Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Minor Injury Unit (MIU), Prince Philip Hospital, Hywel Dda University Health Board

Inspection date: 26, 27 and 28 June 2023

Publication date: 28 September 2023

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

Digital ISBN 978-1-83504-773-6

Patients who attended the Minor Injury Unit (MIU) for assessment, care and treatment of minor injuries were provided with a timely and overall positive experience. Patients told us that they were happy with the care and advice they received from staff.

Patients accommodated for longer periods however on the MIU in medical / surgical 'surge' beds, due to a lack of bed capacity on site or at another acute hospital, received and reported a less positive experience due to a lack of facilities, which negatively impacted upon patient dignity.

We were assured that patients presenting with minor injuries received a good level of safe and effective care from a skilled workforce. We were however not assured that longer stay patients accommodated on the unit in surge capacity beds received timely care when awaiting a bed within the wider hospital or when awaiting transfer out to another acute hospital site. This included patients who required an emergency transfer due to their acuity or deteriorating nature.

We also identified a breadth of additional areas for improvement to ensure that this patient group received safe and effective care according to their clinical needs.

Overall, we found the issues identified applied inappropriate pressures to the functionality of the MIU as a minor injury service. The staff and unit were not fully supported or equipped in light of these pressures to safely and effectively manage all presentations and patients accommodated on the unit.

HIW acknowledges the significant pressures on front door services and, at the time of the inspection, this service was under immense pressure from multiple sources.

Some of the improvements identified in this report extend beyond control of the unit and of the health board. This requires high level discussions with partners to ensure patients receive timely care, in the right clinical environment for their needs. As a result, some of the actions provided within the immediate improvement plan have a longer time scale for completion than usually expected.

The health board must continue to ensure its service provision ensures patients are cared for in the right environment and at the right time. HIW will monitor progress against the actions provided in the improvement plan.

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 of the Minor Injury Unit (MIU) at Prince Philip Hospital, Hywel Dda University Health Board on the evening of the 26 and two full days on the 27 and 28 June 2023.

We did not inspect the Acute Medical Assessment Unit or Same Day Emergency Care (SDEC) Unit. However, we did complete a walkaround of these areas and speak to some staff to establish the 'front door' service arrangements at Prince Philip Hospital.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 8 questionnaires were completed by patients or their carers and 39 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

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

Quality of Patient Experience

Overall Summary

Patients attending the Minor Injury Unit (MIU) for assessment, care and treatment of minor injuries were provided with a timely and overall positive experience. Patients told us that they were happy with the care and advice they received from staff.

Patients accommodated for longer periods however on the MIU in medical / surgical 'surge' beds, due to a lack of bed capacity on site or at another acute hospital, received and reported a less positive experience due to a lack of facilities impacting the dignity and timely care.

Where the service could improve

- There was a lack of toilet and hygiene facilities on the unit for surge patients who are admitted beyond the length of stay associated with an MIU

What we found this service did well

- We found that staff treated patients with kindness, dignity and respect at all times throughout the inspection and all patients who completed a HIW questionnaire told us they had been treated by staff with dignity and respect
- We found that patients arriving with minor injuries to the unit were overall seen and treated in a timely manner
- Minor injury patients told us that staff provided explanations about their care and treatment and were well informed about their next steps of care.

Patients told us:

"All very good"

"Toilet out of order - I had to leave the unit"

Delivery of Safe and Effective Care

Overall Summary

We were assured that patients presenting with minor injuries received a good level of safe and effective care from a skilled workforce. We were however not assured that longer stay patients accommodated on the unit in surge capacity beds received a timely, effective, and consistent level of care.

Overall, we found the issues identified applied inappropriate pressures to the functionality of the MIU as a minor injury service. The staff and unit were not fully supported or equipped in light of these pressures to safely and effectively manage all presentations and patients accommodated on the unit.

Where the service could improve

- The environment was not appropriate for mental health, medical or surgical surge patients who are admitted beyond the lengths of stay associated with an MIU
- We were not assured that there were robust care assessment and planning arrangements in place for medical and surgical 'surge' patients
- We could not be assured that medical and surgical 'surge' patients received timely care when awaiting a medical bed within the hospital or when awaiting transfer out to another acute site
- We could not be assured that there was sufficient and robust support for Emergency Nurse Practitioners at times when there is an unexpected lack of medical cover on the Unit

What we found this service did well

- Care assessment and planning in relation to minor injury patient was completed to a good standard
- Minor injury patients, once seen and treated, had appropriate safety netting in place, which included clear advice on how to manage their condition and what to do in the event of further concern
- Staff we spoke with were knowledgeable and were able to describe aspects of infection, prevention and control (IPC) relevant to their roles and responsibilities
- Learning in relation to controlled drugs incidents had been identified and implemented on the unit.

Quality of Management and Leadership

Overall Summary

We identified aspects of good nursing and medical management on the unit and staff spoke positively of the support they provide to each other on the unit.

Staff however expressed significant dissatisfaction in a number of areas. The health board must ensure that robust and sustained action is taken in response this.

Where the service could improve

- The health board must review this staff feedback in the context of these findings. It must continue to provide a platform to listen to staff and must take robust and sustained actions where appropriate
- The health board must identify and implement clinical skills, learning and development needs of its workforce in line with the current operation of the unit
- The health board must consider its approach to community engagement and communication at a corporate level regarding the 'front door' services available at Prince Philip Hospital and accessing the right service according to need.

What we found this service did well

- Staff spoke positively of the support they provided to each other on the unit
- Falls and pressure damage incidents were reviewed at well documented scrutiny panels, with learning identified and disseminated
- A number of compliments had been received by the service and concerns were managed according to the relevant processes, including duty of candour cases.

Staff told us:

"…There is clearly a lack of unity in the department due to role boundaries and conflicts. Staff are working within multiple roles per shift and a reduced amount of time is given to their designated role. This compromises patient care and safety…"

"We are classed as a Minor Injuries Unit but operate as something that is somewhere between being an MIU/AMAU/A&E. Therefore we can lack in confidence in some instances due to intermittent exposure. We need to be one thing."

"This is in all but name an A&E department. Staffed by nurses and GPs. We deal with A&E patients and seriously unwell Mental Health patients in an unsuitable and unsafe department."

"I suggest the unit becomes multi-professional with a skilled workforce of Paramedics/paediatric nurses/Physiotherapists/Podiatrists/mental health practitioners to name a few. This will engage staff and promote a positive learning environment to deliver quality, safe and effective care."

"The positive about our unit is that we have a very good team of staff that work very hard to cover shift deficits, and to support each other."

Other themes identified within the staff feedback included:

- The operation of the Minor Injury Unit akin to an Emergency Department rather than an MIU due to its 'no turn away' or redirection protocols
- Caring for high acuity of patients and the risk this presents due to either inappropriate attendance or a lack of timely transfer out to another acute site
- A lack of public awareness and engagement within the local community of the services provided at Prince Philip and the MIU

- A lack of privacy, dignity and timely care for patients in medical / surgical surge beds
- Poor staffing skill mix when expected to care for non minor injury patients and being expected to work outside of scope of practice
- Poor engagement and support from senior management and leadership in acting upon concerns

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.