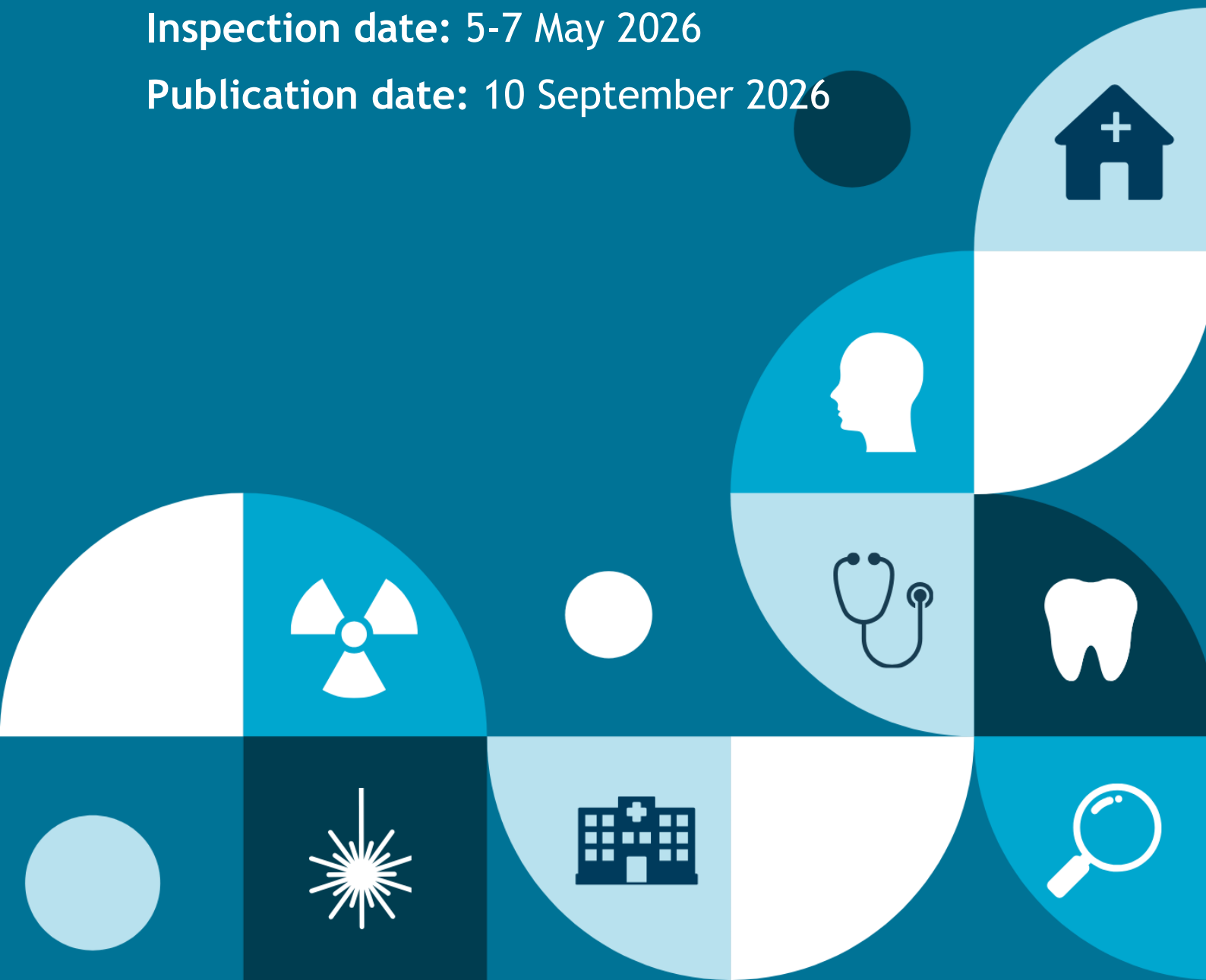
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Emergency Department, Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board

Inspection date: 5-7 May 2026

Publication date: 10 September 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats were produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or Via:

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80853-290-0

Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective and high-quality for everyone.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. 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 Emergency Department, Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board on 5 – 7 May 2026.

Our team, for the inspection comprised of two HIW healthcare inspectors, the Head of Quality and Acute Clinical Advice, two clinical peer reviewers and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experiences of using the service. We also invited staff to complete a questionnaire to tell us their views and experiences of working for the service. A total of 662 questionnaires were completed by patients or their carers and 57 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, patient or staff quotes in this publication may have been translated from their original language.

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

The seriousness of the concerns identified during this inspection resulted in the service being considered through HIW's Service of Concern process. In May 2026, HIW determined that the Emergency Department should be designated as a Service Requiring Significant Improvement (SRSI), reflecting concerns regarding patient safety, leadership, governance, and the service's ability to consistently deliver safe and effective care. The service subsequently became subject to enhanced regulatory oversight and monitoring by HIW.

As a result of the immediate assurance concerns in the original inspection on 5-7 May 2026 and following the designation of the Emergency Department (ED) as a Service Requiring Significant Improvement (SRSI), HIW conducted a follow-up visit to the ED at Ysbyty Glan Clwyd on the evening of 24 August 2026 and throughout the following day. This follow up concentrated on the areas of immediate assurance concerns only.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

The inspection identified a service under sustained pressure, with significant adverse impact on patient experience, timeliness, privacy, dignity and the consistency of care. Patient feedback was substantial, with 662 responses received, and presented a consistent picture of prolonged waiting times, overcrowding, limited comfort and care being delivered in areas not designed for prolonged treatment or observation.

Many patients described waits exceeding 12 hours, with some reporting waits over 24 hours. Patients and carers also described difficulties accessing seating, food, drink, toileting support and regular updates. These issues had a particular impact on older people, carers, patients with additional vulnerabilities and those waiting for extended periods in chairs, wheelchairs, corridors or other non-clinical areas.

Although staff were consistently described as caring, professional and compassionate, communication throughout the patient journey was inconsistent, particularly in relation to delays, next steps and care progression. Observations and patient feedback indicated that staff were making efforts to provide respectful care, but overcrowding, delays and environmental constraints meant privacy, dignity and person-centred care could not always be consistently maintained. Patients were not always regularly reviewed while waiting and carers were sometimes required to provide support without appropriate assistance. Timeliness of care remained a significant concern, with prolonged ambulance handover delays, limited evidence of ongoing clinical monitoring for some patients awaiting treatment and inconsistent adherence to escalation processes and standard operating procedures (SOPs).

Equality and access issues were also identified, with some patients reporting concerns relating to age, disability and other protected characteristics or vulnerabilities. Welsh language provision and identification of language preference were inconsistent.

Despite these challenges, positive aspects included respectful staff interactions, strong multidisciplinary working and valuable contributions from wellbeing and

volunteer support teams, which helped support patient comfort and dignity during prolonged waits.

Overall, while compassionate care was evident, the patient experience was significantly affected by wider system pressures, poor flow, overcrowding, corridor care and inconsistent communication. Urgent and sustained improvement is required to ensure patients receive timely, dignified and equitable care.

These are examples of where the service can improve:

- Waiting times and patient flow, including reducing the prolonged delays and overcrowding
- Privacy and dignity, including reducing corridor care and improving care environments
- Communication with patients, including regular updates and clearer information about delays and next steps
- Consistent provision of basic care including food, drink, comfort, toileting support and ongoing observations
- Ambulance handover and monitoring, including timeliness and adherence to SOPs
- Equitable access, including addressing reported discrimination and improving Welsh language provision.

These are examples of what the service did well:

- Compassionate, respectful and professional staff interactions recognised by patients
- Wellbeing and volunteer support teams enhanced patient comfort, experience and dignity
- Positive multidisciplinary working and respectful team culture observed in practice.

Delivery of Safe and Effective Care

Overall summary:

The department was under significant operational pressure, affecting its ability to deliver consistently safe, timely and effective care. The environment and infrastructure were not sufficient to meet demand, resulting in overcrowding, prolonged waits and frequent use of corridor and non-clinical areas for patient care. These arrangements created risks to patient dignity, clinical monitoring, timely intervention and overall patient safety.

We identified significant risks in the waiting area and corridor spaces, where patients with high clinical risk were not always moved promptly to monitored clinical areas. Clinical oversight, observations, documentation, pain relief, escalation and provision of basic care were not consistently reliable. These findings were particularly concerning given the acuity and vulnerability of some patients waiting for extended periods.

Governance arrangements were in place, but we were not assured they were consistently effective in practice. Regular risk assessments, health and safety audits and infection prevention and control (IPC) monitoring were not reliably undertaken. Although IPC knowledge among staff was good and some audit results were positive, gaps remained in cleaning practices, visibility of hygiene measures and availability of appropriate facilities such as negative pressure rooms.

Serious concerns were also identified in relation to paediatric safety, medicines management, equipment safety, safeguarding oversight and the quality and usability of patient records. This included missing or expired equipment, incomplete safety checks, inconsistent safeguarding documentation, gaps in the supervision of vulnerable patients, and records that did not reliably support safe clinical decision-making or continuity of care.

Risk assessments for falls and pressure damage were not consistently completed or undertaken by the appropriate staff. We also identified gaps in the recognition of situations that may require consideration under deprivation of liberty or wider mental capacity arrangements. These findings indicated weaknesses in the systems intended to identify, monitor and protect patients at increased risk of avoidable harm.

Despite these challenges, patients and carers expressed appreciation for staff

professionalism and compassion. Multidisciplinary working, particularly within the Assessment and Discharge Team, supported discharge planning and patient flow where possible. Nutrition and hydration provision was generally good when available, supported by staff, the wellbeing team and volunteers, although inconsistencies occurred during busy periods and prolonged waits.

Overall, systemic pressures, infrastructure limitations, workforce shortages and governance arrangements that were not consistently effective significantly limited the ED's ability to provide safe, timely and effective care. As a result, we were not assured that risks to patient safety, dignity and experience were being consistently identified, mitigated or managed.

Immediate assurances:

- We could not locate the related safeguarding documentation for a paediatric patient, who was reported to use a Class B controlled drug daily
- Medicines management and equipment safety systems were not effectively implemented, presenting a potential risk to patient and staff safety
- Significant paediatric safety concerns were identified, including the paediatric area being left unattended by staff, a patient requiring closer monitoring being returned to the waiting area without cannulation, no paediatric-trained nurse on duty, unauthorised access to the area and resuscitation equipment was not immediately accessible in an emergency
- Staff feedback indicated a challenging workplace culture linked to senior management, with concerns about behaviours, staff wellbeing, organisational responsiveness, procedural difficulties and delays linked to collaboration with specialties.

These are examples of where the service can improve:

- Reduce unsafe corridor care and overcrowding
- Increase staffing levels and ensure adequate supervision and clinical oversight
- Strengthen medicines management and equipment safety systems

- Improve consistency, structure and quality of patient records and documentation
- Enhance safeguarding oversight and supervision of vulnerable patients
- Implement regular audits and robust governance for risk, IPC, safety checks and clinical documentation.

These are examples of what the service did well:

- Patient and carers recognised staff compassion and professionalism
- Effective multidisciplinary working was evident in some areas, particularly discharge planning
- Wellbeing and volunteer support provided positive support to patients during prolonged waits.

Quality of Management and Leadership

Overall summary:

The inspection identified a committed and resilient workforce operating in exceptionally challenging circumstances. Staff consistently described strong teamwork and dedication to patient care. However, concerns relating to staffing shortages, skill mix, patient flow, corridor care, escalation, environmental limitations and senior leadership responsiveness were widespread and consistent across the inspection.

Governance structures, policies, escalation processes and meeting arrangements were in place. However, there was insufficient assurance these arrangements were consistently effective in practice. Similar concerns relating to staffing pressures, delayed care, documentation, risk management, corridor care and patient flow had been repeatedly identified through governance meetings, incident reporting and staff feedback, yet many remained evident at the time of inspection.

A notable finding was the gap between local support and confidence in wider organisational leadership. Staff were generally more positive about immediate colleagues and line managers than they were about senior leadership visibility,

communication and responsiveness. Staff generally understood how to raise concerns, but confidence that those concerns would result in meaningful action was low. This raised significant concerns about psychological safety, organisational responsiveness and the degree of assurance available to leaders regarding frontline risks.

