department faced challenges in terms of ensuring sufficient security to the staff team and to patients. Through the night the only entrance to the hospital was through A&E so staff told us it was used as a thoroughfare. There was no security across the site so staff were only able to contact porters to try to assist in de-escalation or told us they phoned the police. Staff we spoke with had not undertaken positive behaviour management training and we later discovered 'violence and aggression' training had been cancelled due to the department being unable to release staff for training. Some staff expressed genuine concerns for their safety when treating patients.

Recommendation

The health board is advised to review security arrangements for the A&E Department and ensure there are appropriately trained staff to provide support on each shift.

Policies, procedures and clinical guidelines

Staff were able to access up to date policies and procedures on the intranet. We looked at the medications management policy, Patient Group Directions[1] (PGD) and escalation policies in detail.

We asked for the current medicines management policy and the policy we were given had not been reviewed since 13 May 2011, with an expiry date of 13 May 2012. This meant staff could be working to a policy that does not have accurate and up to date information to inform their practice.

[1] **Patient Group Directions** are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability.

Recommendation

Staff should have access to up to date policies and procedures to inform their practice, specifically in regards to the medicines management policy.

Patient Group Directions were contained within a file which listed individual protocols for each drug given under direction. The protocols were well written, reviewed and up to date, including criteria for inclusion and exclusion of patient groups. The PGDs were appropriately approved by health board officials, clinical leads and pharmacy. The range of drugs under PGD was appropriate for the use of triage trained registered nurses, within an A&E department.

Effective systems for audit and clinical effectiveness

Staff told us that each Band seven nurse was responsible for auditing a particular area of practice, including nutrition, cleaning, hand hygiene, pressure ulcers, infection control and falls. Audits revealed that compliance with cleaning standards had decreased over time and the health board had identified this and put plans in place to improve this. This demonstrated that some reflection and learning took place around audits.

Speaking with staff, they were not aware on an ongoing basis how learning from audits took place and how this was disseminated to the staff team. Staff told us there were infrequent staff meetings and a communication book which wasn't really used. We saw staff put up notices around the department about any changes to practice, for example, when we found issues in the controlled drugs book. We were told such notices tended to increase and staff couldn't keep track with what they had already seen as opposed to any information that was new. Management staff told us they were trying to develop better ways of communicating with staff, for example through email.

Recommendation

The health board should consider how to improve communication between management and the staff team particularly around outcomes from audits and changes to practices on the department.

Patient safety

The physical environment of the department meant that there was a lack of storage as every space available was being used to see patients. As a result equipment such as room dividers, resuscitation trolleys and trolleys storing items such as scalpels, blades and needles were out on corridors. We found a

room divider blocking one door of the ambulance entrance. These issues posed significant health and safety risks to staff and patients.

Recommendation

The health board must review how equipment can be safely stored on the department to avoid unauthorised access to potentially dangerous equipment. We have asked the health board through an immediate assurance letter, to address this concern. The room divider should be removed from the ambulance entrance to ensure it is fully accessible.

The physical environment provided additional significant challenges in terms of safeguarding vulnerable patients and children. We saw that there was no designated waiting area for children and staff told us children were often treated in a bay within the minor injuries unit where risks were posed from other patients accessing treatment there.

Recommendation

For paediatric patients, children and young people attending the department, the health board needs to consider whether the main waiting area and bay on the minor injuries unit is appropriate and make improvements in order to safeguard the needs of children and improve their comfort, privacy and dignity.

In the Clinical Decision Unit there were a number of vulnerable patients. Staff told us that where patients required one to one supervision, (for example, patients with mental health difficulties), they tried to ensure they were allocated beds closest to the nurse's station for easy observation. However due to the layout of the physical environment not all beds were visible from the nurse's station and demand for beds meant this was not always possible. Staffing levels in place also meant there were times staff had to leave the Unit for short periods of time. We also found that a workman had left a set of tools on the Unit including a saw and screwdriver which patients could have accessed. We escalated this to staff and the tools were removed immediately. However, we could not be assured that risks associated with vulnerable patients could be adequately managed within the current environment.

Recommendation

For vulnerable patients, the health board must consider how they ensure the physical environment and staffing can be improved to ensure patients are appropriately safeguarded.

Medicines management

Administration and recording of medicines

Medicines were administered on an individual basis from stock cupboards. We observed staff administering medicines and found them to be skilled and

competent, correctly positioning patients and making accurate recordings in patients' Medication Administration Records (MARs).

