Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Department, Ysbyty Gwynedd, Betsi Cadwaladr University Health Board

Inspection date: 7-9 August 2023

Publication date: 9 November 2023

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

Digital ISBN 978-1-83577-068-9

We found that patients were provided with a generally safe level of care. This was however negatively impact upon by the number of patients presenting to the department and the impact of poor flow out of the ED to the wider hospital site. This created significant pressures on staff to provide care to a large number of patients and in surge areas of the department which were not wholly suitable for patient's needs.

We made a number of recommendations in areas such as workforce, patient oversight and the observation and care of some highly vulnerable patient groups. Aspects of nursing assessment and monitoring were completed to a good standard but must be overall strengthened in a number of areas.

Patients told us that they were satisfied with aspects of their experience, such as receiving kind and respectful care from staff and the ability to communicate in their preferred language. There were however less positive comments provided by patients in relation to the lengths of time experienced at certain parts of their journey through the department.

There were also limitations on the ability of staff and the service to provide wholly dignified care and treatment due to the use of surge areas, including patients sat in corridors or chairs overnight. Despite this, staff worked hard to provide a comfortable experience as far as possible.

We found aspects of strong and cohesive management and leadership at all levels of the department. Management appeared to work cohesively in an appropriate structure and staff reported visible local ED management when there is heightened demand on the department. There were however less positive comments provided by staff in a number of areas and the health board must reflect and take robust actions in response to this.

An area of feedback highlighted as a positive by staff was the training and education provision found within the department and we identified a strong focus from the clinical lead on wellbeing initiatives for training and junior medical staff

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 Emergency Department at Ysbyty Gwynedd, Betsi Cadwaladr University Health Board on 7-9 August 2023.

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 12 questionnaires were completed by patients or their carers and 59 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 Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

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

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

Quality of Patient Experience

Overall Summary

Patients told us that they were satisfied with aspects of their experience, such as receiving kind and respectful care from staff and the ability to communicate in their preferred language. There were however less positive comments provided by patients in relation to the lengths of time experienced at certain parts of their journey through the department.

There were also limitations on the ability of staff and the service to provide wholly dignified care and treatment due to the use of surge areas, including patients sat in corridors or chairs overnight. Despite this, staff worked hard to provide a comfortable experience as far as possible.

Where the service could improve

- Ongoing and effective actions must be taken to ensure that access to specialties, and where required, the onward transfer of patients to tertiary care centres is met in a timely manner
- The viewing room must be able to be accessed in a timely manner and storage of equipment in this area should be avoided
- There must be strengthened engagement amongst all staff groups with training opportunities available to ensure that the care and treatment needs of learning disability patients are met.

What we found this service did well

- All patients told us that staff treated them with dignity and respect
- We observed staff speaking with patients in a kind and respectful manner, including asking them their preferred language choice.

Patients told us:

"Great service overall - thank you NHS"

"All aspects of my visit to hospital and my treatment was very good and delivered to a high standard"

"Quite a long wait between triage chat in A&E before nurses did any observations - they seemed surprised triage hadn't done anything other

Delivery of Safe and Effective Care

Overall Summary

We found that patients were provided with a generally safe level of care. However, this was negatively impacted upon by the number of patients presenting to the department and the impact of poor flow out of the ED to the wider hospital site. This created significant pressures on staff to provide care to a large number of patients and in surge areas of the department which were not wholly suitable for patient's needs.

Despite this, we found a visibly clean and well maintained department and unwell patients were identified and escalated appropriately. It was also positive to note that there was a good emphasis on clinical audit and quality improvement to improve patient outcomes, despite the time and attention required to tackle these pressures.

We have however made a number of recommendations in areas such as workforce, patient oversight and the observation and care of some highly vulnerable patient groups. Aspects of nursing assessment and monitoring were completed to a good standard but must be overall strengthened in a number of areas.

Where the service could improve

- 1-1 observations of patients must be maintained when it has been risk assessed as necessary
- Security arrangements must be strengthened in relation to the mental health assessment room and its location / proximity to open exits
- The ED nurse staffing establishment must be reviewed in the context of the current system pressures
- There must be strengthened oversight of all areas of the department, particularly at times of increased demand on the service, ensuring there are sufficient staff to meet this.

What we found this service did well

- The department was visibly clean and well maintained
- There were a number of clinical audit and quality improvement initiatives underway to improve patient pathways and outcomes
- Unwell or deteriorating patients were identified, escalated and treated appropriately.

Quality of Management and Leadership

Overall Summary

We found aspects of strong and cohesive management and leadership at all levels of the department. Management appeared to work cohesively in an appropriate structure and staff reported visible local ED management when there is heightened demand on the department. There were however less positive comments provided by staff in a number of areas and the health board must reflect and take robust actions in response to this.

An area of feedback highlighted as a positive by staff was the training and education provision found within the department and we identified a strong focus from the clinical lead on wellbeing initiatives for training and junior medical staff.

Where the service could improve

- The health board must reflect upon the staff feedback provided, continuing to provide a platform for staff to provide feedback, and take robust actions where required.

What we found this service did well

- Staff spoke positively of the support provided by the Emergency Department Matron and Clinical Lead
- We observed the nurse in charge of each shift during the inspection demonstrating sound clinical and operational decision making, with a good grip on all areas of the department
- There was a notable emphasis on clinical education and wellbeing for training and junior medical staff.

Staff told us:

"I take great pride in working in the ED, however the recent challenges with regards to patient flow and capacity in the department is making working here very difficult and stressful."

"This is a great ED to work in and very supportive. The only big improvement would be more rooms to see patients during day shifts."

Other themes identified within the staff feedback included:

- The lack of patient flow resulting in caring for patients and acutely unwell patients in inappropriate surge areas, e.g. chairs, and a lack of space to review and accommodate patients
- The need to utilise Same Day Emergency Care (SDEC) more effectively to alleviate ED pressures
- Acuity of the department and increasing pressures, including demands from management to prioritise ambulance offloads
- Enabling local ED staff to have better decision-making powers in relation to escalation, capacity and flow, including the communication and effectiveness of actions when concerns are escalated
- The need to review (nursing) off duty arrangements according to health board policy was noted by numerous staff as an issue affecting staff morale and wellbeing.

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.