Workforce challenges were significant, including insufficient staffing levels, inadequate skill mix, reliance on agency and locum staff and difficulties accessing training and professional development. Staff frequently reported feeling unable to provide the standard of care they wished to deliver.

Survey findings suggested longstanding operational pressures, including overcrowding, corridor care and delays in patient flow, had become normalised within the department. This was concerning given the potential impact on patient safety, dignity, staff wellbeing and organisational culture.

Overall, while leadership and governance arrangements existed, we were not assured they were consistently driving learning, staff engagement, measurable improvement or sustained reduction in risk. The persistence of known risks across multiple evidence sources indicated a disconnect between governance arrangements as described and the experience of staff and patients within the department.

Immediate assurances:

Interviews with a range of medical and nursing staff suggested the presence of a challenging workplace culture associated with senior management. Staff described behaviours and interactions they felt contributed to conflict, negativity and emotional distress, with potential implications for staff wellbeing and patient safety. Staff also described difficulties resolving procedural issues and working with other specialities, resulting in inefficiencies and delays in decision-making for patient care.

These are examples of where the service can improve:

- Governance effectiveness, including implementation, monitoring and evidence of learning from incidents and staff concerns
- Leadership visibility, communication and engagement between senior leaders

and frontline staff

- Staffing levels and skill mix, particularly at weekends within escalation areas and in the provision of paediatric care
- Policy management, to ensure all SOPs are current, ratified and consistently applied
- Patient flow and overcrowding, including reducing corridor care and delays in assessment, treatment and admission
- Use of staff and patient feedback to support psychological safety, organisational learning and measurable improvement.

These are examples of what the service did well:

- Strong teamwork and staff resilience were evident under challenging conditions
- The wellbeing support team had a positive impact on patient experience and dignity
- Established governance and meeting structures provided a foundation for improvement, although their effectiveness required strengthening.

Details of the concerns for patients' safety and the immediate improvements and remedial action required are provided in Appendix B.

Improvement Progress Assessment

During the follow up we noted the work undertaken since the original inspection to address immediate assurance concerns and improve patient safety. Staff continued to work under the pressure of high patient demand and crowded waiting areas.

Positive developments included extensive staff engagement work on culture and wellbeing, improved patient flow through new management initiatives, effective safety huddles, strengthened paediatric governance, improved security measures and better management of medicines and equipment. New and developing staff wellbeing initiatives and actions arising from staff feedback were also noted. These early improvements must be embedded and sustained over the long term.

Challenges remained regarding waiting-room oversight, delays in gaining specialist input following medical and surgical referrals and the sustainability of some new initiatives.

Overall, progress had been made within a short space of time. Continued monitoring, accountability and sustained leadership focus are required to ensure that improvements are fully implemented, embedded and maintained.

HIW will continue to monitor progress through its Service of Concern process.

3. What we found

Quality of Patient Experience

Patient feedback

To inform and support the findings from our unannounced inspection, we issued a patient questionnaire seeking views on patients' experiences of care. Feedback was gathered through paper questionnaires distributed on site and electronically via posters promoting the online survey and through HIW's social media channels. A total of 662 responses were received from patients, relatives and carers. The response rate was notably high and exceeded the level of patient feedback typically received by HIW. However, the survey did not record the dates on which respondents received care. As a result, the findings cannot be attributed solely to the inspection period; rather, they provided a broader reflection of patient experience.

Patient and family feedback presented a consistent picture of an ED operating under significant and sustained pressure. Respondents frequently described prolonged waits, overcrowding, limited comfort and challenges in maintaining privacy and dignity. Concerns were also raised about access to seating, food and drink and the impact of extended waits on older people and patients with additional vulnerabilities. Alongside these concerns, respondents recognised the compassion, professionalism and commitment of staff, particularly once patients had been clinically assessed or admitted.

Waiting times

Extended waiting times were a dominant theme in the patient feedback. Many patients described waits of more than 12 hours, with some reporting waits of over 30 hours before admission or discharge. Delays were not limited to initial assessment but occurred throughout the patient journey, indicating wider system flow challenges linked to capacity pressures and delays in onward care.

One patient described:

> *"We waited 30 hours… elderly patients sitting in chairs trying to sleep with no food or drink."*

While there were examples of timely triage, these were often followed by delays later in the pathway. One patient commented:

> *"Triage was very quick… after that things were very slow."*

The health board must take urgent whole-system action to reduce excessive waits, improve patient flow and minimise delays in assessment, admission and discharge.

Dignity, privacy and basic care

Patient feedback identified significant concerns about dignity and the provision of basic care, particularly for elderly and vulnerable patients. Many respondents described being cared for in corridors or waiting areas for extended periods, with limited privacy and inconsistent access to food, drink, and toileting support.

Examples of patient experience included:

> *"Corridor care is unacceptable and degrading… no dignity."*

> *"My 82-year-old mother spent all night in a wheelchair… in absolute agony… in full view."*

> *"Patients were lying on the floor… elderly people hardly dressed and no one with them."*

These accounts indicated that environmental constraints and sustained demand pressures were impacting on the department's ability to consistently meet fundamental standards of care and dignity, with potential implications for patient safety. The physical environment was frequently described as overcrowded and not suited to current levels of demand, with patients reporting limited seating, inappropriate use of corridor space and difficulty accessing basic facilities.

The combination of high demand and limited space also affected privacy, dignity, cleanliness, IPC, and patient comfort during prolonged waits. Communication with patients and relatives was variable, particularly in relation to waiting times and next steps. While some patients felt informed and supported, others described uncertainty and limited updates, which contributed to anxiety and dissatisfaction with their overall experience.

The health board must:

- **Ensure all patients, including those in non-clinical areas, consistently receive food, drink, toileting support, privacy and basic care**
- **Minimise corridor care and ensure clear mitigating actions are in place where it cannot be avoided**
- **Take immediate action to address overcrowding, cleanliness and patient comfort**
- **Strengthen communication with patients and provide regular, clear updates on waiting times and next steps.**

Staff compassion and quality of care

Despite the concerns identified, feedback showed strong recognition of staff commitment, compassion, and professionalism. Many patients clearly distinguished between operational pressures affecting the department and the efforts of staff to provide care in difficult circumstances.

Comments included:

> *"The staff are wonderful, but they are fighting against a rubbish system."*

> *"While the nursing staff did their best it was a very stressful time due to the lengthy wait."*

Positive feedback highlighted that staff were often caring and respectful while working under considerable pressure, with patients acknowledging the challenges they faced.

Examples included:

> *“The staff were amazing… they work under so much pressure but still deliver a high standard of care.”*

> *"The children's department of A&E were exceptional. Seen quickly, concerns listened to and checked."*

> *“The care I received was exceptional… staff were attentive and respectful despite how busy it was.”*

> *“The nurses and health care assistants were excellent; friendly and compassionate.”*

Where patients were assessed and treated, feedback frequently indicated clinical care was appropriate and, in many cases, of a high standard. Respondents described examples of timely triage and prioritisation, effective clinical intervention once seen, improved experiences following admission to inpatient wards and acts of kindness from staff, including reassurance and support. These examples demonstrated where flow and capacity pressures were mitigated, patients could receive safe and patient-centred care.

Overall, patient feedback described a department experiencing sustained operational pressures, particularly in relation to overcrowding, prolonged waits and limited capacity. These factors negatively affected patient experience, privacy and dignity. Despite these challenges, respondents consistently recognised the compassion, professionalism and commitment of staff, with many distinguishing the quality of individual care from the wider system issues affecting service delivery. Feedback suggested the principal causes of poor patient experience were systemic and operational rather than attributable to individual staff performance.

The health board must ensure staffing and senior clinical oversight are aligned to demand, with clear executive accountability for improvement and measurable outcomes.

Person-Centred

Health promotion

Patients and carers we spoke with were positive about the quality of care provided and did not raise concerns about treatment once it was received. One example highlighted a carer supporting a relative in a corridor area who felt unable to leave because they were providing personal care. The carer was not offered additional support, such as improved seating, refreshments, or access to washing facilities, despite contributing to the patient's care.

Whilst no verbal concerns were raised by patients about care quality, improvements were needed in managing patient expectations regarding waiting times and promoting appropriate service use, prior to attending the ED.

The health board must ensure:

- **Carers accompanying patients in the department are offered appropriate support, particularly when they are unable to leave the patient**
- **Information is displayed on appropriate use of the ED and signposting to alternative services as appropriate.**

Dignified and respectful care

Staff were observed treating patients with respect, kindness and compassion, communicating in a courteous, sensitive and patient focussed manner. Patients and carers we spoke with reflected these observations, describing staff as attentive and respectful. Patients appeared clean, appropriately covered, and comfortable where circumstances allowed, with staff making efforts to provide basic care, including food, drink, and blankets. Whilst personal care was delivered discreetly, overcrowding, corridor care and the use of non-clinical areas limited the extent to which privacy and dignity could be consistently maintained. The wellbeing support team provided valuable supplementary support in helping to address some of these challenges.

Fewer patients were receiving care in corridors than on previous inspections. Staff told us this followed implementation of an SOP, which limited corridor care to 12 patients

and supported improved oversight. Despite this improvement, maintaining privacy, dignity and patient comfort remained challenging. Prolonged waits in chairs continued, including overnight stays and elderly or vulnerable patients were not always able to rest comfortably. Blankets were not always readily available, particularly in corridor areas.

Care delivery in public spaces also made it difficult to ensure conversations and personal care could always be conducted discreetly and confidentially. Patients waiting in these areas reported difficulty obtaining assistance with toileting, refreshments and general support, and were often unclear how to request help. While these challenges primarily reflected environmental and capacity pressures rather than individual staff practice, they continued to adversely affect patient experience. It was positive to observe staff providing reassurance and support to patients, including those experiencing mental health concerns and the paediatric area remained calm and supportive throughout the inspection.

It was a concern to find immunocompromised patients were in open public areas, such as the corridor and waiting room. Moreover, they were not prioritised for isolation or care in a more appropriate environment. This increased their risk of exposure to infection.

The health board must ensure:

- **The dignity and respect of patients is maintained wherever they are in the ED**
- **Immunocompromised patients are cared for in appropriate areas away from public spaces to minimis their risk of exposure to infection.**

The wellbeing support team played a significant role in supporting patients and mitigating some environmental pressures. They served hot meals and drinks to patients in corridor areas, supported patients at risk of self-discharge and responded to individual needs, such as sourcing specific dietary requirements or equipment. Their contribution was described as positive and valuable. However, we were told the removal of the Red Cross volunteers had contributed to longer stays for some medically fit patients, as these volunteers had previously supported transporting patients home with equipment. Delays were now linked to the availability of hospital transport.

The health board must review discharge support and transport arrangements for medically fit patients, including the impact of changes to volunteer support, to ensure patients are discharged safely and without avoidable delay.

Patient survey responses supported our inspection findings regarding the impact of overcrowding and prolonged waits on patient experience. While 63% of respondents felt they were treated with dignity and respect and 55% felt their privacy was protected, a substantial proportion reported unmet basic needs and reported inadequate seating. Only 23% felt they had access to adequate food and drink and only 17% said staff checked on them while they waited. Qualitative feedback frequently described lengthy waits, overcrowding and care being delivered in non-clinical areas, with several respondents specifically raising concerns about privacy and dignity. Staff survey findings reflected similar concerns, with only 32% of respondents feeling privacy and dignity were consistently maintained.

Individualised care

Patient survey responses indicated around half reported positive experiences in relation to communication and involvement in their care. Specifically:

- 58% of patients agreed staff explained what they were doing
- 52% felt staff listened to them and answered their questions
- 50% reported they were involved as much as they wanted to be in decisions about their healthcare.

These findings suggested communication and involvement were evident in some cases but were not consistently experienced by all patients. Staff responses were more positive, with 86% reporting patients were informed and involved in decisions about their care. This difference between staff perception and patient experience, indicated a need to improve staff-patient communication.

The health board must improve communication between staff and patients, so patients feel informed, listened to and involved in decisions about their care.