We found the controlled drugs book was not being fully completed in line with legal requirements and health board policy. For example, there were a number of gaps where signatures or the amount given should be recorded. There were also inconsistencies in stock checks with periods of three to four days where stock was not checked.

Recommendation

The controlled drugs book should be accurately filled in, in line with legal requirements. This should be monitored to ensure ongoing compliance. We have asked the health board through an immediate assurance letter, to address this concern.

A stock of take-home drugs was available for patients. These were pre-labelled by pharmacy with instructions for use. An on-call pharmacist was available for supply of any additional drugs required outside working hours.

Storage of drugs

Not all medication was stored securely to prevent access by unauthorised persons. We found two fridges containing medications located outside the resuscitation rooms were not locked. We also found the door to medicine rooms were sometimes left unlocked. We found the lock on the medicines room in CDU was broken and medications were being stored in unlocked drawers. Staff addressed these issues immediately whilst we were present.

In the majors area we found packets of salbutamol open in the medicines cupboard, each of which contained mixed strengths of the drug. Fluids used for intravenous use and lidocaine (local anaesthetic drug) were stored on an open trolley outside the resuscitation room.

Recommendation

Salbutamol supplies should be re-organised to ensure staff can access the correct strength easily. IV fluids and local anaesthetic drugs should be stored securely to ensure they cannot be accessed by unauthorised persons. We have asked the health board through an immediate assurance letter, to address this concern.

We found several forms of medication had passed their expiry dates. These were removed whilst we were on site. We also found cupboards were not consistently labelled with the medicines they contained to allow ease of access.

Recommendation

We have asked the health board through an immediate assurance letter to demonstrate how it will ensure that suitable arrangements and systems are put in place with regard to the safe storage, management and handling of medicines now, and on an ongoing basis.

We found the paediatric crash trolley used when children require resuscitation was not fully stocked for emergencies. We escalated to nursing staff the presence of an out of date laryseal (airway mask) for intubation (insertion of a tube into the windpipe) and an out of date syringe on this trolley. These were immediately removed by staff. Although there was a record indicating that the trolley was checked regularly by staff, those issues had not been identified.

Recommendation

The health board should ensure crash trolleys are regularly checked and action taken to ensure they are fully stocked and any out of date items are removed.

Documentation

Patient Assessment

We looked at four sets of patient records in detail, including two particularly vulnerable patients, with learning disabilities and mental health needs. We found A&E triage assessments were undertaken and documented electronically. A&E management plans were individualised about how the person's condition should be managed. Care interventions were well documented and updated in real time to ensure accuracy of recording. We found notes were shared across the team, for example we saw entries by an occupational therapist and psychiatric doctor preparing patients for discharge.

We found that risk assessment booklets were in place but not always completed, even when a patient's condition indicated that they could be at an increased risk. For example, in the case of one patient who was diabetic, had a history of falls and had difficulty mobilising, the risk of them developing pressure damage had not been fully assessed and they had slept overnight on a trolley,

increasing the risk of pressure damage. Staff had access to care bundles[2] however, these were not consistently implemented.

Recommendation

The health board is advised to review how patients' risks are managed on the department to ensure documentation is consistently implemented where required to help keep patients safe and manage risk appropriately.

We found documentation in relation to care pathways had been appropriately completed and followed. For example in the case of one patient a cardiac pathway had been initiated which ensured their condition was appropriately managed.

Ward Management

Patient notes were kept securely within nurses stations in each area. We observed verbal handovers (concerning patients' care and treatment) taking place which were discreet and informative.

Effective patient pathways

We saw and staff described to us how the A&E department managed patient pathways in accordance with clinical effectiveness. We saw evidence of the stroke, fractured hip, sepsis and cardiac pathway being effectively followed with the recommended care interventions.

We also tracked two vulnerable patients, one with learning disabilities and one with mental health needs to see how their pathways of care were managed. In both cases we found sensitive and appropriate treatment had been given and referrals to appropriate professionals had been made.

We saw a team at work who were excellent at clinical prioritisation and all patients we tracked with urgent need were seen and treated promptly. We saw medical and nursing staff working very closely together to ensure patients received consistency in their care and treatment and that all areas were remaining as safely staffed as possible.

[2] **Bundles are** All Wales or Health Board wide agreed interventions and approaches to specific areas of health care. These ensure consistent evidence based nursing practice.

