Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Emergency Department, Withybush General Hospital, Hywel Dda University Health Board
Inspection date: 21, 22 and 23 August 2023
Publication date: 23 November 2023

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

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Patients overall told us that they were happy with aspects of their experience at Withybush Hospital Emergency Department (ED), including the kind and respectful interactions with staff. Patients expressed an understanding of the pressures facing the ED, but there was frustration in relation to the lack of privacy, dignity and information regarding when the next steps of their care would take place.

There were significant limitations on staff to provide patients with a dignified experience, but through our review of patient records, we found that staff were making good efforts in ensuring that fundamental care needs were met. This included timely triage of patients upon their arrival to the ED.

We found that patients were provided with a generally safe level of care. However, demand on the ED far exceeded capacity. This posed a risk to patients and presented challenges to staff in providing a consistent level of care to all patients.

We identified three immediate assurance issues which required the health board to take timely actions in response to these concerns.

There is a need for the service and health board to carefully monitor the way in which patients, particularly in surge and newly established areas, are accommodated within the ED moving forwards. This includes the need to review and measure the effectiveness of these changes.

HIW notes that the health board declared an internal major incident on the 15 August 2023 related to the identification of Reinforced Autoclaved Aerated Concrete (RAAC). We acknowledge the significant challenges this presented to the Emergency Department due to the closure of over 100 beds on wards within the wider hospital site and the inability of the ED to transfer patients to these closed wards. This caused significant overcrowding challenges during this inspection, in addition to pre-existing pressures at this site and system wide pressures.

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 Withybush General Hospital, Hywel Dda University Health Board on the 21-23 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 11 questionnaires were completed by patients or their carers and 34 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, two clinical peer reviewers and a 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 overall told us that they were happy with aspects of their experience at Withybush Hospital Emergency Department (ED), including the kind and respectful interactions with staff. Patients expressed an understanding of the pressures facing the ED, but there was frustration in relation to the lack of privacy, dignity and information regarding when the next steps of their care would take place.

There were significant limitations on staff to provide patients with a dignified experience, but through our review of patient records, we found that staff were making good efforts in ensuring that fundamental care needs were met. This included timely triage of patients upon their arrival to the ED.

Where the service could improve

- The health board must continue to focus on and review the privacy and dignity needs of patients as changes to use of surge areas are implemented
- The health board must ensure that communication with patients in relation to their care is strengthened
- The health board must ensure that there is sufficient supply of pillows and blankets to ensure patient comfort.

What we found this service did well

- We observed staff engaging with patients in a kind and respectful manner at all times
- Relatives provided positive feedback in relation to the care provided to their loved who was at the end of their life.

Patients told us:

"Can't fault the staff. They are overworked and do a great job."

"Staff superb working in very difficult environment."

Delivery of Safe and Effective Care

Overall Summary

We found that patients were provided with a generally safe level of care. However, demand on the ED far exceeded capacity. This posed a risk to patients and presented challenges to staff in providing a consistent level of care to all patients.

We identified three immediate assurance issues which required the health board to take timely actions in response to these concerns. These included:

- Improvements to infection, prevention and control processes were required in order to minimise risks to patients, staff and visitors
- Improvements to the process for checking and recording of checks in relation to emergency resuscitation trollies were required
- Improvements to the risk assessment, mitigation and overall governance of the use of surge areas in the ED.

There is a need for the service and health board to carefully monitor the way in which patients, particularly in surge and newly established areas, are accommodated within the ED moving forwards. This includes the need to review and measure the effectiveness of these changes.

Where the service could improve

- The health board must ensure that there are adequate processes in place to identify, risk assess and flag vulnerable individuals or those at risk
- The health board must ensure that there is a suitable mental health assessment room available within the ED, which is subject to a risk assessment prior to its use
- The health board must ensure that there is a system in place to identify to patients to staff who require assistance eating or any dietary / allergen requirements
- The health board should measure the effectiveness of the proposed changes to the ED in light of the challenges identified during the course of the inspection.

What we found this service did well

- Triage had been completed in a timely manner for the majority of patients that we reviewed
- We identified positive practices in relation to certain pathways, including Same Day Emergency Care (SDEC) and notably the frailty service
- We observed timely, effective and dignified implementation of a care pathway for an end of life patient.

Quality of Management and Leadership

Overall Summary

We confirmed that there was an appropriate management structure in place within the department and local clinical leaders demonstrated imminent plans with the intention of strengthening aspects of the ED in response to the pressures faced by the service.

We found that workforce plans were under review to increase staffing, skill mix and overall resilience within the service. However, there is a need to move at pace regarding certain positions to ensure there is a robust management and leadership at all levels of the ED.

The health board is recommended to reflect upon all staff feedback provided within this report, taking robust action where required.

Where the service could improve

- The health board is recommended to strengthen senior nurse management and leadership in the ED (Senior Sister / Charge Nurse)
- The health board should ensure that there are robust interim arrangements in place for the induction and on-going support of new staff
- The health board should reflect on the less positive feedback provided by staff in order to identify and take robust actions where required.

What we found this service did well

- There was a committed workforce amongst all staff groups within the ED
- The majority of staff told us that senior managers were visible.

Staff told us:

"…Engaged, motivated and passionate staff who want the best for their patients. Hampered by the significant and persistent overcrowding in ED long before the RAC issue and now made even worse…

"As a department we are currently having to manage long stay patients as part of a ward and I feel that we are doing this well but feel that patients are suffering because of this by being doubled up in rooms, there is no privacy/dignity."

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.