Qualitative feedback reflected examples of compassionate and personalised care despite significant operational pressures. Several respondents specifically praised

paediatric services, while others described staff as caring, approachable and committed to supporting patients in difficult circumstances. These examples demonstrate patient-centred care remained evident across parts of the service despite the challenges facing the department.

Timely

Timely care

Ambulance handover times over the 24–48 hours preceding the inspection were variable, ranging from two to seven hours. On the first night of the inspection, we observed a significant handover delay, with seven ambulances and two additional vehicles waiting. Ambulance staff reported such delays were commonplace, including a one hour wait for triage.

Ambulance staff also described working relationships with ED staff as generally positive, respectful and supportive. However, they also reported handover practice varied depending on the senior staff member or nurse in charge on duty. Some patients remained in ambulances for prolonged periods due to departmental pressures. Decisions to transfer patients into the department when it was already at maximum capacity raised safety concerns, particularly where no designated space or staff oversight was available.

The health board must ensure consistent ambulance handover arrangements and only transfer patients into areas where appropriate space, care ad oversight can be provided.

Responsibility for patients remained with the ED staff once they had been triaged. Ambulance crews advised they would consult with ED staff if a patient's condition deteriorated while waiting to transfer into the department.

Most patients we observed had been triaged by ED staff. Patients awaiting transfer into the ED were managed in line with those already within the department or were waiting in designated areas. Following triage, patients were not routinely reviewed by ED medical staff while awaiting transfer into the department, or while waiting in designated non-clinical areas.

During extended waits in ambulances and corridor areas, patients' basic needs were not consistently met. Concerns included limited access to food and drink, inconsistent attention to comfort and skin care, reduced privacy and a lack of continuous supervision in some areas. Patients accommodated in the ambulance corridor were reported to experience particularly poor conditions, including exposure to cold temperatures. While staff were allocated to oversee patients in corridor areas, our observations indicated continuous supervision was not consistently maintained. These factors presented risks to both patient dignity and safety.

We found limited evidence of timely direct admission pathways to specialty services. Staff described patients experiencing delays of up to 18 hours for specialist input. Examples were provided regarding Ear, Nose and Throat (ENT) and maxillofacial patients and another example, highlighted an incident when an ENT patient was discharged, but later re-attended the ED.

Although escalation policies and SOPs were in place to manage overcrowding, these were not consistently followed in practice. Incidents were reported through several mechanisms, but staff indicated the Datix was not being fully used for escalation and wider organisational learning. Reporting was limited to key stakeholders reducing opportunities for learning and improvement.

The health board must ensure Datix reporting is used consistently throughout the ED to ensure risks, incidents and near-misses are reported, investigated and shared for learning.

Patient feedback reflected significant concerns regarding delays throughout the care pathway, with 55% of respondents reported waiting longer than 30 minutes for initial assessment, 18% waiting 8–12 hours for treatment and 46% waiting longer than 12 hours. Some described waits exceeding 24 hours.

We viewed the Ambulance Handover and Management of Patients on Ambulances SOP which was found to be out of date with no indication of review. The Hospital Arrival Screen, intended to support patient tracking and triage, was not observed to be functioning and no alternative system was identified.

Overall, findings demonstrated significant gaps between policy and practice, with limited evidence of clinical monitoring, escalation, or documentation for patients waiting in ambulances. These issues indicated weak operational oversight and non-adherence to established procedures, presenting risks to patient safety. Examples included:

- The procedure outlined rapid access pathways for high-risk patients (for example cardiac, stroke and maternity). However, examples were observed where such patients remained in the waiting area
- The 'Trolley Clear' process, which required ongoing clinical review of patients waiting in ambulances, including observations, pain management and basic care needs, was not evidenced in practice
- A request for immediate ambulance release being denied, contrary to the procedure requirement for prioritisation.

The health board must work with the Welsh Ambulance Services University NHS Trust (WAST) to review and update the SOP and ensure its requirements are followed in practice.

Equitable

Communicating and language

At an individual level, staff communication observed from staff was positive but not consistent throughout the patient journey. Limited initiative-taking communication during prolonged waits had a significant impact on patient experience. There were opportunities to strengthen communication through more structured updates, clearer information for patients and carers and improved visibility of staff roles and language capabilities.

Current waiting times were displayed on a monitor in the main waiting room, alongside information about triage waiting times, the number of patients in the department, advice to inform staff if a patient's condition worsened and reminders to treat staff with respect. However, given the extended waits and the number of patients located in corridors and overflow areas, this approach alone was not sufficient. The introduction or expansion of a progress chaser role to provide regular verbal updates could help manage patient expectations, reduce repeated queries and support frontline staff. Progress chasers were described as supporting the Emergency Practitioner in Charge

(EPIC) and the Nurse in Charge (NIC) by monitoring patient flow and helping to facilitate timely and effective progression through the department.

There was limited formal information available to support patients and carers understand their care journey through the department. We recognised the variability of patient presentations made standardised information challenging. However, although areas within the department were signposted, navigation could be improved through clearer displays, such as a site map, floor-based directions or identifying markers, to support patients and visitors in finding key areas more easily. Improved signage would also help patients access facilities independently, including washing and shower facilities during prolonged waits.

Feedback from patients and carers we spoke with was positive about staff communication, with many saying staff were willing to listen and explain aspects of their care. However, poor communication was a recurring theme in response to the patient questionnaire, particularly in relation to limited updates on waiting times and a lack of clarity about next steps or care progression. Patients indicated more regular and initiative-taking communication would significantly improve their experience. Concerns were also raised about how patients were called from waiting areas, including difficulties hearing names when called.

The health board must ensure:

- **Signage is improved within the ED to direct patients around the department and to inform patients about self-care and management**
- **Patient communication is enhanced and patients are provided with clear updates on delays and care processes.**

There was no consistent staff identification board in place within the department. Although a staff identification sheet was present in the paediatric area, it had not been completed at the time of our observations, which limited its usefulness in helping patients and visitors identify staff roles.

The health board must ensure the staff identification, 'who's who,' board within the department is kept up to date.

We noted Welsh language training was available to staff, and some staff were observed wearing lanyards or other identifiers to indicate Welsh language ability, however, this was not consistent. The health board had a Welsh Language Policy, aligned with the Welsh Language Standards which set out expectations that Welsh-speaking staff should wear a 'Iaith Gwaith' badge and patients should be asked their preferred language on admission.

There was a clear gap between Welsh language policy and practice, particularly in relation to asking patients about their language preference and promoting staff Welsh language skills. We were told information could be made available in different languages and formats on request and information was available in Welsh. However, patient questionnaire responses indicated that, of the 5% of respondents who identified Welsh as their preferred language, 87% reported they had not been actively offered the opportunity to speak Welsh. These findings suggest the Active Offer of Welsh language was limited.

Staff questionnaire responses also highlighted inconsistencies. While 35% of staff identified as Welsh speakers, 44% reported they did not wear a 'Iaith Gwaith' badge. In addition, only 38% stated they asked patients about their preferred language, although 63% reported they actively used Welsh in their role.

We also observed patients were not routinely asked their preferred language at reception, with practice appearing to rely on assumption rather than proactive enquiry. This indicated inconsistent identification and promotion of Welsh language needs and available staff Welsh language skills, despite a proportion of staff being able to speak Welsh.

The health board must ensure:

- **Patients are asked about their language preference, and this is recorded when they first present at the ED**
- **Staff who can speak Welsh, or are learning Welsh, wear an appropriate 'Iaith Gwaith' badge.**

Rights and equality

A designated relatives' room was available which was clean, tidy and welcoming, with appropriate arrangements to support privacy. During the inspection, we observed this room being used appropriately to facilitate private and sensitive conversations with family members and carers, including when communication difficult or distressing information. A dedicated viewing room was also available for bereaved relatives, demonstrating consideration for patients and families at end of life.

Patients were able to receive visitors within reasonable hours, with arrangements described as sensitive to the needs of others in the ED. Family members and carers were also able to participate in and support patient care where appropriate, including when patients were critically unwell.

Staff demonstrated awareness of patients' individual needs, rights and preferences, including spiritual, religious and cultural considerations, which were routinely considered as part of care delivery. Staff also indicated they would respect individuals' preferences in relation to chosen names and appropriate forms of address, supporting inclusive and respectful care.

The health board had a clear strategic commitment to equality, diversity and inclusion through its Strategic Equality Objectives and Action Plan 2024–2028. This recognised equality and inclusion as fundamental to improving health outcomes and aimed to create a working environment in which staff felt valued, safe and supported.

Staff confirmed they had access to mandatory equality and diversity training and were aware of how to raise concerns, including access to designated staff for support and advice.

We were informed equality impact assessments were undertaken during policy development, including in relation to key operational pressures such as corridor care and delayed transfers of care.

Survey data indicated 83% of staff felt the workplace was supportive of equality and diversity and 72% felt they had fair and equal access to workplace opportunities. One staff member commented positively:

"The department would not function without the amazing diversity of staff we have here."

However, 10 of the 43 staff members who responded to this question reported experiencing discrimination within the previous 12 months. This indicated further work was required to ensure a fully inclusive and supportive working environment.

The health board must ensure processes are in place to:

- **Enable all staff to report concerns internally and ensure concerns are appropriately investigated and responded to**
- **Ensure staff are treated fairly and equally, with any instances of discrimination addressed promptly and appropriately.**

Patient feedback highlighted significant concerns about equitable access to care. Survey findings showed 58% of respondents did not feel they were able to access the right care at the right time on an equal basis. In addition, 146 respondents did not answer "no" to the question about whether they had experienced discrimination when accessing or using services. Reported grounds included age and disability, alongside additional themes relating to weight stigma, specific health conditions, including HIV and alcohol dependency and sexual orientation. Pregnant patients described unsafe care experiences, while wider system issues, including understaffing, delays and reliance on patients being assertive, were reported to have exacerbated inequalities.

Patients who described perceived discrimination across several areas reported these experiences were often compounded by staff attitudes and communication styles, which some described as dismissive or lacking compassion.

The health board must provide HIW with details of how it will ensure patients are treated fairly and equitably and discrimination is not tolerated and any concerns are addressed promptly and appropriately.

Our review of patient comments identified recurring concerns about access to primary

care services, particularly GP and dental appointments. Reported barriers included long waiting times, limited appointment availability and restrictive booking systems. As a result, some patients described increased reliance on EDs for issues that may not otherwise have required emergency care.

Feedback also highlighted extensive waiting times across services, which patients frequently reported as contributing to deterioration in health, increased anxiety and reduced confidence in accessing care. These included long waits in the ED, often exceeding 24 hours, as well as delays in referrals, surgical procedures and ambulance response times.

Patients and staff consistently described the ED as overcrowded and operating beyond capacity, resulting in prolonged waits, corridor care and delays in accessing specialist care. Concerns were also raised regarding coordination between services, including communication between primary care, hospitals and NHS 111. Respondents described delayed or lost test results, conflicting advice and difficulties navigating services, which contributed to feelings of frustration and being unsupported.

Several patients and staff linked these issues to increased risks to patient safety, particularly where delays affected access to urgent assessment or specialist treatment. Some respondents reported these experiences had reduced their confidence in accessing NHS services, with a small number stating they had considered delaying treatment or seeking private healthcare. Some positive experiences were reported, including timely emergency care and good experiences of individual specialist services. However, feedback highlighted significant barriers to accessing care and their impact on patient wellbeing and confidence in healthcare services.

Overall, feedback highlighted significant and widespread challenges in accessing healthcare services. Whilst many issues reflected wider system pressures, the impact on patients was substantial, affecting safety, confidence and overall experience of care. Addressing these concerns will require coordinated action across primary, secondary and community care services.

The health board must ensure:

- **It reviews the patient experience feedback highlighted in this report and takes action to address the issues identified, implementing timely and sustained improvements**
- **Staff training, accessibility, governance and patient-centred care is strengthened to support equitable, safe and compassionate services.**

Delivery of Safe and Effective Care

Safe

Risk management

The department was generally clean, tidy and well maintained, with domestic staff visible and actively covering all areas. Waiting areas and toilet facilities were clean and well stocked despite high patient volumes. However, the entrance was frequently observed as unclean, particularly given its layout and high footfall.

The current infrastructure was not sufficient to meet the needs of patients attending the department. The layout did not support efficient care delivery, with issues including reliance on corridor areas for patient care and challenges in accessing diagnostic services.