We saw examples of a multidisciplinary approach to discharge planning involving input from both medical and nursing staff in addition to the wider professional team such as the frailty consultant, physiotherapy and occupational therapy staff.

Diabetes Care

We looked at two sets of notes in detail for diabetic patients (one patient with type one diabetes and one patient with type two diabetes) and discussed diabetes care with staff. The set of notes for both patients showed that care had been planned, appropriate actions had been taken as a result and diabetes care had been evaluated in the nursing notes.

We found that blood glucose testing was recorded at regular intervals and insulin medications were appropriately written up in the prescription chart and administered on time.

There was a food trolley which meant patients received regular meals and snacks and it was flagged up on the board in each area which patients were diabetic to ensure they received regular meals. We noted that for the type two diabetic patient, a food chart had not been put in place to monitor their food intake and a skin care assessment had not been undertaken even though their condition would put them at moderate risk.

Recommendation

The health board is advised to ensure food and fluid charts are consistently implemented and updated for diabetic patients and any risks associated with skin care are identified and managed appropriately.

There was a diabetes link nurse who acted as a local point of contact and shared best practice on diabetes care. The link nurse had frequent input to A&E patients, held diabetic clinics and often had prior knowledge of patients because of working with patients in the community.

There was one ‘hypo-box’ on the department which was broken and did not contain all the equipment and medication required to treat a diabetic emergency such as low blood sugar. We escalated this and on the second day of the inspection staff had put four new, well stocked hypo-boxes in place to cover each area of the department.

Records we saw indicated staff had appropriately responded to a patient presenting with hypoglycaemia (otherwise known as low blood sugar). However it was not clear when the patient’s blood glucose had been rechecked to confirm hypoglycaemia had been treated correctly.

Recommendation

Patients' blood glucose charts should be regularly updated to evidence that staff are appropriately managing their diabetic treatment needs.

Staff told us training on diabetes management was cascaded from trainers and we saw a flow-chart guideline for the management of diabetic emergencies within the drugs room for ease of access.

6. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit their improvement plan to HIW within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified within the Accident and Emergency Department at Nevill Hall Hospital will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/ units of the health board.

The health board's improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing dignity and essential care inspection process.

Please note that where we refer to immediate assurance letters in the improvement plan below, the health board has now provided us with sufficient assurance that concerns have been addressed. Details can be found in the health board's full improvement plan published below.

