Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Dignity and Essential Care Inspection (unannounced)

Betsi Cadwaladr University Health Board: Wrexham Maelor Hospital, Accident and Emergency Department

30 September / 1 October 2014

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Digital ISBN 978-1-4734-2696-2

Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced dignity and essential care inspection in Wrexham Maelor Hospital Accident and Emergency Department (A&E), part of the Betsi Cadwaladr University Health Board on 30 September and 1 October 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
- 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

The A&E department at Wrexham Maelor Hospital is a large, busy centre which treats a high number of patients each day in its minor injuries unit, major injuries unit and clinical decision unit. The ambulance arrival entrance is separate from the walk in entrance. Walk in patients are triaged[1] as soon as possible after arrival to the A&E department and are then seen in whichever clinical area of the department is most appropriate for their needs and condition. There are four resuscitation bays, eleven bays in the major injury unit, six bays in the minor injuries unit, and six beds in the clinical decisions unit. There is a separate paediatric waiting room for children and a two-bay assessment unit which are not currently open, but there are plans to open them by the end of 2014.

On the days of inspection, the unit was experiencing a high volume of patient attendees. Two wards within the hospital were unable to accept patient admissions, either because they were full, or due to necessary precautions, needing to be taken to prevent spread of infections within these wards. This resulted in patients waiting in the A&E for admission to wards for anywhere up to 20 hours. The high number of patients awaiting transfer to hospital wards was also causing a significant number of ambulances to wait for space in the unit before being able to offload incoming patients. We noted up to 11 ambulances waiting outside the A&E over the course of the day. The high number of patients within the A&E waiting to be seen and those patients waiting in the back of ambulances for A&E space led to a decision in the afternoon of the 30 September to divert ambulances to other surrounding hospitals until the flow of patients through the A&E could be improved.

We raised one immediate action with the health board. During our inspection, we observed staff effectively prioritising clinical need and patient care and therefore we did not require escalation of any actual patient safety issues. However, we did observe an A&E department working to full capacity and we were made aware that this has been the situation for some time.

Given the extreme capacity that we found the department working in, we were not satisfied that the A&E department would be able to maintain an adequate

[1] Triage of patients is the process of determining the priority of patients' treatments based on the severity of their condition

level of patient safety in the event of any increase in demand/or in the event of continued demand at the level seen.

The health board provided HIW with their immediate actions on this issue, which will be published in the health board improvement plan.

4. Summary

All patients and relatives we spoke to stated unanimously that they were very happy with the care received at the A&E, once they were seen. However, many comments were made regarding the high numbers of patients in the A&E and the lengthy waiting times experienced by patients. We found that patients and members of the public were generally tolerant of having to wait for long periods of time, even when having to wait in an ambulance outside the A&E for room to become available for them to be seen within the department. For those patients experiencing long waits in ambulances, the environment of care is not ideal for the provision of the best patient experience or attention to fundamental aspects of care.

We observed a highly efficient staff team working under pressure. All staff provided care and interacted with patients using a sensitive and professional approach. Children and adults received care in the main department and while staff were sensitive to the needs of children, the environment was not always appropriate for children to experience.

In the A&E, we observed patients being spoken to by friendly, polite staff. We also noted a number of nursing staff conversing in Welsh with patients. We found that some patients were confused and unsure about the progress of their treatment and did not seem to know the most up-to-date status regarding their plan of care.

We saw patients being treated with kindness and respect by staff. Those patients spoken to were also very complimentary about the manner in which they were treated by staff. We found that due to the extremely high numbers of patients within the department on the days of inspection, and long waits for hospital beds to become available for admission, patient dignity and privacy was difficult to maintain and may have been compromised in a department which is not set up for long patient stays.

As the department is not intended for lengthy stays, many patients were in the early stages of treatment and stabilisation. We did not see patient independence being actively promoted or prioritised in the A&E but we also noted that the design of the department offered limited opportunities for active promotion of patient independence. However, longer stays in the department mean that promoting independence must still be considered.

Many patients presented at the department with relatives/carers and we saw staff encourage the presence of these individuals.

The department was exceptionally busy, noisy and at times, chaotic. Overall, it is not an environment which is conducive to being able to rest or sleep.