Whilst no significant clutter hazards were identified, corridor areas presented challenges for patients with mobility difficulties, particularly where belongings such as suitcases were present. In addition, clinical oversight in this area was limited.

Staff reported to us that staffing levels were insufficient, particularly in the waiting area, where one nurse and one healthcare support worker were typically responsible for a high number of patients. Staff described the challenges associated with maintaining oversight of patients during periods of pressure. One respondent commented:

> *"Up to 50 patients can potentially be in the waiting room with only one nurse and one HCA. Staff are anxious due to the increase responsibility. Unable to complete intentional rounding and observations on all with only one nurse."*

This limited staff capacity to support patients with toileting needs, nutrition, hydration, comfort and supervision. We observed patients relying on family members or carers for support. These concerns were also reflected in staff survey responses. Staff described difficulties providing timely personal care, undertaking observations and maintaining oversight of patients waiting for assessment or admission because of staffing pressures, competing demands and the suitability of the environment. This supported

our findings that overcrowding and limited clinical space were affecting both patient safety and dignity.

No evidence was provided that regular health and safety audits were being undertaken. Risk assessments relating to identified concerns, including corridor care and delayed transfers of care, were not consistently completed or documented.

The health board must ensure regular health and safety audits and risk assessments are undertaken across all areas of the ED, with identified risks documented, monitored and addressed in a timely manner.

The department was overcrowded and using corridor care, while the waiting area was operating under significant pressure due to sustained overcrowding and prolonged waiting times. We identified concerns relating to:

- Limited clinical oversight and visibility of patients
- Delayed recognition and response to deterioration
- Inconsistent monitoring of patients with known clinical risks
- Delays in access to pain relief
- Inadequate provision of basic care needs
- Lack of consistent staffing model to support safe observation.

These findings indicated current arrangements did not support the delivery of timely, safe and responsive care, particularly in relation to the monitoring and managing acutely unwell patients in the waiting area. **These concerns were addressed through our Immediate Assurance Process and are detailed in Appendix B of this report.**

Staff responses in the HIW questionnaire relating to the environment, facilities and ability to provide care indicated mixed views on the suitability of the environment, with a considerable proportion reporting facilities and the environment were not adequate to deliver care. In addition, challenges including limited clinical space, lack of equipment and pressures associated with corridor care, were affecting dignity and safety.

Although there was an SOP for corridor care, we were told the maximum numbers set out in in the SOP were often exceeded. We were also told the SOP may have had the unintended impact of affecting ambulance handovers, as described earlier. Where a patient waiting in an ambulance needed to be brought into the department, staff described using a risk-based approach.

The health board must ensure corridor care is delivered in line with the SOP and any breaches are authorised by senior management and reported through Datix.

We noted staff used the national early warning system (NEWS) and paediatric early warning system (PEWS) to identify deterioration in patients' clinical condition. We were also told ED teams were appropriately trained to deal with medical emergencies, corridor care and delayed transfers to wards.

When we spoke with staff about escalation arrangements when the department was at, or close to, capacity, some lower grade nurses were not fully aware of the escalation policy. Senior staff within the unit were able to explain the escalation process but told us they did not believe the health board always responded effectively to escalation concerns or provided additional support when required.

The health board must ensure ED escalation processes are clearly understood by staff and escalation concerns are responded to promptly, with appropriate senior oversight and support.

Infection prevention and control (IPC) and decontamination

The department had designated areas for the isolation of patients with suspected or confirmed infectious diseases, including several single rooms. During the inspection, we observed a deep clean being undertaken in one of these rooms, which demonstrated active IPC practice. However, we noted that no negative pressure rooms were available, which limited the department's ability to safely manage some airborne infections.

Staff told us they had completed mandatory IPC training and demonstrated confidence in their understanding of infection prevention principles, including their individual roles and responsibilities. Whilst we were informed IPC audits were undertaken, these were only completed when staffing capacity allowed, which limited their consistency and

effectiveness as an assurance mechanism. Audit information provided to us showed 100% compliance in the most recent hand hygiene audit, 100% mattress compliance and an average of 45% compliance in the commode audit.

We reviewed the Infection Prevention Hand Hygiene Procedure, which was current and aligned with standard IPC precautions. The procedure supported staff to undertake effective hand hygiene, reduce the risk of infection transmission and work in accordance with wider infection prevention policies and protocols.

We observed all areas of the ED and found, overall, the department appeared clean and well maintained at the time of inspection. Findings included:

- Domestic staff were visible throughout the department, although they were observed balancing cleaning duties with responding to patient queries
- Toilets were clean, stocked and in working order
- Hand sanitiser stations were stocked, although their placement near the main entrance and reception area was limited
- Furniture and equipment were in a good state of repair

We noted chairs in the waiting area were not cleaned between patient use. We also found hand sanitiser at the ED entrance was not clearly visible, which may reduce use by patients and visitors on arrival.

Patient survey responses relating to IPC measures differed to our observations and indicated mixed perceptions of IPC practice. Overall, 63% of respondents believed IPC measures were either followed or partially followed, while 23% felt they were not. In addition, 64% of respondents rated the environment as either fairly clean or very clean. This suggested, while general cleanliness was acceptable, there was scope to improve the visibility, consistency and assurance of IPC practices.

Qualitative patient feedback also indicated variable confidence in IPC practices and reinforced the need to strengthen visibility, consistency and governance of IPC measures. Patient comments included:

"...the only reason it wasn't clean was because of people using the service; often leaving used cups/food wrappers/water on the floor under chairs. It was NOT the fault of the staff."

"The rooms were not being cleaned, there was blood on the bed and drip stand from a previous patients use..."

"...Two days later back in A&E Majors unit, we found him in a bed covered in blood and fluids where the cannula had burst hours before, nobody had been in to check or clean him up..."

"After four days in a waiting room had to ask could they clean my husband up sat in own mess four days they did then throw the bag of human waste at me and said not our problem I had to then put in a litter bin in waiting room, this was in front of everyone so embarrassed and what about infection, disgusting place."

"...Poor domestic staff were more caring and visible that any care or nursing staff and they were trying to keep the place clean while interacting with patients and helping..."

The health board must ensure:

- **Appropriate facilities are available, or clear escalation arrangements are in place, for the safe management of patients requiring isolation for airborne infections**
- **IPC audits are undertaken consistently, with clear oversight, action plans and monitoring where compliance issues are identified**
- **Hand hygiene facilities are clearly visible and accessible throughout the waiting area, particularly at entry points**
- **Cleaning arrangement in high-turnover areas, including waiting room seating, are strengthened and clearly documented**
- **Staff respond promptly and appropriately to patients' basic care and environmental needs, including where IPC risks are identified**

- **Learning from patient feedback relating to cleanliness and IPC is reviewed and used to inform improvement action within the department.**

Safeguarding of children and adults

At the time of inspection, staff advised there were no patients in the department subject to Deprivation of Liberty Safeguards (DoLS). However, we observed an incident involving a confused patient who was unsupervised and wandering within the department. The patient was dressed in a hospital gown and was observed entering side rooms and attempting to interact with other patients. The patient had moved through two sets of double doors and was found in an area away from their assigned bed space. The staff response was limited, except for one healthcare support worker (HCSW), who made appropriate efforts to safely support and redirect the patient back towards their bed area. This observation raised concerns regarding the ongoing assessment of patient capacity, the recognition of situations where a deprivation of liberty may be occurring and the effectiveness of supervision arrangements for confused or vulnerable patients.

Staff we spoke with reported they were aware of the organisation's safeguarding policies and procedures for both children and adults at risk. Some staff were unable to clearly describe how to access these policies, although they were able to explain the process for making safeguarding referrals. Staff demonstrated a general understanding of mental capacity and safeguarding principles and there was evidence to demonstrate relevant training had been completed. We were informed patients identified as being at risk would be placed under appropriate levels of observation and safeguarding concerns would be escalated in line with established procedures. For patients at risk of self-harm or suicide, staff described the use of a designated mental health room and risk assessment processes to guide care and supervision.

These findings suggested a need for enhanced oversight and reinforcement of safeguarding practice to ensure vulnerable patients were consistently protected, appropriately supervised and supported in a way that upholds their rights.

The health board must ensure:

- **Vulnerable or confused patients are appropriately assessed, monitored and supervised, with clear escalation where risks are identified**

- **Staff recognise and respond appropriately to situations may require consideration under DoLS or wider mental capacity arrangements**
- **All staff know how to access safeguarding policies and procedures and understand their responsibilities for escalating safeguarding concerns**
- **Safeguarding documentation is completed, retained and readily available for review where risks or concerns are identified.**

We reviewed safeguarding documents in use within the organisation, which were aligned with the Wales Safeguarding Procedures (2019). The Adults at Risk procedure included a clearly defined process, supported by a flowchart. This outlined the requirement for an emailed safeguarding report, supported by a risk assessment and protection plan.

The Child at Risk procedure provided clear guidance if there were concerns a child was experiencing, or was at risk of, abuse, neglect, or harm, or had identified care and support needs. The procedure was supported by training delivered by the Corporate Safeguarding Team and escalation processes through the North Wales Safeguarding Board, including the Resolution of Professional Differences protocol.

We also reviewed the SOP dated May 2022 for children and young people under 18 who attended the ED but left before being seen by a clinician. This procedure outlined the management and review of these cases, including safeguarding considerations to ensure risks were identified and escalated where appropriate.

We noted a paediatric patient, who was reported to use a Class B controlled drug daily, was admitted to the paediatric ward from the ED. However, we could not locate the associated safeguarding documentation. **These concerns were addressed through our Immediate Assurance Process and are detailed in Appendix B of this report.**

Medicines management

The department had access to a dedicated on-site pharmacist service. Pharmacy support was available during core hours, with out-of-hours advice available through an on-call pharmacist and site-based arrangements to support continuity of medicines management when required. We were also told WAST crews had access to a separate medication management room.

Staff told us systems were in place to support the safe administration of medicines, and we observed medicines were generally stored securely in line with expected standards. The controlled drugs (CDs) checked during the inspection were in date, countersigned and reconciled correctly against the stock check. However, the CD registers were not consistently completed, with missed daily checks in the resuscitation area.

We noted the health board was in the process of updating its Medicines Policy framework, including policies relating to the safe custody, management and use of CDs and the safe storage of medicines in clinical areas. These policies were intended to provide a clinical and corporate governance framework for medicines management.

We reviewed resuscitation equipment in the Majors area and found the MyKitCheck digital system was being used to record equipment checks. Although checks were documented as completed, we identified significant deficiencies, including missing defibrillator pads, absent bag-valve masks and incorrect syringes were unsuitable for use.

Across the department, we identified multiple concerns relating to medicines and equipment management. Several items were out of date, including potassium, feeding equipment and pH testing kits, with some expired as far back as 2020. Medications and fluids, including sodium chloride and metronidazole, were also found to be improperly stored or left unsecured.

Chlorine-based cleaning products were accessible in unsecured utility rooms, and one utility room door could not be locked despite this having been reported. Further concerns included incomplete daily safety checks, an overfilled medication fridge affecting safe storage and inappropriate access to stored fluids.

Overall, we were not assured medicines management and equipment safety systems were effectively implemented. The issues identified presented potential risks to patient and staff safety. **These concerns were addressed through our Immediate Assurance Process and are detailed in Appendix B of this report.**

Preventing pressure and tissue damage

We reviewed documentation and practice relating to the assessment and prevention of skin pressure and tissue damage within the ED. We found pressure risk assessments and associated wound care documentation were not completed consistently or in a timely manner. There was limited evidence to demonstrate assessments were routinely undertaken, reviewed, or updated during patients' time within the department.

We also found insufficient evidence that appropriate preventative measures were consistently implemented or recorded, including the use of pressure-relieving equipment and regular repositioning. This was not in line with expected standards for pressure ulcer prevention and presented a potential risk to patient safety, particularly for patients who were immobile, frail or at increased risk of skin breakdown.