Appendix A

Dignity and Essential Care: **Health Inspectorate Wales Improvement Plan**

Hospital: **Nevill Hall**

Ward/Department: **Accident and Emergency Department**

Date of Inspection: **3 and 4 December 2014**

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Quality of the Patient Experience				
7 Point 1	The health board is advised to review the waiting area environment and facilities to ensure facilities are in working order and relevant patient information is available and communicated to patients and the public.	• Environmental re audit undertaken on 12th January 2015 with the Service Group Manager and the H&S Team.	General Manager Head of Facilities Health & Safety Manager	Complete
		• The Chief Operating Officer, General Manager and Divisional Nurse undertook a review of the facilities on 23rd January 2015. • Estates reviewing refurbishment options – for action within capital budget • Findings to be reviewed by the Health Board Environmental Committee and the Executive Team to agree action – report to Exec Team Feb 2015	Chief Operating Officer General Manager Divisional Nurse	February 2015
		• Patient Information leaflets in place. • Disability signage in place to identify the availability of disabled toilets for patients and carers. • Reception staff and triage nurses advising patients about approximate waiting times.	Senior Nurse	Completed
7 Point 2	The health board is advised to consider whether staffing levels are appropriate to ensure patients are seen as soon as possible after triage and how to keep patients up to date on the progress of treatment.	• Nurse staffing review undertaken during 2014, 10 extra registered nurses employed. • Acuity and activity reviewed on a daily basis to ensure safe staffing. • SBAR Reporting in place to enable front line staff to escalate concerns if they think staffing is not at the right level due to acuity	Divisional Team and Divisional Nurse Lead Divisional Nurse	Completed Monthly establishment reviews in place February 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
7 Point 2 (cont.)	The health board is advised to consider whether staffing levels are appropriate to ensure patients are seen as soon as possible after triage and how to keep patients up to date on the progress of treatment.	• Shift patterns within the department have been reviewed and standardised to meet service need. • The department has recently moved to electronic roistering. • Escalation policy is well established and staff reminded of need to escalate when required – daily review is undertaken	Divisional Nurse and Senior Nurse	Completed Monthly establishment reviews in place
		• ENP service is being further developed to bring it in line with the rest of the Health Board. A dedicated ENP service introduced in January 2015. • Model for ENP service agreed for clinical futures Health Board wide including a programme to develop the team.	Divisional Team Executive Team	January 2015
8	The health board is advised to consider how patients who are waiting to be seen in the reception area can be monitored sufficiently to identify any deterioration in their conditions.	• Patients now being triaged on arrival • A dedicated ENP service and triage arrangements have been put in place to ensure compliance and escalation of any deterioration must be escalated – formal review to be undertaken of effectiveness in 1 month	Divisional Nurse and Senior Nurse All Staff	Implemented January 2015
Delivery of the Fundamentals of Care				
9	The health board should provide relevant, up to date information in waiting areas. The health board is also advised to consider how patients in the waiting area can be kept up to date on their treatment plan and waiting times.	• Patient information available in treatment area. • Nursing Staff within will inform patients of progress and waiting times as part of new triage arrangments	Senior Nurse Sisters/Charge Nurses	Implemented December 2014
10	The health board should make complaints information easily accessible to patients.	• Complaints information visibly available and accessible in the waiting area and the Department	Senior Nurse and Lead Clinician	Implemented December 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
11	The health board should ensure that staff are able to undertake full and accurate patients assessments, undressing patients where needed.	• If patients need to be clinically examined they are taken to an appropriate area, where dignity and safety can be maintained. • In times of high escalation, prioritisation will be given to this issue	Senior Nurse and Lead Clinician	Completed
11 Point 3	The health board is advised to review the environment to consider where suitable storage areas can be made available.	• This is being reviewed with the environmental review and will require capital monies when considered at Exec level See point I		February 2015
12 Point 4	The health board should consider how to make the environment as accessible as possible to those patients with dementia and/or confusion.	• Dementia and cognitive impairment are being factor as part of the review • Review of service is being undertaken to fast track dementia/confused patients to appropriate areas. • Dementia Boards in place – additional trans for staff to be undertaken	Chief Operating Officer General Manager Divisional Nurse Head of Facilities	February 2015
12 Point 5	The health board is advised to review how patients' loved ones can be appropriately accommodated when patients are waiting to be seen on trolleys.	• Carers waiting facilities are being considered within the environmental review. Constraints of the department do make specific carer waiting facilities difficult – All action is taken to provide carers with suitable setting	Chief Operating Officer General Manager Divisional Nurse Head of Facilities	February 2015