Within the A&E, nursing staff were working at close proximity to the patients in their care and we noted that they were completing patient records as soon as possible after providing care or when a patient's condition changed. We saw pain scores in use to monitor levels of pain and we saw these being responded to and appropriate interventions being given to reduce pain.

There were a number of patients waiting in the back of ambulances for space within the department to become available. Their comfort and pain may have been severely compromised by a long wait on trolleys which are inappropriate for lengthy use.

We found that nursing staff in the A&E were trying to support with personal hygiene needs as best as they could. However, the team were extremely busy and pressurised. Patients did not have access to bathroom facilities and the department did not have stocks of some basic hygiene equipment. As a result, the department was not delivering high standards of care in this respect.

We examined records and spent time observing in the A&E and despite the highly pressured and busy department; we saw staff helping patients to the toilet promptly when they were asked. We also noted that the two toilets and commodes appeared clean.

We did not see any evidence of oral health care being provided in the A&E. We also noted that staff did not have access to a stock of toothbrushes or oral swabs for providing mouth care to patients who might need it. The A&E nursing documentation does not routinely include oral health assessments.

Due to the pressure in the A&E on the days of inspection, we found that pressure area care was seriously compromised. The A&E is not equipped with pressure relieving equipment as standard. Pressure area care for patients waiting in the back of ambulances for admission is seriously compromised.

We learned that the department has had to adapt to the increasing lengths of time patients spend in the A&E before admission to wards and therefore a food trolley is now brought down to the department each mealtime to serve patient meals. Patients waiting in the back of ambulances are offered snacks by the paramedics providing their care.

We saw a unit that was managing high volumes of patients requiring treatment on the days we were present. We saw that the physical and environmental resources were not sufficient to manage the intensity of the work. As a result, delivery of the fundamentals of care was compromised and a number of

patients were waiting in ambulances for long lengths of time on inappropriate trolleys, intended for transfer only and with reduced access to food, drink and toilets.

This report has highlighted many negative findings and challenges faced by the A&E staff relating to the way in which the fundamentals of care are delivered in the A&E. However, we saw a team of staff who were excellent at prioritising patients' clinical needs and emergency/urgent care needs. We saw that when patients needed urgent care they consistently received it promptly, including those patients arriving in ambulances. In using their skills and abilities of clinical prioritisation, the staff team were excellent at ensuring patients received urgent care when their condition was most unstable. For those patients who had a more stable condition, yet required to be seen by and doctor or nurse, delays were experienced due to the total volume of patients in the department and a team of very busy staff.

5. Findings

Quality of the Patient Experience

All patients and relatives we spoke to stated unanimously that they were very happy with the care received at the A&E once they were seen. However, many comments were made regarding the high numbers of patients in the A&E and the lengthy waiting times experienced by patients. We found that patients and members of the public were generally tolerant of having to wait for long periods of time, even when having to wait in an ambulance outside the A&E for room to become available for them to be seen within the department. For those patients experiencing long waits in ambulances, the environment of care is not ideal for the provision of the best patient experience or attention to fundamental aspects of care.

We observed a highly efficient staff team working under pressure. All staff provided care and interacted with patients using a sensitive and professional approach. Children and adults received care in the main department and while staff were sensitive to the needs of children, the environment was not always appropriate for children to experience.

Emergency department findings

During this inspection we spoke informally to a number of patients and relatives in A&E who were being treated and awaiting admission to ward areas. We were also able to speak informally to a number of patients waiting in the main waiting area prior to being seen by a nurse practitioner or a doctor to have their condition assessed and treated.

All patients and relatives we spoke to stated unanimously that they were very happy with the care received at the department, once they were seen. Many comments were made regarding the high numbers of patients in the department and the lengthy waiting times. Patients did not speak critically about the long waiting times, seeming instead to be resigned to them and accepting that they would be unlikely to be seen quickly and unlikely to be moved quickly to wards in the hospital (if this were to be the case).