The health board must ensure systems and practice to support pressure ulcer prevention are strengthened including:

- **Timely and consistent completion, review and updating of pressure risk assessments**
- **Clear documentation of preventative interventions, including repositioning and skin integrity checks**
- **Availability and timely access to appropriate use of pressure-relieving equipment**
- **Effective oversight and assurance arrangements to monitor compliance and address gaps in practice.**

Falls prevention

In an ED setting, falls risk assessments should be completed as soon as possible following admission and ideally within one hour. This was particularly important for

patients who were acutely unwell, frail, immobile or otherwise at an increased risk of falls or avoidable harm. These early assessments were essential to identify individual risk, inform care planning and enable timely preventative action. However, we found falls assessments were not consistently completed within the expected time. Bed rail risk assessments were also not routinely undertaken where applicable.

We identified concerns regarding staffing levels, specifically the availability of HCSWs, which affected the department's ability to safely support patients at risk of falls. There was insufficient staff capacity to assist patients who required support with mobilisation, including access to toilet facilities. This presented a potential risk to patient safety, particularly for patients at increased risk of falls.

We also identified HCSWs were undertaking initial risk assessments for falls and skin integrity. This was not in line with expected practice. Risk assessments should be completed by a registered healthcare professional and used to inform clinical decision-making and care planning. HCSWs should support the implementation of care interventions based on the assessed risks and in line with established care plans. This lack of role clarity contributed to inconsistencies in assessment quality and increased patient safety risks. Moving and handling assessments were completed appropriately.

The health board must ensure:

- **Falls risk assessments are completed by appropriately trained staff within the expected time**
- **Preventative actions, including falls prevention measures and the use of bed rails where appropriate, are fully documented**
- **There are sufficient staff available to support patients at increased risk of falls, including those requiring assistance with mobilisation and toileting**
- **Staff roles and responsibilities for completing assessments and implementing care interventions are clearly defined, understood and followed.**

Nutrition and hydration

We observed mealtime arrangements to assess how staff supported patients with food and drink. Hydration provision was generally available, with multiple water refill stations stocked with cups.

The wellbeing team provided support during mealtimes, including assisting patients and cleaning surfaces where possible. A designated server was available during lunch periods. However, responsibility for evening meal distribution often fell to HCSWs and nursing staff. During periods of increased demand, this contributed to delays in meals being served.

The food we observed appeared appetising and varied, with options available to meet a range of dietary and cultural needs. Additional items, including desserts, sandwiches, yoghurts and snack bags containing fruit and biscuits or chocolate were also available. Patients in waiting areas were offered snack bags and breakfast options, such as cereals, through a morning trolley service.

Patients and carers we spoke with during the inspection were generally positive about food and drink provision and confirmed they were offered choices and assistance where required. The availability of snacks and beverages throughout the day, supported by the wellbeing team and nursing staff, was a notable strength. However, improvements were needed to ensure provision was consistent during peak periods and prolonged waits and to improve visibility and availability of drinking aids.

Patient questionnaire comments presented a mixed picture. Some patients described regular offers of food and drink, while others reported difficulties accessing suitable food, drinks, or dietary alternatives during prolonged waits. Comments included:

> *“Food that was on offer was junk food from a vending machine or tea or coffee machine (which was out of order) …”*

> *“…Being a diabetic, I was lucky to get breakfast, and my family brought me food and drink in at other times…”*

“Better access to Gluten-free / dairy free foods. It's not possible to check ingredients in the vending machines and with coeliac disease and lactose intolerance, it was a long and hungry 18 hours till I made it to a ward.”

“My grandparent has dementia, every day for mealtimes she would be given food that included gluten, My grandparent has an allergy, it was in the notes, but nothing was done about it.”

“My 79-year-old father-in-law, a cancer patient, was made to wait in the a&e corridor in a chair for 3 days. He had no food or drink for the full three days…”

“Myself and many others have received treatment in the corridors on a chair, not being offered food or drink…”

However, experiences were not all negative and some patients reported positive support with food and drink. One respondent commented:

"The staff were marvellous; we were offered food & drink regularly."

The health board must ensure patients, including those in waiting areas and corridor care, have timely and consistent access to appropriate food, fluids and assistance with nutrition and hydration. This must include arrangements for patients with specific dietary, cultural, allergy-related, or clinical needs and clear processes to ensure food and drink provision is maintained during prolonged waits and periods of increased demand.

Patient records

We reviewed six patient records and identified significant concerns regarding clarity, structure and usability of clinical documentation. These issues had implications for patient safety, continuity of care and the ability of staff to make timely and informed clinical decisions.

Overall, patient records were inconsistently structured and often difficult to navigate. Documentation did not follow a standardised layout, with key clinical information,

observations, escalation decisions and risk assessments recorded at various times and in different sections. This made it challenging to obtain a clear, chronological understanding of each patient's clinical journey. In several cases, observations were recorded but not promptly entered within formal scoring systems, reducing their effectiveness in supporting timely clinical decision-making.

As a result, the records would not reliably support safe care delivery, particularly for agency or other staff unfamiliar with the documentation format. Important clinical risks, including immunocompromised status, sepsis indicators, falls risk and safeguarding needs, were not always clearly highlighted or consistently acted upon. Documentation also frequently lacked clear escalation plans, evaluation of interventions and evidence of ongoing clinical review. This increased the risk staff would need to interpret incomplete information or rely on verbal handover.

Across the cases reviewed, delays in assessment, diagnosis and treatment were a consistent theme and were often compounded by poor documentation. This included one example where there were delays in blood sampling and escalation of care, although sepsis screening was eventually completed. While documentation improved later in the patient journey, early recognition of risk and timely response was not adequately prioritised. These issues presented a significant risk to patient safety, particularly for vulnerable patients experiencing prolonged ED stays or receiving care in corridors.

The health board must strengthen patient record-keeping arrangements to ensure:

- **Assessments, treatment decisions and escalation actions are documented clearly, promptly and consistently**
- **Patient records follow a clear and standardised structure supports safe, effective and continuous clinical care**
- **Clinical pathways, including sepsis and deterioration pathways, are followed and clearly evidenced in the patient record**
- **High-risk patients are clearly identified, monitored and reviewed, with risks and actions documented in a timely manner**
- **Records clearly evidence the delivery, review and evaluation of fundamental care.**

Effective

Effective care

Patients and carers we spoke with were grateful for the care provided. Several described experiencing long waits, often linked to difficulties accessing care in the community before attending the ED. Despite these pressures, patients consistently commented on the kindness of staff and recognised how hard staff were working.

We met with the Assessment and Discharge Team (ADT) based in the ED quadrant. Although the team's remit was limited to patients who were medically fit for discharge, there was clear evidence of effective multidisciplinary working across a range of specialties. Despite the absence of consistent social work input, the team demonstrated a strong commitment to improving collaboration between health and social care services, with a focus on timely discharge planning and access to care packages.

The team described effective coordination with progress chasers, ward staff and ED colleagues to support the prompt discharge of medically fit patients. The team also highlighted the "winter sprint" initiative, which introduced enhanced assessment and support at home. This approach contributed to more timely discharges and its outcomes were being reviewed by the health board.

Feedback received by the team from patients and carers was generally positive, with many expressing gratitude for the care received and consistently acknowledging the kindness and dedication of staff.

We reviewed the corridor care SOP. This defined limits for corridor use, including to three trolleys in Majors A, two trolleys in Majors B within line of sight, four ambulatory patients in the main corridor and two treatment chairs in the Simple Triage and Rapid Treatment (STaRT) area. The SOP stated corridor care must not breach safe nursing ratios of one to four patients, and every patient must have a named nurse. It also included strict exclusion criteria, including patients presented with deteriorating observations, frailty, a requirement for continuous monitoring or active resuscitation, high falls risk, delirium, dementia with wandering, or suicidal ideation.

The SOP made clear that corridor care was not commissioned and should only be used as a temporary risk mitigation measure. It must not become routine practice. The SOP

also stated corridor care should cease if fire safety was compromised, staffing levels fell below 16 registered nurses, a corridor patient deteriorated, or any patient remained in the corridor for more than six hours.

Due to the pressures within the ED, these conditions were frequently breached. We observed five patients on trolleys in Majors A and three in Majors B and were told some patients remained in corridor areas overnight.

The health board must:

- **Ensure that corridor care is used only in exceptional circumstances and is managed safely, with appropriate staffing, clinical oversight, escalation arrangements and respect for patient dignity**
- **Take sustained action to reduce reliance on work towards corridor care.**

Staff questionnaire responses about the quality and safety of care indicated, while more than half of staff were satisfied with the care they personally provided, 45%, expressed concerns about overall quality of care. Comments indicated that staff often felt they were often unable to deliver the standard of care they wished to provide, particularly due to overcrowding and limited resources.

We reviewed a range of audits, from 2024 and 2025, including audits relating to chest pain, blood gas, knee assessment, venous thromboembolism risk assessment and appropriateness of ankle X-rays. These audits were reported through meetings and consistently identified gaps in fundamental clinical assessments. Although these issues had been identified and recorded, they reflected weaknesses in core routine care.

The health board must ensure lessons learned from audit findings are translated into timely improvement action, with clear ownership, monitoring and feedback to staff to support sustained improvements in practice.

We observed examples of compassionate care and additional support being provided in the waiting area. Staff were clearly doing what they could within the constraints of the environment and available resources. However, the volume of patients meant there

were insufficient staff to meet patients' needs. This reflected wider system pressures, including demand generated by difficulties accessing appropriate advice and care through community services, general practice and NHS 111.

We were told GPs were sending referrals to an email address that was not being monitored. As a result, some patients arrived at the ED without the department having prior knowledge of their referral. We were also provided with information about 29 ED attendances, which showed 15 had been inappropriately referred to the ED by a GP or the community service. In a further 14 cases, there was reported reluctance by specialities to accept referrals from the ED, with some requiring escalation to an ED consultant. This placed additional pressure on the ED, increased demand on triage and contributed to delays for patients who required emergency care.

The health board must ensure:

- **Referral pathways into the ED are clearly communicated to GPs, community services and other referrers**
- **Incorrect or inappropriate referrals are reviewed with the referring service to support learning and reduce recurrence**
- **Speciality teams respond promptly to appropriate ED referrals to support patient flow and avoid unnecessary delays**
- **Unmonitored referral routes are closed or clearly redirected, and referrers are informed of the correct process for making referrals.**

We spoke with a senior member of staff in the Same Day Emergency Care (SDEC) department and identified several concerns. These related to:

- Clinical decision-making and safety, including instances of inappropriate referrals to SDEC
- Capacity and environment, including patients being accommodated overnight in SDEC areas designed for chair-based care, with beds introduced temporarily and limited privacy screening
- Pathway and capacity constraints, with the unit heavily used for follow-up patients, such as repeat blood tests, which restricted availability for ED referrals

- Overnight care in SDEC, including patients being held overnight, sometimes for extended periods of up to one week, in facilities not designed for this purpose and without appropriate privacy or infrastructure. Patients requiring nutrition relied on support from other units, such as the surgical assessment unit.

We were told staff were sometimes reluctant to direct patients from triage to SDEC because this was not perceived as usual practice and because SDEC capacity was often limited. Staff told us patients deemed suitable for SDEC would be accepted where capacity allowed. These findings indicated a need to strengthen staff understanding and consistent use of the SDEC pathway.

The health board must ensure:

- **The use of the SDEC is reviewed to ensure it is appropriate, safe and aligned with its intended function**
- **Any overnight use of SDEC is reviewed to ensure patients are cared for in an appropriate environment that maintains safety, privacy and dignity**
- **Staff are provided with clear guidance and training on the SDEC pathway, including referral criteria and escalation arrangements.**

We observed the paediatric emergency department and identified the following concerns:

- The paediatric emergency department was left unattended by medical and nursing staff while patients were present
- Following triage, a paediatric patient was returned to the paediatric waiting room when enhanced monitoring would have been more appropriate and cannulation had not yet taken place
- There was no paediatric trained nurse present in the paediatric ED at the time of inspection. We were told two paediatric trained nurses were scheduled to start in September 2026
- A patient, reported to be detained under the Mental Health Act in a nearby unit, entered the paediatric ED but was challenged by staff

- The paediatric resuscitation trolley was kept in one of the paediatric treatment bays, which meant it was not readily available in an emergency.

These concerns were addressed through our Immediate Assurance Process and were detailed in Appendix B of this report.