13	The health board is advised to ensure that linen cupboards are well stocked at all times to ensure patients' comfort and encourage rest.	• Linen audits are in place stock levels increased	Senior Nurse and Nurse in Charge	Implemented December 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
14	The health board should ensure nurses and doctors respond to patients' pain scoring at triage, administer pain relief where required and evaluate the effectiveness of pain relief for patients.	• Actioned • Awareness raised with staff • Lead Clinical staff to continue to raise awareness • Pain assessment tool to be used for all suitable patients and audited by pain lead nurse in next month	Senior Nurse and Clinical Lead	Implemented December 2014 February 3rd 2015
14	Staff should evaluate and record patients' ongoing pain scores to ensure pain management plans are in place where required and they treat patients' pain appropriately and effectively over time. This is particularly important for those patients who stay on the department for significant periods of time.	• All staff reminded of pain assessment tool available and must be used appropriately • Pain Lead Nurse to undertake audit to provide further assurance.	Pain Lead Nurse	February 3rd 2015
15	The health board should ensure that patients have access to suitable facilities to assist with their personal care needs, particularly those patients who are now staying on the department for longer periods of time.	• Shower facilities are available • DECi Audits to be undertaken monthly to provide assurance.	Senior Nurse, Nurse in Charge and Clinical Lead	January 2015
		• Patients who remain in the department who are scoring high on the water low score will be transferred onto a bed. • DECi audit to provide assurance • Awareness raising of staff		Implemented December 3rd 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
16	The health board should ensure that where patients require assistance with eating and drinking, this is identified and there are sufficient staff to assist. Staff assisting with meals should wear appropriate protective clothing and ensure patients are offered wipes to wash their hands before eating.	• Previous audits have stated that patients are content re sufficient fluids and diet • Awareness raised with staff about hand hygiene prior to patients eating • Awareness raised with staff to reinforce expected standards with nutrition and Hydration • House keeper appointed to further support this agenda. • DECi audit and FOC audits to be undertaken to measure performance and compliance.	Senior Nurse and Nurse in Charge	Implemented December 4th 2014
	Where patients are identified as at risk in relation to their nutritional needs, documentation should be consistently implemented and food and fluid charts updated to ensure their nutritional needs are being met.	• Senior Nurse to promote importance and effective documentation of patients' nutritional and fluid intake.	Senior Nurse and Nurse in Charge	Actioned
		• Nutrition and Fluid Carts now in place for all patients in majors		Actioned
17 Point 6	Appropriate oral health assessments should be introduced, particularly for those patients staying on the department for periods of time up to and above 24hours to ensure their oral health care needs are met.	• The All Wales Oral Health Care Bundle has been implemented and being followed. • Performance will be measured as part of the FoC with Senior Nurse ownership	Senior Nurse and Nurse in Charge	Actioned Implemented December 2014
17 Point 7	A system should be put in place so that staff are able to easily see which commodes have been cleaned and are ready for use.	• Commode Cleaning Standard to be adhered by all staff • Awareness raised with staff including the use of I'm clean tags • Review via DECi Audit and infection control spot checks by infection control staff	Senior Nurse, Nurse in Charge and Infection Control team	Implemented December 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
18	The health board must ensure that patients can be made as comfortable as possible on beds if they are required to wait in the A&E for a length of time before admission. The health board must ensure that where patients' are identified as at risk of developing pressure sores, staff undertake appropriate assessments, which are updated and appropriate care, attention and treatment is provided.	• Policy is clear that if patient in department for long periods of time, will be transferred to a bed and assessment of pressure areas reviewed. • Awareness raised with staff about consistent use of water low scoring and use of pressure relieving equipment. • DECi Audit and FOC audits • Unannounced spot checks by Divisional Nurse	Senior Nurse, Nurse in Charge and Tissue Viability team Divisional Nurse	In place and ongoing Actioned
Quality of Staffing Management and Leadership				
20 Point 9	The health board is advised to review how it provides support to the high number of newly qualified staff on the department. This is to ensure that both newly qualified and existing staff are supported and patient safety is maintained.	• The Health Board has committed to ensuring appropriate establishments are in place within the Emergency Department. In September 2014 an extra 10 Registered Nurses were appointed • All new qualified undertake the health board's comprehensive induction programme for registered nurses as well as receiving preceptership within the clinical setting. • All new staff have undertaken a 2 day A&E induction a 2 week supernumerary period and access to mentors. • Senior Support for Mentors and Preceptors is in place to ensure support and enable the growth in the team.. • The service is supported by the Divisional Nurse, Corporate Nursing and Corporate Training Team who respond to any extra support required by the service. • Leadership development programme is in place for the development of Sisters/Charge Nurses. • Sickness management PADR policies in place, compliance has been reviewed by senior nurse	Divisional Nurse Senior Nurse and Nurse in Charge Corporate training team	Completed