We noted that there was a separate, dedicated emergency facility for children with its own waiting room and treatment areas. We were able to look around this area, although at present it is not in use due to staffing issues. The nurse in charge informed us that the health board is in the process of recruiting further registered children's nurses so that this area can be fully opened for use. We

noted this was an attractive area; it was light with bright paintings and child appropriate toys, furniture and wall décor. Once this facility is open, it will offer an improvement in comfort and enhanced privacy and dignity for children. However, at present, there is very little to occupy children who must wait with all other A&E attendees. We were made aware of a situation whereby a young child was waiting until late into the night whilst patients under the influence of alcohol were also waiting to be seen. It is important that within a busy A&E, all staff recognise the importance of maintaining the safety and comfort of children in an appropriate environment. The main waiting area and treatment area as currently set up do not provide a suitable environment for children.

The department works to a policy whereby it prioritises the assessment of children to understand the severity of their illness leading to earlier treatment where required. Staff provided HIW with an awareness of their knowledge of child safeguarding, although the release of staff for training has been problematic to achieve full training for all staff.

Recommendation

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

To further improve the experience for children and their family at the time of critical emergency treatment, a fully dedicated paediatric resuscitation area or room would enable the staff to provide care in a more sensitive and dignified environment, which would provide more privacy for the child and their family. For children attending with severe critical illness, there is a resuscitation bay set up with paediatric equipment. The resuscitation bay area can be screened off with curtains, however, screening off is not soundproof and it is not a solely dedicated bay because it has a dual use for adult care when not required for children.

Recommendation

The health board is also advised to consider how the main waiting area can be improved for the comfort of all patients waiting long periods of time.

Delivery of the Fundamentals of Care

Communication and information

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

In the A&E, we observed patients being spoken to by friendly, polite staff. We also noted a number of nursing staff conversing in Welsh with patients. We found that some patients were confused and unsure about the progress of their treatment and did not seem to know the most up-to-date status regarding their plan of care.

We spoke to a number of patients and they were all very happy with the care provided, once they were actually seen within the department. We were told by patients that they found staff friendly and thoughtful despite being extremely busy.

Staff made us aware that there were translation facilities available and they knew the process to follow should this be needed. There were a number of Welsh speaking nursing staff.

We noted that medical and nursing staff were completing records with real time updates of the care and treatment they were providing and any changes in patient condition. As a result, the documentation of treatment and care was very up-to-date.

More than one patient we spoke to in the A&E was confused about what they were waiting for and did not understand fully where they were in the process between admission to the A&E, treatment and either admission to a ward in the hospital or discharge home. This was also the case for some relatives/carers. We noted that all staff were extremely busy and spent as much time as possible with individual patients, however, sometimes there were long periods when they were busy dealing with other patients and unable to give updates on care to those patients waiting in between being seen and treatment. We observed only a minimum number of healthcare support workers whose roles were useful to support registered nursing staff in delivering the fundamentals of care, especially where older patients required time from staff to support individual care needs, including communication and information requirements. Older patients were waiting in the department for over two hours and for longer in the medical area because ward beds were not available for timely patient transfer.

Recommendation

The health board is advised to improve the staffing levels and skill mix needs of the A&E and ensure staffing is sufficient for delivering care in a highly pressured and busy department, catering for a wide range of patients with varied needs.

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 patients being treated with kindness and respect by staff. Those patients spoken to were also very complimentary about the manner in which they were treated by staff. We found that due to the extremely high numbers of patients within the department on the days of inspection, and long waits for hospital beds to become available for admission, patient dignity and privacy was difficult to maintain and may have been compromised in a department which is not set up for long patient stays. We found that patients seemed to be very tolerant of the very long waits delays for transfer into and out of the department.

We found an A&E working to capacity, with very little space and with a number of patients experiencing extreme waits before beds were becoming available on inpatient wards. The design of the A&E is not intended for lengthy patient stays and therefore the two patient toilets were not adequate for the number of patients in the department (17 beds across the major injuries unit and clinical decision unit, plus additional patients in the minor injuries unit). The location of the toilets also meant that patients may have to be taken through other parts of the department. We saw an instance where a patient was being wheeled to the toilet on a commode which was being used as a wheelchair. This is inappropriate use of equipment and not as dignified as a transfer by wheelchair.

Recommendation

The health board must consider how patient privacy and dignity and fundamental aspects of care are compromised when staying for a long time in the emergency department and take appropriate steps to rectify this.

