Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital, Cwm Taf Morganwwg University Health Board

Inspection date: 31 July, 01 and 02 August 2023

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

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Feedback from patients and their carers was generally positive regarding the service they had received.

With the exception of the Ambulatory Care area, the other areas of the Emergency Unit and the Clinical Decisions Unit generally allowed staff to adequately protect the privacy and dignity of patients.

Challenges with maintaining patient flow through the hospital and the wider health and care system meant patients were waiting in the EU for longer periods than they should expect.

We found staff working extremely hard to provide patients with safe and effective care at a time when the hospital was at a heightened level of escalation due to service pressures.

We received positive staff feedback on the approach of managers and the impact they had on the culture within both the EU and the CDU. However, staff feedback on other elements of the service was mixed.

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 Prince Charles Hospital, Cwm Taf Morgannwg University Health Board on 31 July, 01 and 02 August 2023. The following areas were reviewed during this inspection:

- Emergency Unit (EU)
- Clinical Decisions Unit (CDU)

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

The feedback we received from patients and their carers indicated they were generally satisfied with their care and treatment, and the approach of the staff.

With the exception of the Ambulatory Care area, the other areas of the Emergency Unit (EU) and the Clinical Decisions Unit (CDU) generally allowed staff to adequately protect the privacy and dignity of patients. However, the washing and toilet facilities within the EU were inadequate for patients waiting in the unit for extended periods, especially overnight.

Challenges with maintaining patient flow through the hospital and the wider health and care system meant patients were waiting in the EU for longer periods they should expect.

Where the service could improve

- The health board must take suitable action to promote the privacy, dignity and comfort of patients within the Ambulatory Care area
- The health board must review the provision of washing and toilet facilities within the EU
- The health board must take suitable action to deliver the 'Active Offer'.

What we found this service did well

- We saw staff treating patients and their carers with respect and kindness
- QR codes were displayed in the Paediatrics area, which allowed patients or their carers to access a wide range of health information and advice
- We saw consideration had been given to environment of the CDU to help those patients with a cognitive impairment locate the washing and toilet facilities
- We found staff provided information to patients and their carers using plain language and this was especially evident in the Paediatrics area
- We saw significant efforts and been made to make the Paediatrics area suitable for young children through use of child friendly décor and the provision of toys.

Patients told us:

“The staff were very helpful, supportive and very professional! They were very busy but always had time for us in this hard situation.”

“Good experience. Lots of cups of tea.”

“Prefer not to spend night in an ambulance.”

“The department was busy but no one seemed in a rush to help.”

“Happy with service.”

“Arrived night before sent home, 5 hours wrong department. Hospital couldn't find paper work.”

Delivery of Safe and Effective Care

Overall Summary

We found staff working extremely hard to provide patients with safe and effective care at a time when the hospital was in a heightened level of escalation due to service pressures.

We identified areas for improvement in a number of areas. There were two areas where we required the health board to take immediate action.

Where the service could improve

Immediate assurances:

- We identified gaps in the records of checks conducted of emergency equipment stored on resuscitation trolleys within the EU and were not assured checks were being conducted to confirm the necessary equipment was available in the event of an emergency
- We identified poor compliance with mandatory resuscitation training on both the EU and the CDU and were not assured a sufficient number of staff had the required up to date skills to perform effective resuscitation

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

- The health board must take suitable action to complete risk assessments of the Mental Health Assessment rooms and the Triage rooms
- The health board must take suitable action to ensure risk assessments are completed in relation to patients in the EU developing pressure damage and in relation to patient falls
- The health board must take suitable actions to ensure patients in the Ambulatory Care area have an adequate means to summon assistance
- The health board must take suitable action to improve staff compliance with the health board's policy for hand washing to help reduce cross infection
- The health board must take suitable action to improve the meal provision in the EU
- The health board must take suitable action to ensure patients' clinical and care records are readily available to staff when required.

What we found this service did well

- The EU and the CDU were accessible to patients and visitors with mobility impairments

- The hospital capacity and escalation status were discussed regularly throughout the day via safety huddles and twice daily ‘Safe to Start’ meetings
- An effective system for the initial assessment and the ongoing monitoring of patients waiting in ambulances was in place
- The EU and the CDU were visibly clean and generally tidy
- The sample of records we reviewed were easy to navigate, the handwriting was clear and legible, and entries were logically set out

Quality of Management and Leadership

Overall Summary

A management structure was in place and clear lines of reporting and accountability within the EU and CDU were described and demonstrated.

We received positive staff feedback on the approach of managers and the impact they had on the culture within both the EU and the CDU. However, staff feedback on other elements of the service was mixed.

Staff we spoke with were knowledgeable regarding their roles and responsibilities within the areas they worked. Overall, we saw good compliance with mandatory staff training.

Senior staff described appropriate arrangements for recording, investigating, and responding to concerns, and they showed a good understanding of their responsibilities under the Duty of Candour.

Arrangements for regular audit were described and we saw a good level of compliance.

Where the service could improve

- The health board must take suitable action to respond to the less favourable staff feedback and comments described throughout this report
- The health board must take action to support staff with health and wellbeing matters and raise staff awareness of the help available
- The health board must take action to increase staff confidence that when they raise concerns, these will be addressed.

What we found this service did well

- We found strong leadership in both the EU and the CDU
- Additional senior posts had been created with the aim of providing an increased level of senior support to staff teams and staff we spoke to described this had been very beneficial

- A Senior Nurse for Professional Development had been appointed and staff made positive comments regarding the benefit of having an individual with specific responsibility for the training and development of staff teams
- We found staff working within the EU and the CDU were committed and aimed to provide patients with a good level of care
- The majority of staff who provided feedback told us they would feel secure raising a concern about unsafe practice
- Overall, we saw good compliance with mandatory staff training.

Staff told us:

"There are often (daily) delays in patient assessment due to the lack of accessible space within department for patients to be assessed due to the large volumes of patients presenting to the department. Space is consumed by patients awaiting transfer to inpatient beds due to lack of space and flow."

"I feel that due to low staffing levels that it is often impossible to provide the level of care to patients that is required. Staff are often made to work multiple areas which again means patients have to wait for personal care needs. This also has a massive impact on staff moral and wellbeing."

"We have improved so much with regards to patient privacy care and safety by stopping the corridor in majors and ensuring all patients are in single rooms or bays however ambulatory is now a high risk area due to high volume and acuity of patients."

"The care given to the patients is outstanding, in my opinion. There is a lack of capacity in the department almost constantly. The worst hit area is Ambulatory Care, where often patients who self-present to A&E are sicker than that area can support and there often isn't room to accommodate them in an appropriate area."

"Ambulatory areas are not fit for the purpose. There are no facilities for patients hygiene needs and patients are often kept there in excess of 48 hours. The volume of speciality referrals coming through the department make the environment unmanageable. Not enough staff nurses or HCA's on every shift."

"Good leadership from the top has turned the department around in the last 18 month, supportive, caring, encouraging environment."

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.