Managing Patient Flow

We spoke with staff about governance, patient flow and clinical safety. Accountability for patient flow and safety-critical decisions was not clearly defined, with staff providing varied responses about where ultimate responsibility sat. Although roles such as site manager and coordinator were identified, decision-making appeared to vary depending on individuals involved. There with limited clarity about escalation pathways and inconsistent recording of safety-critical decisions**.** Staff also raised concerns about the timeliness and accuracy of information shared and how effectively this was translated into operational practice.

Processes to manage flow and escalation were in place. However, frontline staff were not consistently aware of these processes and there was limited evidence they were implemented or monitored effectively. Staff reported raising concerns through line management, but there was little evidence of follow-up action, audit, or feedback.

We identified significant gaps in clinical risk assessment, including inconsistent use of observations and NEWS scoring, with delays in recognising deterioration. Frailty, safeguarding and mental health assessments were not completed consistently, and escalation was often dependent on visual recognition rather than structured processes.

Admission and bed allocation decisions were reported to be influenced by available of space rather than clinical need. There were delays in specialist review and patients waited for extended periods without reassessment. Handover processes were inconsistent, often verbal and not supported by comprehensive documentation.

Patients remained in the ED for prolonged periods. Corridor care was widely used and had become normalised, often without adequate monitoring or consistent provision of basic care needs. Observations, medication administration and escalation processes were not consistently maintained during these periods.

Staff survey responses reinforced these findings, with one member of staff stating:

> *"Biggest issue in ED affecting care and dignity is the lack of flow out of ED creating very long bed waits and people held in inappropriate area awaiting a bed on a ward."*

Staffing pressures were evident, with limited escalation actions taken in response to unsafe staffing levels. Flow-related delays impacted delivery of time-critical treatments and there was limited evidence of consistent monitoring, audit, or learning from incidents.

Overall, systems intended to support safe patient flow were not consistently applied. This created significant risks linked to inconsistent governance, limited clinical oversight and persistent operational pressures. Staff survey feedback strongly reflected these findings. Staff consistently identified patient flow as the most significant operational challenge affecting the department, describing delays in transferring patients to inpatient wards, prolonged ED stays and the routine use of corridor areas as consequences of wider hospital capacity pressures. Staff linked these issues to reduced privacy and dignity, delays in care and increased risk to patients and staff.

The health board must ensure patient flow arrangements include clearly defined accountability, escalation routes and documentation of safety-critical decisions, with evidence concerns are acted upon and monitored.

We were informed that patient flow and bed management were overseen at site level through a structured leadership framework, including the deputy head of site and senior managerial oversight. Daily flow was managed through scheduled meetings and huddles, including early morning, midday and afternoon calls, as well as system-wide resilience meetings. These meetings provided an overview of capacity, demand and operational pressures, including bed availability, discharges and system pinch points.

Processes were in place to monitor patient flow, including sitrep screens, electronic systems and shared communication platforms. These were updated regularly and used to inform decision-making. Discussions included bed capacity across specialties, outliers, patients medically fit for discharge and availability of community placements.

Plans to improve flow included forward boarding and escalation discussions with ward teams, supported by progress chasers.

Arrangements to ring-fence beds for specific specialties were described, including stroke, cardiac and critical care areas. However, these beds could be reallocated according to demand, with capacity created when required. Reviews of patient placement and length of stay were undertaken regularly, although some reporting activity was noted to have lapsed during staff absence.

Overall, structured processes for managing patient flow were in place, with regular review and coordination across the hospital and wider system. However, these arrangements were not consistently effective in reducing risk or preventing prolonged waits in the ED.

We reviewed a range of patient flow and bed management documents, which outlined the health board's processes for managing capacity, escalation and safe patient movement across the hospital. Several procedures were in date and clearly defined, including the Accelerated Boarding in Extremis SOP. This set out a structured process for the temporary boarding of clinically stable patients overnight when the hospital was at full capacity and all standard flow measures had been exhausted. This document emphasised that boarding was a crisis measure, rather than routine practice, intended to maintain patient safety and ambulance flow. Similarly, the Your Next Patient / Forward Waiting SOP provided a framework to support timely patient flow and reduce delays, with the aim of ensuring patients were cared for in the most appropriate setting as early as possible.

Other documents provided clear operational guidance, including the patient transfer procedure, which outlined roles, responsibilities and requirements for safe patient transfers, including escort levels and continuity of care. The Inpatient Patient Boarding and Transfer SOP, dated November 2025, described processes to reduce risk during periods of overcrowding by facilitating transfer of patients to inpatient wards.

We also reviewed supporting documents, including escalation action cards, admission pathways and protected bed policies, which described expected standards for prioritisation and patient placement. However, several documents were found to be undated, incomplete, or overdue for review, including the Non-Invasive Ventilation SOP, pre-emptive boarding guidance and a general risk assessment document. The risk

assessment identified significant operational risks, including extended ambulance waits, overcrowding, lack of appropriate care spaces, reduced privacy and dignity and staffing pressures.

Overall, whilst a comprehensive suite of patient flow documentation was in place, the contrast between the number of patient flow policies, escalation processes and operating procedures in place and the experiences described by patients and staff, was particularly striking. Whilst arrangements existed on paper, both inspection findings and survey feedback indicated prolonged waits, overcrowding and corridor care continued to be routinely experienced in practice.

The health board must ensure patient flow policies, SOPs and risk assessments are current, complete, regularly reviewed and consistently implemented in practice.

During the inspection, we identified examples where patient flow was not effective, which included:

- Flow between the ED, the surgical assessment units and the acute medical unit was limited because these areas could not actively transfer patients where no bed spaces were available, despite repeated meetings and escalation
- Demand for inpatient beds exceeded available capacity, including three resuscitation beds being occupied by patients awaiting medical and surgical ward beds
- Onward referral and specialty acceptance were delayed in some cases, with staff reporting some patients remained in the ED for longer because the department was perceived as a place of safety.

The health board must ensure:

- **Patient flow through the ED is improved through clear, measurable and sustained whole-hospital actions**
- **All relevant specialties and hospital teams share responsibility for improving patient flow and reducing waits in the ED**

- **Senior managers outside the ED are responsive to patients and staff risks within the ED and actively support improvements across the wider hospital system.**

Staff comments in the HIW questionnaire reinforced these findings. Staff consistently described the department as operating over capacity, with poor patient flow identified as a key concern. Comments highlighted delays in moving patients through the department and onto wards, resulting in prolonged ED stays and the continued use of corridor areas. Only 17% of staff agreed patients were assessed within four hours, with the majority disagreeing.

The health board must strengthen specialty referral and escalation arrangements to ensure patients are reviewed, accepted and transferred in a timely way according to clinical need.

Quality of Management and Leadership

Staff Feedback

We issued a questionnaire to obtain staff views and understand their experiences on patient care, professional development and management within the ED. In total, we received 57 staff responses.

Staff feedback described a service operating under sustained operational pressure, with staffing shortages, poor patient flow and environmental limitations affecting both staff experience and delivery of care. While staff demonstrated strong commitment, resilience and teamwork, responses highlighted concerns about capacity, leadership visibility, communication and organisational responsiveness. These factors contributed to low morale and reduced confidence in the ability to provide consistently safe and dignified care.

Views of immediate line managers were generally positive; with many reporting they felt supported locally. However, confidence in senior management was more limited. Staff described poor communication, limited visibility of senior leaders and a perceived lack of engagement with frontline staff. Free text comments also reflected concerns about organisational culture, including staff feeling undervalued, unheard and insufficiently involved in decisions affecting the department.

A considerable proportion of staff reported the environment, and facilities were not suitable to support safe and effective care. Respondents highlighted limited clinical space, equipment availability and the impact of corridor care, with many indicating patient privacy and dignity could not always be maintained. Staff frequently described the challenges of balancing emergency care with the ongoing care needs of patients experiencing prolonged stays within the department.

Staff comments consistently highlighted strong teamwork, resilience and commitment, with many stating they were doing their best in difficult circumstances. The paediatric area was specifically highlighted positively in two responses. However, concerns regarding patient flow, overcrowding, staffing pressures and senior leadership visibility were recurring themes concern across both quantitative and qualitative feedback. Feedback from staff, patients, families and carers also identified concerns regarding oncology patients not always being cared for in clinically appropriate environments.

The consistency of staff survey feedback was notable. Responses from a range of professional groups described many of the same concerns, including patient flow, overcrowding, corridor care, staffing levels, skill mix and the impact of these pressures on patient safety, dignity and experience. Whilst staff consistently described a caring, resilient and committed workforce, many responses reflected frustration that longstanding operational pressures continued to affect both patient care and staff wellbeing.

Of particular concern was the extent to which issues such as overcrowding, corridor care, workforce pressures and delays in patient flow appeared to be viewed by some respondents as normal features of service delivery rather than exceptional circumstances. Staff frequently described feeling unable to provide the standard of care they wished to deliver and reported limited confidence concerns raised would consistently result in meaningful action or sustained improvement.

Staff feedback described a workforce that remained committed to delivering safe and compassionate care despite significant operational pressures. However, the extent to which longstanding operational issues appeared to have become normalised presented a risk that unacceptable conditions may increasingly be viewed as unavoidable rather than requiring urgent and sustained improvement.

The health board must:

- **Ensure operational risks highlighted by staff, including those relating to patient flow, corridor care, staffing levels, skill mix and patient safety, are not accepted as routine practice**
- **Demonstrate sustained action to address these issues and provide assurance concerns raised by staff lead to timely review, decision-making and measurable improvement.**

Leadership

The department had established governance arrangements in place, including relevant policies, formal meetings and scheduled clinical huddles throughout the day. Staff survey findings provided important context to our leadership and governance findings.

While staff consistently described colleagues as committed, hardworking and focused on providing the best possible care for patients, responses also highlighted significant concerns regarding patient flow, overcrowding, staffing levels, skill mix and the impact of these pressures on care delivery. Staff frequently described low morale, limited confidence that concerns raised would result in meaningful action and a perceived disconnect between frontline experience and organisational decision-making. Collectively, the findings suggested a workforce that remained resilient and committed to patient care but was increasingly affected by sustained operational pressures and longstanding system challenges.

Documentation reviewed showed processes for oversight, audit and incident review were in place. However, we found limited assurance these arrangements were consistently implemented in practice. There was insufficient evidence to demonstrate policies, procedures and agreed actions were reliably followed at operational level. This gap between documented processes and observed practice reduced the effectiveness of governance systems.

Clear leadership structures were in place, and senior teams were reported to engage regularly with one another. Staff confirmed senior managers attended the department. However, we identified a gap between senior leadership and frontline staff, particularly in relation to communication and the translation of decisions into practice. Information was shared effectively at senior levels, but there was limited evidence of this being consistently communicated to, or embedded within, the ED team.

Staff feedback also suggested frontline teams did not always feel sufficiently involved in decisions affecting the department. Comments included:

> *“Senior management are good however I do feel like they don't speak to the staff working the floor when trying to implement changes; if they did the changes would be better and safer for the patients."*

> *"Staff are not adequately involved in changes. Senior management do not involve the clinical team in decision making."*

This reflected a broader theme within the staff survey. Whilst many staff reported feeling supported by immediate colleagues and line managers, confidence in senior

leadership was lower. Staff described limited visibility, inconsistent communication and concerns that frontline experience was not always reflected in organisational decision-making.

Communication arrangements between management teams were evident. However, effective communication between the ED and the Board was not consistently demonstrated. Upward and lateral communication, between staff, managers and leadership teams was reported to take place, but downward communication to frontline staff was inconsistent, with limited visibility of decisions, actions or resulting changes in practice.

Staff views regarding local leadership were mixed. While some concerns were raised, respondents also described positive support from immediate leaders. One member of staff commented:

> *"Our matron is very supportive and tries* to get staff to engage as much as *possible with improvements within the department."*

The department sought to maintain staffing through internal resources. However, due to workforce pressures, there was a regular reliance on bank and agency staff to support safe service delivery.

We reviewed a range of policies and SOPs and found several were out of date, unratified, or overdue for review. The absence of current and ratified documentation presented a risk to safe, consistent practice and staff guidance. These included:

- ED Huddles, Handover and Escalation SOP – not ratified and out of date
- WAST SOP – out of date since February 2026
- Physical Restraint Guidance – dated 2018, requiring update
- Ward Administration SOP – over 12 months out of date and still in draft form.