We noted with concern that due to a lack of space in the department, patients were being required to wait for long periods in the back of ambulances outside.

We felt that this compromised patient dignity and privacy as access to toilet facilities was difficult.

Recommendation

The health board must consider how waiting a long time in the back of an ambulance negatively affects patient privacy and dignity. The Health Board should determine alternative and more appropriate ways of managing ambulance queues.

Promoting independence

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

The A&E is not a department intended for long patient stays and many patients there were in the early stages of treatment and stabilisation. We did not see patient independence being actively promoted or prioritised in the A&E, but we also noted that the design of the department offered limited opportunities for active promotion of patient independence. However, longer stays in the department mean that promoting independence must still be considered.

We saw staff actively in discussion with patients about their care in the minor injuries, major injuries and resuscitation areas. However, most of these discussions were in relation to immediate needs and did not relate to longer term planning. Some of the patients in the Clinical Decisions Unit (CDU) were receiving input from an intermediate care specialist, who was helping to plan for their discharge home including liaison with therapists and family/carers.

We were told that a senior member of nursing staff has been given some training in providing current best practice care to patients with dementia, however due to workload pressures we also learnt that there had not been the opportunity to teach other staff, nor to implement any of the principles of this training which included the use of the 'butterfly scheme'[2].

[2] The Butterfly Scheme allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

We mostly saw patients being nursed on trolleys. There were one or two full size beds with air mattresses for patients who required them and a small number of patients were sitting in chairs. There was limited choice for patients as the department areas are all small with little space in between each patient area/cubicle.

Recommendation

The health board must ensure that the escalation processes open to staff working in the A& E are being implemented responsively and sufficiently, to maintain the welfare of patients and staff working in the A&E.

The health board must ensure that the equipment available is appropriate for long stay needs. At present patients are being forced to wait long periods of time in an inappropriate space and staff do not have access to sufficient equipment designed for long stay needs.

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 encourage the presence of these individuals.

We saw that staff encouraged the presence of accompanying relatives/carers, respecting and appreciating the help they could give with keeping patients calm and at times helping staff to collect information about the issue(s) which had brought them to the A&E. Due to limited space at the bedside of each patient, we mostly saw only one or two visitors with each patient but did not note how A&E staff ensured that the numbers of visitors remained appropriate and safe.

There was a relatives' room which was adjoined discreetly to a viewing room, where deceased patients could be seen but with a private, dignified space nearby.

Within the main hospital corridors we found the volunteers very helpful. These volunteers provided signposting information to relatives/carers who were not familiar with the hospital site and how to find particular wards/departments.

Rest, sleep and activity

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

The department was exceptionally busy, noisy and at times, chaotic. Overall, it is not an environment which is conducive to being able to rest or sleep.

HIW saw many staff, patients, relatives/carers and paramedics in the department. There were patients at different points in their treatment and with different levels of need/input, all of which made for a noisy and at times, chaotic environment. Within the busy major injury unit, there were alarms and machines sounding constantly, which along with conversations made for a very noisy environment. Each patient bay/cubicle could be closed off with curtains which would provide some level of privacy for resting. Where patients are required to wait for lengthy periods on trolleys, HIW were concerned to note that the sheets used did not completely cover the mattresses, meaning patients could be resting for some time against the rubber material. The department agreed to address this and also agreed to investigate whether the sound from the monitors in the major injuries unit could be reduced.

Ensuring comfort, alleviating pain

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

Within the A&E, nursing staff were working at close proximity to the patients in their care and we noted that they were completing patient records as soon as possible after providing care, or when a patient's condition changed. We saw pain scores in use to monitor levels of pain and we saw these being responded to and appropriate interventions being given to reduce pain.

There were a number of patients waiting in the back of ambulances for space within the department to become available. Their comfort and pain may have been severely compromised by a long wait on trolleys, inappropriate for lengthy use.

As nursing staff were working closely with their patients, we saw that the needs of the patient within the A&E were being responded to quickly and without delay. The A&E nursing documentation encouraged regular checking and evaluation of patient pain levels and we noted this being done.