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
21	The health board should review patient assessment in corridors to ensure sufficient staffing. We have asked the health board through an immediate assurance letter, to address concerns around assessment of patients in corridors.	• The consultants at the Emergency Department are clear that they would prefer patients in the corridor rather than remain in an Ambulance. Patients who require physical examination are moved in to screened bay for examination. • Escalation policy in place and staff reminded of use • ENP service expanded to assist with timely management of patients • Performance of the service managed via emergency performance meeting Chaired by COO. • Staffing escalation policy in place for action	Chief Operating Officer, Nurse Executive/Medical Director Divisional Director and Divisional Team	Ongoing and reviewed daily
22 Point 10	The health board is advised to review escalation procedures and to make improvements where identified to ensure appropriate responses to keep patients and staff safe. The management team should consider how they communicate with staff so that staff feel their concerns are listened to and they are informed of new initiatives that may help to improve their working environment.	• Health Board's escalation policy reviewed by executive team on 5th January 2015 in line with the Welsh Government escalation process • Compliance at front line reviewed daily by Divisional Management Team. Access to COO and Exec Team available and regular walk arounds undertaken at times of high pressure and at scheduled safety walkabouts/visits by Independent Members and Execs.	Executive Team Divisional Management Team	Implemented January 2015
22 Point 11	The health board is advised to review the current training needs of staff and prioritise staff receiving the training they require. This is to ensure staff are equipped to carry out their roles, act legally in terms of the Mental Capacity Act and DOLS and also to ensure staff feel valued and are able to develop.	• Training and service needs analysis to be concluded by the end of January 2015. • Detailed planning has been undertaken to demonstrate future need of advanced practice and ENP requirements.	Divisional Nurse Senior Nurse Assistant Director of Nursing	31st January 2015 Implemented
		• Assistant Director of Nursing with the Lead for Safeguarding will work with the Division to ensure training is in place for in respect of Mental Capacity Act and DOLS • Investment has been agreed for additional Best Interest Assessment for immediate recruitment (for across organisation)	Divisional Director Assistant Director of Nursing	Plans to be outlined by 31st January 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
23	The health board should ensure staff had access to timely PDRs.	• The Divisional team to support the staff PADR process within the department to ensure staff have access and improve compliance. • Refresher training to be made available to Band 7 & Band 6 team leaders if required. • Divisional team and Directorate team to agree a programme with the senior nurse to ensure time is available to enable the effective PADR process. • Senior Nurse/Clinical Director has developed a timetable for all staff.	Divisional Nurse Senior Nurse and Team Leaders Divisional Director	December 2014 (monthly review of performance and compliance)
		• The revalidation agenda within nursing will ensure this remains a key priority, the performance and compliance will be managed by the Divisional Nurse for nursing.	Corporate Nursing Divisional Nurse	February 2015
Delivery of a Safe and Effective Service				
24	The health board is advised to reflect on incidents and identify trends to enable learning. The health board is also advised to ensure staff at Department level, including front line staff, are supported following incidents and that any learning around incidents is disseminated through the team.	• An unscheduled care report is presented at Board bi-monthly by Chief Operating Officer • The Putting Things Right team produce and publish a Lessons Learnt report bi monthly that sets out learning opportunities and trends of incidents or near misses. This information is used to inform training needs across the health board. This information will be shared at regular team meetings with front line staff. • Review communication to ensure the feedback is widely available to staff.	Divisional Team	In place
25 Point 12	The health board is advised to review security arrangements for the A&E Department and ensure there are appropriately trained staff to provide support on each shift.	• The Health Board are undertaking a security review. • Immediate safety issues from review e.g. replacement door lock are being actioned. • A paper for consideration regarding security on site will be reviewed by Exec in February. Changes costing 110K to be considered	Joint with Divisional Director, Facilities and Head of Health & Safety	End January 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
25 Point 13	Staff should have to up to date policies and procedures to inform their practice, specifically in regards to the medicines management policy.	• Prior to the HIW visit, the Health Board's medicines management and professional practice policy had been ratified and has since been implemented across the Health Board via the Intranet. • Training session for RCN have been implemented	Chief Pharmacist, Senior Nurse and Lead Clinician	Complete review date 2017
26 Point 14	The health board should consider how to improve communication between management and the staff team particularly around outcomes from audits and changes to practices on the department.	• Regular learning events including themes from complaints /SI's shared with staff. Quality and Patient Safety Lead Nurse shares information on a monthly basis with this department and the remaining areas in Unscheduled Care via reports, monthly meetings and newsletter. • Divisional Nurse and other members of the Divisional and Directorate management team to continue having a visible Leadership presence within the department • All audits to be performance managed in Division at divisional level and action taken where required e.g. COO and Director of Nursing will jointly monitor this plan	Senior Nurse Clinical Lead Divisional Director Divisional Lead for assurance	In place an ongoing
26 Point 15	The health board must review how equipment can be safely stored on the department to avoid unauthorised access to potentially dangerous equipment. We have asked the health board through an immediate assurance letter, to address this concern. The room divider should be removed from the ambulance entrance to ensure it is fully accessible.	Recommendation Actioned • Sharps storage was managed with immediate effect. • Room divider removed from Ambulance entrance with immediate effect	Senior Nurse Lead Clinician Divisional Team	3rd December 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
27 Point 16	For paediatric patients, children and young people attending the department, the health board needs to consider whether the main waiting area and bay on the minor injuries unit is appropriate and make improvements in order to safeguard the needs of children and improve their comfort, privacy and dignity.	• Please refer to point 1 (page 7) • Review also by Head of Children's Nursing and the Assistant Director of Nursing for Safeguarding – report to executive to be considered in February	Divisional Team	January/ February 2015
27 Point 17	For vulnerable patients, the health board must consider how they ensure the physical environment and staffing can be improved to ensure patients are appropriately safeguarded.	• Please refer to point 1 and point 2 (page 7)		
28 Point 18	The controlled drugs book should be accurately filled in, in line with legal requirements. This should be monitored to ensure ongoing compliance. We have asked the health board through an immediate assurance letter, to address this concern.	Recommendation actioned • The process of night staff rechecking the controlled drug stock and controlled drugs book is actioned. The Nurse in Charge of the unit on night duty has responsibility to ensure this is recorded and undertaken nightly. This will be monitored by the Senior Nurse. • The audit process and the quality of assurance for controlled drug recording will be reviewed as a component of the weekly pharmacy audit. The findings of these audits will be reported weekly to the Divisional Nurse.	Divisional Nurse Senior Nurse Department Pharmacist	3rd December 2014 On a weekly basis