We reviewed records from the three ED governance meetings between January and March 2026. These demonstrated incidents, audits and operational challenges were regularly discussed. However, we found limited evidence of sustained improvement

over time. Similar issues were raised with us across consecutive meetings during the inspection, including those relating to serious and catastrophic incidents, with limited evidence of new learning, measurable improvement, or effective implementation of actions.

Recurring themes discussed at governance meetings included:

- Extended waiting times and delays in patient care
- Patients remaining in inappropriate clinical environments for prolonged periods
- Incomplete or delayed documentation
- Missed or delayed risk assessments, in some cases contributing to adverse patient outcomes
- Operational pressures linked to human factors.

The governance meeting minutes of 8 January 2026 included discussion of a rapid review case in which delay, crowding and the patient's low initial clinical score were identified as factors affecting escalation. The discussion recorded reflection on whether the patient could have been streamed directly to surgery or received earlier surgical review. Although no specific new learning points were identified, the case was recorded as reinforcing existing themes around long waits, prioritisation and escalation. The minutes also noted clinical commentary that prolonged waits of around 11–12 hours could turn initially straightforward clinical problems into more complex cases, particularly where time-critical intervention was required.

We identified that, although a rapid feedback approach had been adopted to support reflection and professional development, there was no consistent formal documentation of all events or learning outcomes. The absence of documented reporting and follow-up limited the department's ability to demonstrate learning, track improvement over time and provide assurance from a governance and legal perspective. This was particularly concerning given the known issues with the timeliness and completeness of clinical documentation.

Of particular concern was the disparity between staff awareness of reporting mechanisms and confidence in organisational response. Whilst staff generally understood how to raise concerns and report risks, significantly fewer felt confident

concerns would result in meaningful action. This raises questions regarding the effectiveness of feedback mechanisms, organisational responsiveness and the degree of assurance available to leaders regarding frontline concerns.

Overall, governance structures, leadership frameworks and formal meeting processes were in place. Policies, procedures, governance meetings, incident reporting arrangements and escalation mechanisms demonstrated that systems existed to support oversight and risk management. Evidence reviewed during the inspection showed that concerns relating to patient flow, corridor care, staffing pressures, documentation, risk assessment and delays in care had been identified through a range of governance processes, including incident reporting, staff survey findings and governance meetings.

A notable finding from the staff survey was the difference between staff views of local leadership and perceptions of wider organisational leadership. Staff were generally more positive about support from immediate colleagues and line managers than they were about senior leadership visibility, communication and organisational responsiveness. This suggested whilst local leadership relationships were often viewed positively, confidence reduced as concerns were escalated through the wider system.

Taken together, inspection findings, governance documentation, staff feedback and incident reporting data indicated a disconnect between governance arrangements as described and the experience of staff working within the department. Whilst structures, meetings and policies were in place, there was insufficient assurance these arrangements were consistently resulting in learning, improvement, staff engagement or a sustained reduction in risk. Persistent concerns regarding patient flow, staffing pressures, corridor care and escalation had been recognised through multiple governance mechanisms, yet many of these issues continued to be raised by staff and were reflected in our inspection findings.

The health board must ensure it:

- **Strengthens the implementation, monitoring and evaluation of governance processes to ensure they are effective in practice**
- **Improves communication between senior leaders, managers and frontline staff, including clear feedback on decisions, actions and progress**

- **Promotes a positive, open and psychologically safe culture that supports escalation, learning and staff engagement**
- **Maintain policies and procedures so they are current, ratified accessible and actively used in practice**
- **Embed a robust system for documenting, reviewing and learning from incidents, with clear ownership, timescales and evidence of completed actions.**

We reviewed 210 Datix incidents, covering the 12 months before the inspection and relating to care within the ED. Several recurring themes were identified, particularly in relation to corridor care, patient safety, communication and documentation. The analysis identified recurring concerns relating to:

- Patient safety within corridor care environments
- Delayed or absent clinical monitoring
- Communication issues between staff and with external services
- Incomplete clinical documentation
- Ineffective recording of patient movement or redirection.

A considerable proportion of reported incidents related to pressure damage, with patients accommodated on unsuitable chairs or trolleys without adequate pressure-relieving measures. In several cases, patients were reported to have remained unobserved for extended periods, with limited evidence of regular checks or repositioning. We noted serious incidents relating to patient safety while in corridor areas.

The recurrence of similar themes within Datix reports, governance meetings, staff survey findings and inspection observations raised concerns regarding the effectiveness of organisational learning and the extent to which known risks were being mitigated. The persistence of these issues across multiple assurance mechanisms suggested opportunities to translate learning into sustained improvement had not always been fully realised.

The health board must strengthen review and learning from ED Datix incidents, including corridor care, pressure damage, monitoring and documentation, to support sustained improvements in patient safety.

Workforce

Skilled and enabled workforce

Staff demonstrated an understanding of the importance of communicating with patients in their preferred language. Welsh language skills were considered during recruitment, although they were not identified as an essential requirement for posts within the department.

Staff reported staffing levels were insufficient to meet clinical demand, particularly within escalation areas. Although staff understood their escalation responsibilities and described effective multidisciplinary working, including with the ADT, they said they did not have sufficient time or capacity to provide care safely and consistently to meet patient needs.

We reviewed the ED Roster Management SOP, which was due for review in June 2025. The SOP outlined arrangements for reviewing, identifying and responding to potential clinical risks, in line with the Royal College of Emergency Medicine guidance. It also provided direction on ward administration duties within the ED.

Staffing levels across nursing and medical teams were a significant concern, particularly at weekends. Staff reported rota gaps, with middle-grade doctor shifts frequently filled by locum staff. Consultants confirmed concerns about staffing had been escalated, but requests for additional resource had not been approved. Staffing levels were not aligned to patient acuity, including within resuscitation areas where high-acuity patients were being managed with limited staffing and insufficient paediatric-specific provision. Awareness of escalation arrangements varied, with senior staff generally demonstrating a clearer understanding of the process than junior staff. Although escalation policies were in place, staff reported that escalation did not consistently result in effective organisational action.

The health board must ensure:

- **All staff understand escalation policies and procedures**
- **Escalation concerns are recorded on DATIX where appropriate**
- **Organisational responses to escalation are documented and communicated to staff.**

We were informed a business case for increased staffing had been submitted over a two-year period, but this had not resulted in changes to staffing levels. Weekend staffing levels were described by one clinician as "*grossly understaffed*."

Absence rates were reported at 8.64% and there was evidence of reliance on agency and locum staff.

The department did not meet the requirement for two registered children's nurses where children were treated. Plans were in place to address this, with two posts expected to be in place by September 2026.

Section 25B of the Nurse Staffing Levels (Wales) Act 2016 placed a duty on health boards to calculate and maintain appropriate nurse staffing levels in specified inpatient settings. Although this statutory duty does not apply directly to EDs, the acuity and complexity of patients in the ED meant that similar workforce planning principles were relevant. We were not provided with evidence to demonstrate that staffing levels had been regularly reviewed against patient demand, acuity and activity, or that staffing had been maintained at a level sufficient to meet these needs.

Despite workforce planning processes and escalation mechanisms being in place, we found evidence of sustained staffing shortfalls, particularly at weekends. Staffing levels and skill mix were not sufficient to consistently meet patient demand, with ongoing reliance on locum and agency staff and gaps in paediatric provision. Staff survey responses consistently highlighted concerns regarding staffing levels and skill mix. One respondent stated:

> *"More often than not we work under our core staffing and with poor skill mix."*

Staff survey findings also indicated workforce challenges were not limited to staffing numbers alone. Responses consistently referred to difficulties relating to skill mix, training opportunities, retention of experienced staff and the ability to release staff for development and professional learning. Taken together, these findings suggested a workforce under pressure not only from demand levels, but also from the cumulative impact of prolonged operational strain.

The health board must ensure:

- **ED staffing levels and skill mix are reviewed against patient demand, acuity and activity**
- **Staffing reviews are undertaken at least quarterly and result in clear actions where gaps are identified**
- **Paediatric nursing provision is strengthened to meet the needs of children attending the ED**
- **The availability of practice development, education and professional support arrangements within the ED is reviewed to ensure staff can access mandatory, specialist and developmental training in a timely manner.**

Training was managed through the Electronic Staff Record, which senior managers used to monitor compliance. Overall mandatory training compliance was 91% for nursing staff and 67% for medical staff. However, compliance varied significantly across teams, ranging from 100% to 8.5%, indicating inconsistent uptake. From our review of five staff training records, we identified gaps in key training areas, including portable oxygen cylinder training and de-escalation training.

Staff survey responses suggested operational pressures were affecting access to training and professional development. Several respondents described being unable to attend planned training because of staffing pressures and identified a need for further role-specific development, including triage, major incident, paediatric, trauma and life-support training. Staff also highlighted the absence of a dedicated practice development role within the department. One respondent reported:

> "Always pulled off training due to poor staffing levels.

Most staff reported they had received an appraisal, annual review, or development discussion. However, just over half of staff reported having appropriate training, while others indicated training was only partially sufficient or insufficient. Free-text responses identified a lack of structured training support, including the absence of a dedicated practice development role and difficulty accessing mandatory or specialist training. Staff commented:

> *"Currently we don't have a practice development nurse in post, therefore training was lacking in most part and generally expected to be done in our spare time. Appropriate hours were not given for example for eALS, face to face hours given, but not the 10 hours e-learning that was mandatory to pass."*

The health board must ensure:

- **Mandatory training, including face to face training is completed in a timely manner**
- **Staff can access protected time, appropriate educational support and practice development resources to complete mandatory, specialist and developmental training.**

Culture

People engagement, feedback and learning

Patient feedback was gathered through the Patient Advice and Liaison Service (PALS), with reports produced monthly. Our review of records identified a stronger emphasis on positive feedback, with limited evidence to show how negative feedback was analysed or used to inform service improvement. Wider cultural concerns relating to staff engagement, psychological safety and leadership visibility also had the potential to affect staff wellbeing and the organisation's ability to respond effectively to feedback and concerns.

We reviewed PALS reports and patient feedback data for January to April 2026. These included direct and candid patient comments, with some patients describing care as rude, lacking empathy and contributing to patient distress. Some feedback indicated care was perceived as undignified, with a small number of comments described significant emotional distress.

Despite these concerns, we found limited evidence that themes from PALS feedback had been translated into clear improvement actions. Although positive comments were also included in reports, the presentation of results emphasised favourable feedback, with less focus on negative experiences. Survey data indicated that just over 200 of approximately 500 responses were positive, suggesting a more mixed patient experience than initial summary reporting implied.

Trend data showed a gradual decline in patient experience measures over time. Between December 2025 and January 2026, the proportion of patients reporting shorter-than-expected waiting times fell from 44% to 33% and those reporting they felt well cared for decreased from 69% to 65%. Measures relating to dignity, listening and involvement in care also showed minor reductions. Further data from March 2026 showed continued small declines 2% to 5% across key indicators, including feeling listened to, dignity and clarity of explanations. Overall experience ratings decreased from 58% rating care as good or very good in February, to approximately 55% in March.

Outdated Putting Things Right (PTR) guidance was still displayed, and we found no clear evidence of the new NHS Wales complaints process, Listening to People, was visible within the department. Although information on how to provide feedback was displayed across the department, including in waiting and clinical areas, signposting to Llais, the independent advocacy body, required improvement. There was also no visible evidence demonstrating to show how patient feedback had led to service changes or improvements.

The health board must ensure:

- **Patient feedback, including actions taken in response, is clearly displayed in the ED**
- **Signposting to Llais is displayed prominently in the ED**
- **The new NHS complaints process, Listening to People, replaces outdated complaints guidance and is displayed throughout the ED.**

Staff feedback raised concerns regarding psychological safety, particularly in relation to raising concerns or providing feedback. Several staff members reported fear of repercussions, and some chose to raise issues outside formal organisational channels.