Over the course of the inspection, we noted a significant number of ambulances waiting in the car park for space to become available to bring patients into the department for treatment. Whilst patients were still inside an ambulance, paramedics were providing their care on narrow ambulance trolleys. These

trolleys are not designed for use over long periods and may have been seriously compromising and detrimental to patient comfort and pain levels.

Recommendation

The health board must consider its duty of care to all patients presenting to Wrexham Maelor hospital including those who are required to wait in ambulances for space in the department. The health board must also consider its wider duty of care to the community it serves. If patients in ambulances are triaged on arrival some could be treated, thus releasing ambulance crews back into the community to respond to other calls. The health board and the Welsh Ambulance Services NHS Trust (WAST) should work together on these developments and should continue to progress the work of the 'All Wales guidance on Ambulance Handovers'.

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 found that nursing staff in the A&E were trying to support with personal hygiene needs as best as they could. However, the team were extremely busy and pressurised. Patients did not have access to bathroom facilities and the department did not have stocks of some basic hygiene equipment. As a result, the department was not delivering high standards of care in this respect.

We noted patients being given wet, soapy wipes to clean their hands after using a commode by the bedside. Those patients we saw were either wearing their own clothes or hospital gowns.

For patients who had spent any length of time within the department and wanted to wash or freshen up, the only option for doing this would be at the bedside using a bowl of water, or in one of the two toilets at the hand basin. There were no toothbrushes, combs or denture pots seen in the stocks of equipment available to the nursing staff and there were no pre-packaged hand wipes seen. We noted that before a meal was served, patients had not been given any opportunity to wash their hands first. However, staff did not have easy access to wipes which could have enabled them to do this.

Recommendation

The health board must consider patient hygiene needs and ensure that there are adequate supplies of items such as hand wipes which would make it easier for staff to offer opportunities for patients to maintain their personal hygiene.

The staffing levels and skill mix of the staff in the department must also be considered so that registered nursing staff are able to focus on triage and patient assessment and be further supported in the provision of total patient care.

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 learned that the department has had to adapt to the increasing lengths of time patients now spend in the A&E, before admission to wards. Therefore, a food trolley is now brought down to the department each mealtime for serving patient meals. Patients waiting in the back of ambulances are offered snacks by the paramedics providing their care.

Patients told us that they were pleased to be offered hot meals within the A&E department, as they had not been expecting to have access to these in a department intended for short stays only. We were present during one evening mealtime and saw that there was a limited choice of hot meals or sandwiches offered to those patients within the department who were able to eat.

During our inspection we were very concerned to see that there were a number of patients waiting in the back of ambulances for admission to the A&E, some of whom were waiting for anywhere up to four hours. During this time, patients were being offered drinks, snacks and sandwiches by the paramedics who were working very hard to provide care and keep them comfortable in the confined space of an ambulance with poor access (or lack of access) to basic facilities such as toilets and food.

Recommendation

The health board must consider the implications for patients who currently wait in the back of ambulances over mealtimes and if this practice continues, must consider the foods which are currently available for the paramedics to offer them.

The health board must consider whether the staffing levels and skill mix of staff in the A&E is appropriate, so that there are staff available over

mealtimes to give assistance if patients need support with eating and drinking.

Oral health and hygiene

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

We did not see any evidence of oral healthcare being provided in the A&E. We also noted that staff did not have access to a stock of toothbrushes or oral swabs for providing mouth care to patients who might need it. The A&E nursing documentation does not routinely include oral health assessments.

During our inspection, we found that a number of patients had been waiting significant lengths of time for admission to wards (up to 20 hours) during which time we saw no documented evidence that any oral healthcare had been provided. We also noted that there were no toothbrushes, toothpaste or denture pots available for patient use.

Recommendation

The health board must ensure that the A&E has stocks of the basic equipment needed for staff to provide and support with oral hygiene. We found that patients are routinely staying for longer periods in the A&E and in the CDU are expected to stay anywhere up to 24 hours, therefore appropriate oral health assessments should be introduced.

Toilet needs

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

We examined records and spent time observing in the A&E and despite the highly pressured and busy department; we saw staff helping patients to the toilet promptly when they were asked. We also noted that the two toilets and commodes appeared clean.

The facilities in the A&E are limited. There are only two toilets for patient use in addition to commodes at the bedside. 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.