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28 Point 19	Salbutamol supplies should be re-organised to ensure staff can access the correct strength easily. IV fluids and local anaesthetic drugs should be stored securely to ensure they cannot be accessed by unauthorised persons. We have asked the health board through an immediate assurance letter, to address this concern.	Recommendation Actioned • The drugs cupboard has now been reorganised to ensure that the different strengths of Salbutamol are stored in different areas on the cupboard. All drugs have been checked for the correct packaging, that the boxes are labelled and the integrity of these containers checked to ensure labels can be easily read. The importance of this has been conveyed to all staff. These actions have been undertaken with the support of the ward Pharmacist. Independent audits will be undertaken by the Pharmacist weekly and reported to the Divisional Nurse.	Senior Nurse Clinical Lead Department Pharmacist Divisional Nurse	Completed
28 Point 20	We have asked the health board through an immediate assurance letter to demonstrate how it will ensure that suitable arrangements and systems are put in place with regard to the safe storage, management and handling of medicines now and on an ongoing basis.	Recommendation Actioned • Agreement has been given for a medication vending machine within the Emergency Department which will further improve the medicine management. The health board has experienced an improvement in this process with the introduction of this vending machine on the Emergency Assessment unit.	Chief Pharmacist, General Manager, Divisional Nurse, Lead Clinician and Senior Nurse	3 monthly review
		• The NMC standards for Medicines Management has been re-circulated to all Registered Nurses to ensure compliance with the standards	Assistant Director of Nursing Divisional Nurse Senior Nurse	3rd December 2014
29	The health board should ensure crash trolleys are regularly checked and action taken to ensure they are fully stocked and any out of date items removed.	Recommendation Actioned • Daily checks in place. This will be audited by the Senior Nurse to provide assurance.	Senior Nurse	Implemented 3rd December 2014
30	The health board is advised to review how patients' risks are managed on the department to ensure documentation is consistently implemented where required to help keep patients safe and manage risk appropriately.	• All risk assessments are undertaken and appropriate taken. The Senior Nurse will also undertake spot check documentation audits reporting outcomes to Divisional Nurse. Frequent and unannounced DECI audits and spot check documentation audits will be scheduled throughout the year. Findings reported to the Quality and Patient Safety Committee.	Senior Nurse and Management Team Divisional Nurse	Implemented and ongoing
31 Point 21	The health board is advised to ensure diabetic care plans and fluid charts are consistently implemented and updated for diabetic patients and any risks	Recommendation Actioned • Awareness raised by Senior Nurse in respect of Diabetic Care and documentation • Daily reviews by Diabetic team remain in place	Senior Nurse Team Leaders Consultant Diabetic Lead Specialist Nurses	Implemented 4th December

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	associated with skin care are identified and managed appropriately.	• Diabetic Specialist Nurse to undertake spot check documentation audit within the department to provide assurance.	Diabetic Specialist Nurse	W/C 1st February 2015
		• The Health Board undertakes the All Wales glucose monitoring audit which is conducted by the near patient testing team to provide neutrality, all results from those audits have proved to be accurate, this is done on a monthly basis.	Near Patient Testing team Corporate Nursing	Implemented September 2013
31 Point 22	Patients' blood glucose charts should be regularly updated to evidence that staff are appropriately managing their diabetic treatment needs.	• Documentation audits • Senior Nurse awareness raising • Diabetic Specialist Nurse spot audits	Senior Nurse	December 2014

Health Board Representative:

Name (print): **Denise Llewellyn / Jamie Marchant**

Title: **Executive Director of Nursing / Chief Operating Officer**

Signature:

Date: **2nd February**