Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff and Vale University Health Board

Inspection date: 20, 21 and 22 June 2022

Publication date: 30 September 2022

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

Digital ISBN 978-1-80364-884-2

We found that improvements to the environment where needed to promote the privacy and dignity of patients being seen in both the Emergency Unit and the Assessment Unit.

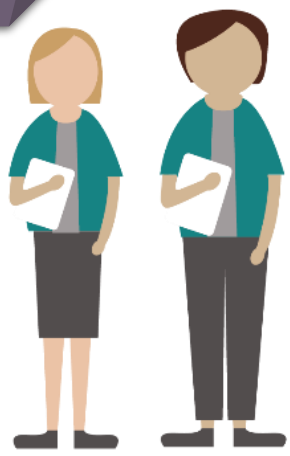
Patients told us they had been provided with enough information about their care. However, further efforts should be made to promote the use of the Welsh language and to make information available on how patients may provide feedback.

We were not assured that effective systems were in place to promote aspects of safe and effective care. We required the health board to provide HIW with immediate assurance on the action taken to prevent infections, to safely store medicines and to check emergency equipment.

We confirmed a suitable management structure was in place and senior staff described initiatives to improve the service provided to patients. We saw audits were being conducted to identify areas for improvement. However, given our findings the health board needs to ensure these audits are effective.

Responses from staff working in both units were generally negative with issues being raised around the environment, lack of equipment, inadequate staffing levels and skill mix, and a poor relationship with senior management.

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



What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at the University Hospital of Wales on 20, 21 and 22 June 2022.

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

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

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

Quality of Patient Experience

Overall Summary

The majority of patients told us that staff had treated them with respect and had taken measures to protect their privacy when being seen in the Emergency Unit or the Assessment Unit.

Generally, patients agreed that staff provided them with enough information to help them understand their health care and their medical conditions.

We found that the environment of both the Emergency Unit and the Assessment Unit impacted negatively on the privacy and dignity of patients. Comments from staff also indicated they felt the environment needed to be improved to promote dignified care for patients.

While a suitable pain assessment tool was available to assess and record patients' pain, this was not well completed by staff.

Generally the Welsh language was not well promoted within the Emergency Unit nor the Assessment Unit.

While information on 'Putting Things Right' was available, this was not prominently displayed in either the Emergency Unit or the Assessment Unit.

Where the service could improve

- The health board needs to take action to promote the privacy and dignity and comfort of patients
- The health board needs to make further efforts to promote the use of the Welsh language
- The health board needs to make further efforts to make available information on 'Putting Things Right'.

Patients told us:

"They do an excellent job."

"All been fine only been in 2 hours."

"Would like to thank staff."

Delivery of Safe and Effective Care

Overall Summary

We found the physical environment of both the Emergency Unit and the Assessment Unit was poorly maintained and cluttered.

In the Emergency Unit, patient records generally showed that nursing staff had assessed patients for their risk of developing pressure ulcers and provided skin care. In the Assessment Unit, records also showed that nursing staff had assessed patients for their risk, however, there was no evidence of care planning or implementation of SKIN bundles to prevent patients developing pressure ulcers.

In both the Emergency Unit and the Assessment Unit we were not assured effective processes were in place or being followed to prevent healthcare acquired infections. In addition, we were not assured that medicines were being stored safely or that checks of emergency equipment were regularly conducted to identify missing items required in the event of an emergency.

Staff told us that facilities in both units were inadequate and generally they did not have easy access to the equipment they needed.

Senior staff described a number of initiatives were ongoing to develop and improve the service to patients. We were told that feedback from patients using the 'Virtual Ward' service has been very positive.

What we found this service did well

- Initiatives were described to improve the service to patients

- Vulnerability and violence nurses were employed and were an integral part of the safeguarding team
- Two hourly safety 'huddles' were held to share relevant information about the operation of the units.

Where the service could improve

Immediate assurances:
The health board was required to provide us with details of the action taken to:

- promote effective infection prevention and control and decontamination
- ensure medicines are managed safely
- ensure the contents of the resuscitation trolleys are regularly checked and an accurate record of these checks is maintained
- provide assurance that care being provided is meeting the needs of patients.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board needs to take action to ensure the environment is maintained to a sufficient standard
- The health board need to take action to respond to and address the less favourable staff comments in relation to facilities in both units and access to equipment.

Quality of Management and Leadership

Overall Summary

A suitable management structure was in place and senior staff described clear lines of reporting.

We found relevant audits were being conducted, however, given our findings from this inspection, we were not assured of the effectiveness of the audit activity and follow up processes used.

Responses from staff working in both the Emergency Unit and the Assessment Unit were generally negative with issues being raised around the environment, lack of equipment, inadequate staffing levels and skill mix, and a poor relationship with senior management.

Where the service could improve

Immediate assurances:
The health board was required to provide us with details of the action taken to:

- improve compliance with mandatory resuscitation training.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board needs to seek assurance that audit activity and follow up processes are effective
- The health board needs to take action to respond to and address the less favourable staff comments highlighted within the Quality of Management and Leadership section of this report
- The health board needs to take action to improve compliance with other mandatory training.

Staff told us:

"It's not fit for purpose, not enough space, although attempts are being made to make it better, there's still too many patients for the space."

"Inadequate built environment for delivering safe, dignified paediatric emergency care."

"Nursing staffing levels are extremely stretched and this impacts on the skill mix on each shift, teaching has been limited so maintaining and improving skills and knowledge for new and existing staff has been affected. Sickness levels and then moving staff from their roles … to fill gaps is having a significant effect on morale."

"The hospital is unfit for purpose. We need a new hospital, more staff, nursing and medical. We have a long way to go."

"Look at waiting times in chairs. Patients left sitting in chairs for 70hrs + when they are unwell."

"Provide shower facilities… patients on unit for days with nowhere to shower."

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

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

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