Recommendation

If patients are to continue waiting for long periods in the A&E before inpatient admission, the health board must consider how they can appropriately ensure that more comprehensive nursing assessments are commenced in a timely manner. The skill mix of staff in the A&E should form part of this consideration, in addition to considering which team of staff should most appropriately carry out any in-depth assessments that are deemed necessary – it may not be the A&E nursing staff who are best placed to provide this additional work.

Preventing pressure sores

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

Due to the pressure in the A&E on the days of inspection, we found that pressure area care was seriously compromised. The A&E is not equipped with pressure relieving equipment as standard. Pressure area care for patients waiting in the back of ambulances for admission is seriously compromised.

A number of patients in the A&E had been waiting long lengths of time for admission to wards. 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. For those patients not assessed as needing proper beds, or where staff had not yet been able to assess their need in this area, they were being nursed on smaller A&E trolleys with no pillows and with a bottom sheet which did not cover up the rubber of the mattresses.

A&E staff and paramedics alike told us that patients waiting significant lengths of time in the back of ambulances before being admitted to the department is common at Wrexham Maelor. We have serious concerns about the negative effect that waiting on ambulance trolleys could have on tissue viability as these trolleys are narrow and have thin, hard mattresses.

Recommendation

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 the A&E staff are supported with additional resources (potentially additional staff) at

times when they need to swap trolleys and beds and source pressure relieving equipment.

The health board must consider the current practice of not allowing ambulances to off-load patients and if this is to continue, must work with the Welsh Ambulance Service NHS Trust to find appropriate solutions to address the negative impact on patients that this is currently having.

Quality of Staffing, Management and Leadership

We saw a unit that was managing high volumes of patients requiring treatment on the days we were present. We saw that the physical and environmental resources were not sufficient to manage the intensity of the work. As a result, delivery of the fundamentals of care was compromised and a number of patients were waiting in ambulances for long lengths of time on inappropriate trolleys, intended for transfer only, and with reduced access to food, drink and toilets.

During the inspection, we were well supported by the site management team who agreeably met with us to provide a picture of the management structure within the directorate and also at hospital site management level. We were provided with information about how the directorate team monitors and supports quality across the directorate. We also observed the site management team actively co-ordinating the hospital and supporting ward and departmental staff in their day–to-day work. The site management team was visible and involved across the hospital site. This was recognised by staff who told us they could access senior managers and felt supported at ward level.

We found that there were a number of band six and seven senior nursing staff employed to work in the A&E, which is positive as these grades indicate clinically confident, experienced staff.

The A&E reached crisis point early on in the morning of the first shift we observed (30 September), and we noted that the shift leader needed to escalate the situation to more senior management from outside the department. Once it was escalated, a number of additional senior staff came immediately to provide support within the department and also some were deployed to elsewhere in the hospital to provide support with discharges so that inpatient beds could be made available. This additional help was in place for a short amount of time after which these staff had to return to their other work, leaving the staff within the department to continue managing the immediate work, under extreme pressure.

After some time of the department operating at this extreme level, a decision was taken by senior management to ask for further assistance from other surrounding hospital A&Es. Once this happened, we noted that the workload of staff began to improve and the number of ambulances waiting outside reduced for a period of time.

Recommendations

The health board should consider using additional staff at lower grades who could provide invaluable support and contribution to the delivery of care provided in the department.

The health board must consider when to enact their escalation procedures and whether providing very short term additional staff is sufficient on shifts where the workload is as high as we observed.

There should be consideration to providing additional staff for entire shifts and the health board also must consider the point at which they ask for assistance from other nearby hospitals.

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.

This report has highlighted many negative findings and challenges faced by the A&E staff relating to the way in which the fundamentals of care are delivered in the A&E. However, we saw a team of staff who were excellent at prioritising patients' clinical need and emergency/urgent care needs. We saw that when patients needed urgent care, they consistently received it promptly, including those patients arriving in ambulances. In using their skills and abilities of clinical prioritisation, the staff team were excellent at ensuring patients received urgent care when their condition was most unstable. For those patients who had a more stable condition, yet required to be seen by and doctor or nurse, delays were experienced due to the total volume of patients in the department and a team of very busy staff.

Effective patient pathways

We saw, and staff described to us, how the A&E department manages patient pathways in accordance with clinical effectiveness for stroke, fractured neck of femur and acute coronary syndrome. We saw evidence of the stroke pathway being effectively provided to patients. However, we could see a potential risk in relation to busy periods in the department when a major injury trolley bed is not available for stroke care. Staff were able to use other areas in the department, such as a free resuscitation trolley bay, to provide an assessment area and manage the stroke pathway. This would not have been possible however, had the resuscitation area been in use at the time of arrival of a patient requiring urgent stroke assessment and swift management of patients would be compromised.

Paramedics described to us and gave examples of patients waiting in ambulances with a potential cardiac condition. We observed some patients with chest pain waiting in ambulances, however they were stable and pain free at the time and well observed and cared for by paramedics. For patients who experience chest pain and/or became less stable, the paramedics were able to escalate changes in the condition of patients waiting outside in ambulances and gain an immediate transfer into the department. This is not ideal as patients should not be waiting outside the A&E department within ambulances. Arrival at the A&E department should achieve an immediate handover and timely medical and nursing clinical assessment being provided within the department.

We did not see any formal pathways for direct ambulance transfer into the appropriate hospital department for acute medicine, surgical assessment, or for children. At times when the A&E is working under extreme pressure, direct senior specialist medical/surgical assessment and paediatric assessment, with early direct transfer to the appropriate specialist unit within the hospital, would benefit patients and reduce extreme pressures in the A&E department.

We noted that there were delays in the department for the transfer of older people who had been admitted with a fractured hip. The care of these patients would be improved with timely transfer to the orthopaedic ward to enable timely surgery for the condition. We were not aware of any theatre delays for this group of patients. However, there were delays within the department where ward based routines for pressure area care, pain relief and other aspects of focused orthopaedic care are not possible for the A&E staff to consistently provide.

We saw a team at work who were excellent at clinical prioritisation and all patients with urgent need were seen and treated promptly. In order to do this, the staff were keeping a small amount of space in the department constantly free so that they could still manage and treat any urgent ambulance arrivals or deterioration of patients already in the department.

We saw medical and nursing staff working very closely together to ensure that all areas were remaining as safely staffed as possible. We saw that at times this was very challenging for the shift team leader to manage. For example, there were a number of acutely ill admissions in quick succession and staff resources were moved around the department to focus enough staff in the resuscitation bays. There were two areas where hand soap and hand sanitising gel had run out and not replaced. We were told that this was the responsibility of domestic staff to replace, however the A&E do not have domestic staff on duty at all times.

Recommendation

The A&E department would benefit from formalised care pathways for pre-arrival triage and direct admission to specialist areas within the hospital for patients requiring early specialist medical assessment for acute medical and surgical conditions and for children. The health board should ensure that the Welsh Ambulance Services NHS Trust (WAST) are involved in developing any direct referral care pathways.

Record keeping

We saw staff writing real time updates in patient records, these were detailed but also concise and easy to understand. The department documentation is

mainly written for short stay assessments and for documenting the care given to stabilise and treat immediate needs. However, on the days of inspection and what HIW was told is on a frequent basis, patients are spending long periods of time waiting for inpatient beds in the A&E. This means that important nursing assessments of longer term needs are being delayed as the A&E staff do not have the time to implement these in addition to providing immediate and urgent care.

Recommendation

The health board must review the staff resource available for the A&E so that patient assessments and the subsequent implementation of important nursing care is not delayed to the detriment of their patients.

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 Accident and Emergency Department at Wrexham Maelor 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.

Appendix A

Dignity and Essential Care: Improvement Plan

Hospital: Wrexham Maelor

Ward/ Department: Accident and Emergency Department

Date of Inspection: 30 September and 1 October 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	Quality of the Patient Experience			
Page 9	For paediatric patients, children and young people attending the department, the health board needs to consider whether the main waiting area is appropriate and make improvements to a designated area for children in order to safeguard the needs of children and improve their comfort, privacy and dignity.			
Page 9	The health board is also advised to consider how the main waiting area can be improved for the comfort of all patients waiting long			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	periods of time.			
	Delivery of the Fundamentals of Care			
Page 11	The health board is advised to improve the staffing levels and skill mix needs of the A&E and ensure staffing is sufficient for delivering care in a highly pressured and busy department catering, for a wide range of patients with varied needs.			
Page 11	The health board must consider how patient privacy and dignity and fundamental aspects of care are compromised when staying for a long time in the emergency department and take appropriate steps to rectify this.			
Page 12	***The health board must consider how waiting a long time in the back of an ambulance negatively affects patient privacy and dignity. The Health Board should determine alternative and more appropriate ways of managing ambulance queues.***			
Page 13	The health board must ensure that the			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	escalation processes open to staff working in the A& E are being implemented responsively and sufficiently, to maintain the welfare of patients and staff working in the A&E.			
Page 13	The health board must ensure that the equipment available is appropriate for long stay needs. At present patients are being forced to wait long periods of time in an inappropriate space and staff do not have access to sufficient equipment designed for long stay needs.			
Page 15	***The health board must consider its duty of care to all patients presenting to Wrexham Maelor hospital including those who are required to wait in ambulances for space in the department. The health board must also consider its wider duty of care to the community it serves. If patients in ambulances are triaged on arrival some could be treated, thus releasing ambulance crews back into the community to respond to other calls. The health board and the Welsh Ambulance Services NHS Trust (WAST) should work***			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	together on these developments and should continue to progress the work of the 'All Wales guidance on Ambulance Handovers'.			
Page 15	The health board must consider patient hygiene needs and ensure that there are adequate supplies of items such as hand wipes which would make it easier for staff to offer opportunities for patients to maintain their personal hygiene.			
Page 15	The staffing levels and skill mix of the staff in the department must also be considered so that registered nursing staff are able to focus on triage and patient assessment and be further supported in the provision of total patient care.			
Page 16	The health board must consider the implications for patients who currently wait in the back of ambulances over mealtimes and if this practice continues must consider the foods which are currently available for the paramedics to offer them.			
Page 16	The health board must consider whether the			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	staffing levels and skill mix of staff in the A&E is appropriate so that there are staff available over mealtimes to give assistance if patients need support with eating and drinking.			
Page 17	The health board must ensure that the A&E has stocks of the basic equipment needed for staff to provide and support with oral hygiene. We found that patients are routinely staying for longer periods in the A&E and in the CDU are expected to stay anywhere up to 24 hours, therefore appropriate oral health assessments should be introduced.			
Page 17	If patients are to continue waiting for long periods in the A&E before inpatient admission, the health board must consider how they can appropriately ensure that more comprehensive nursing assessments are commenced in a timely manner. The skill mix of staff in the A&E should form part of this consideration, in addition to considering which team of staff should most appropriately carry out any in-depth assessments that are deemed necessary – it may not be the A&E nursing staff who are best placed to provide this additional work.			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
Page 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 the A&E staff are supported with additional resources (potentially additional staff) at times when they need to swap trolleys and beds and source pressure relieving equipment.			
Page 18	The health board must consider the current practice of not allowing ambulances to offload patients and if this is to continue must work with the Welsh Ambulance Service NHS Trust to find appropriate solutions to address the negative impact on patients that this is currently having.			
	Quality of Staffing Management and Leadership			
Page 20	The health board should consider using additional staff at lower grades who could provide invaluable support and contribution to the delivery of care provided in the department.			
Page 01	The health board must consider when to enact their escalation procedures and			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	whether providing very short term additional staff is sufficient on shifts where the workload is as high as we observed.			
Page 20	There should be consideration to providing additional staff for entire shifts and the health board also must consider the point at which they ask for assistance from other nearby hospitals.			
	Delivery of a Safe and Effective Service			
Page 23	***The A&E department would benefit from formalised care pathways for pre-arrival triage and direct admission to specialist areas within the hospital for patients requiring early specialist medical assessment for acute medical and surgical conditions and for children. The health board should ensure that the Welsh Ambulance Services NHS Trust (WAST) are involved in developing any direct referral care pathways.***			
Page 24	The health board must review the staff resource available for the A&E so that patient			

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	assessments and the subsequent implementation of important nursing care is not delayed to the detriment of their patients.			

Health Board Representative:

Name (print): .....

Title: .....

Signature: .....

Date: .....