This was consistent with staff survey findings and responses suggested staff generally understood how to raise concerns and were aware of organisational reporting processes. However, confidence that concerns would be acted upon was substantially lower than awareness of reporting mechanisms. This indicated that the principal issue may not be staff knowledge of reporting arrangements, but confidence in the organisational response once concerns had been raised.

Leadership visibility was described as inconsistent and not all leaders were perceived as approachable. Staff described aspects of the departmental culture as uncomfortable and, at times, unforgiving from both staff and patient perspectives.

Although staff were aware of organisational values and whistleblowing processes, confidence in using these processes appeared limited because of the prevailing culture. Staff morale was described as low, with some respondents indicating they viewed their role as 'just a job' and expressed an intention to leave. One respondent summarised staff feelings, by stating:

> *"We give our best all of the time. Morale is so low."*

While communication measures showed some improvement, the overall trend indicated increasing pressure on patient experience. We found no clear evidence of a structured response or improvement plan aligned to the Listening to People framework.

The health board must ensure patient feedback is reviewed, acted upon and monitored through a structured improvement plan with clear measures of progress.

Staff survey feedback showed that most respondents felt encouraged by the organisation to report errors, near misses and incidents. However, confidence was lower in relation to how incidents were managed and learning was shared. Specifically, only:

- 65% of staff felt individuals involved in incidents were treated fairly
- 61% believed action was taken to prevent recurrence

- 65% reported receiving feedback on changes made following incident reporting.

These findings suggested variability in staff confidence in organisational learning and the response to incidents. Staff feedback also highlighted concerns about psychological safety when raising concerns. Some staff described fear of repercussions, which may impact their willingness to use formal reporting channels. This was further evidenced by staff choosing to raise concerns directly with inspectors outside standard processes.

Staff survey responses indicated a strong understanding of the Duty of Candour; with 95% reporting they understood both the duty and their responsibilities. In addition, 86% agreed the organisation encouraged openness when things had gone wrong. While most staff, 93%, stated they knew how to raise concerns, only around half felt secure doing so in relation to unsafe clinical practice and only 25% were confident concerns would be addressed.

Feedback suggested a perception that issues raised were not consistently acted upon. Staff views on immediate line managers were generally positive, with 70% describing them as supportive. However, confidence in senior leadership was notably lower. Only 41% of staff felt senior managers were visible, 27% felt communication from senior management was effective and 49% believed senior leaders were committed to patient care. Free text responses highlighted concerns regarding limited engagement with frontline staff and lack of consultation on changes. Staff morale was widely described as low, with some comments referencing a negative or unsupportive culture.

The health board must develop and implement a staff engagement and psychological safety improvement plan for the ED. This should include actions to improve leadership visibility, staff engagement, confidence in raising concerns, feedback mechanisms and organisational responsiveness, with progress reported through established governance arrangements.

Interviews with medical and nursing staff indicated a challenging workplace culture associated with senior management. Staff described behaviours and interactions they felt contributed to conflict, negativity and emotional distress, with potential implications for staff wellbeing and patient safety. Staff also described difficulties resolving procedural issues and working with other specialities, resulting in inefficiencies and delays in decision-making for patient care. Additionally, staff

reported reluctance among some teams outside the department to accept responsibility for ED patients, despite the established SOPs in place. **These concerns were addressed as part of our Immediate Assurance Process and were detailed in Appendix B of this report.**

Learning, improvement and research

Quality improvement initiatives

We observed the wellbeing support team had a positive impact across the department, supporting both patients and staff. The initiative, introduced by the health board, was recognised as a valuable addition to patient care, although there was some variability in the consistency of the service provided.

The team provided holistic and compassionate support, focusing on the emotional and practical needs of patients during prolonged waiting periods. Although these contributions may not be easily measured through standard performance indicators, their impact was evident in improving patient experience and supporting dignity during extended waits. Patient feedback also reflected positively on these interventions, with some respondents referring to refreshments, snack bags, practical support and reassurance during prolonged waits. This suggested the wellbeing support arrangements helped mitigate some of the negative effects associated with overcrowding and extended stays, although the feedback also indicated not all patients had experienced this support consistently.

During the inspection, we observed the wellbeing team supporting a patient receiving care in a corridor, who was considering self-discharge. The team supported the patient and their spouse by providing a hot meal and enabling them to sit and eat together in a way that helped preserve comfort, dignity and a sense of normality. This intervention helped support the patient to remain in the department in challenging circumstances.

The wellbeing team reported they felt supported by most nurses in charge, which enabled them to provide this level of patient-centred care. Overall, the service was had a positive influence on patient wellbeing during extended waits and was supported by local management.

The health board must review the wellbeing support team model to ensure it is delivered consistently and that learning from the initiative is used to inform wider improvements in patient experience and dignity.

Whole-systems approach

Partnership working and development

We spoke with the Home First Step Down Team, who described a structured approach to supporting discharge and improving patient flow from acute services into community settings.

The team included a community representative within the acute setting who coordinated transfers to community services and provided guidance to ward teams. Patients who were medically fit for discharge but required ongoing support were referred for community hospital placement, enhanced care services or reablement pathways. Referrals were reviewed by consultants specialising in Care of the Elderly, who triaged patients to identify the most appropriate pathway.

The service aimed to support patients to return home wherever possible. Enhanced services, including multidisciplinary input such as district nurses and social work teams, were used to bridge gaps until formal care packages were in place. Where required, patients could be transferred to a community hospital, with a target placement of 48 hours.

The team worked across the central areas of the health board, including Conwy and Denbighshire and maintained oversight of patient flow by monitoring length of stay and maintaining patient tracking lists. These were shared with ward managers and site management teams. Regular multi-agency meetings were held with local authority, Continuing Healthcare and therapy teams to review patients and minimise delays. We found evidence of collaborative working, including:

- Follow-up contact with care homes within 24 hours of discharge
- Use of GP beds where appropriate
- Strong working relationships between the ADT, ED and ward teams.

The ADT, including occupational therapy input, was described as working effectively to support timely discharge planning. This included initiatives to enable discharge directly home following assessment. However, we were informed patient flow was affected by external system pressures, including:

- Limited availability of social care and reablement services
- Limited ability to progress discharges at weekends in some local authority areas.

These constraints resulted in medically fit patients remaining in hospital longer than necessary, including within the ED or discharge areas. Despite these challenges, we noted positive efforts by ED, ward and community teams to support patient flow and identify appropriate discharge pathways.

Patient and staff feedback both highlighted wider system challenges beyond the ED itself, including difficulties accessing primary care, delays in specialist review, discharge delays, limited community capacity and challenges accessing social care support. Collectively, these factors contributed to increased attendance at the ED and delays in progressing patients through the wider healthcare system.

The health board must work with system partners to reduce discharge delays, improve access to community, reablement and social care services and strengthen weekend discharge arrangements where these affect patient flow.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these were detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they were taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they were taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified were specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions was provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings were not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were resolved on this inspection.			

Appendix B – Immediate improvement plan

Service: **Emergency Department (ED) Ysbyty Glan Clwyd**

Date of inspection: **5 – 7 May 2026**

Findings:	Following interviews with a range of medical and nursing staff, findings suggest the presence of a challenging workplace culture associated with senior management. In this context, problematic behaviours were defined as actions that consistently cause conflict, negativity and emotional distress, which may affect staff wellbeing and patient safety. Staff indicated that management frequently disregarded complaints, feedback or concerns raised by the department, leading many employees to feel that their perspectives were undervalued. Staff regularly encountered difficulties resolving procedural matters and collaborating with other specialities, resulting in inefficiencies and delays in decision-making for patient care. Additionally, there was hesitation among staff outside the department to assume responsibility for ED patients, despite the established standard operating procedures (SOPs) in place. As a result, we were not assured that staff wellbeing and patient risks were being managed in an appropriate manner.

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	The health board must ensure that:				
1.	Leadership culture is improved and addresses senior management behaviours through leadership development and clear behavioural	Governance and Leadership – Culture	Cultural Health Assessment to be undertaken across the Emergency Department to develop a baseline measure, with input from the Workforce and Organisational Development team, including organisational culture leads.	IHC Director of Therapies/Associate Director of Workforce IHC Director of	30th June 2026 31st July

	expectations to foster a respectful, supportive work environment.		Staff were to be provided with time and support to complete the assessment, along with a clear understanding of why this is being undertaken and what will be the outcomes.	Therapies/Associate Director of Workforce	2026
			Series of workshops to be undertaken by senior leaders with staff to co-produce meaningful actions to improve cultures and behaviours.	IHC Director of Therapies/Associate Director of Workforce	30th June 2026
			Behavioural expectations for leaders and staff to be outlined and reinforced through compassionate leadership.	IHC Director of Therapies/Associate Director of Workforce	30th June 2026
			Training needs analysis to be undertaken for all managers at band 7 and above and medical leaders to compile a management development plan with an emphasis on compassionate leadership.	IHC Director of Therapies/Associate Director of Workforce	1st June 2026
			Promotion of the role of cultural change leaders and encourage volunteers to come forwards for training in the next cohort. Culture change leaders form part of the wider BCUHB's approach to support staff on the ground to use their training and tools of how to help change culture in their place of work.	IHC Director of Therapies/Associate Director of Workforce	1st June 2026

2.	Senior management actively respond to staff concerns and implement clear processes to acknowledge, investigate and feedback on staff complaints and concerns.	Governance and Leadership – Culture	The process for staff who wish to raise concerns and complaints in accordance with WP4 will be promoted and communicated to staff. Communications lead fully engaged in supporting this process. Named senior clinical and managerial contacts within the ED space will be identified for staff concerns, with expectation of timely acknowledgement and feedback. Promote the role of the Speak Out Safely Guardian and ensure that details were widely available to staff. Staff can contact the Guardian by e-mailing: BCU.SOSGuardian@wales.nhs.uk Staff concerns and actions were to be a standing agenda item on the monthly People and Culture meeting. The named contacts and the speak out safely guardian will be invited to attend or provide a report. Items for escalation from People and Culture committee were fed into the Senior Leadership Team meeting. ED directorate management team to continue to facilitate regular 'Wellbeing Wednesdays' sessions where ED staff were invited to take part in various wellbeing activities, seek support and given the opportunity to discuss any personal concerns with	IHC Director of Therapies/Associate Director of Workforce IHC Director of Therapies/Associate Director of Workforce IHC Director of Therapies/Associate Director of Workforce IHC Director of Therapies/Associate Director of Workforce Head of Nursing EQ /Directorate General Manager EQ / Clinical Director EQ	30th June 2026 1st June 2026 30th June 2026 21st May 2026 onwards 29th May 2026

			senior management. Internal and external support agencies will continue to be invited to deliver on various topics from workforce, wellbeing and personal advice.		
3.	Senior management strengthen joint working and support adherence to agreed SOPs and clarify accountability between the emergency department and other specialties.	Governance and Leadership – Culture	The HMT will be asked to review the SOP with senior leaders across the site and revise where necessary. All senior leaders within the hospital will be invited to attend a meeting with the IHC Directors to reinforce the importance of team working and adherence to the following SOPs: • Your Next Patient /Forward Waiting Standard Operating Procedure • Interprofessional Standards • Caring for Patients in Non-Designated Spaces (Corridor Care): Standard Operating Procedure Teamworking principles and training will be rolled out across the HMT, initially to all staff at band 7 and above. The HMT will be held accountable by the IHC directors for strengthening joint working and adherence to the SOP.	IHC Director of Therapies/Associate Director of Workforce IHC Directors/Associate Director of Workforce IHC Directors/Associate Director of Workforce IHC Directors	31st July 2026 31st July 2026 31st July 2026 31st July 2026

4.	A mechanism is in place to support staff wellbeing and promote psychological safety and provide accessible wellbeing support to reduce distress and enable staff to raise concerns early.	Governance and Leadership – Culture	Clarify and (re)communicate existing wellbeing support routes (Occupational Health, Staff Wellbeing Psychology, Speak Up Safely, external support such as Canopi, appropriate use of line management) to all ED staff, including how to access support confidentially. Visible leadership messaging acknowledging staff distress and reinforcing psychological safety, including reassurance that raising concerns will not result in detriment. Recognising that if staff do not believe this right now because psychological safety is low and previous experiences of raising concerns have not been dealt with in the way they should have been. Directorate management team will continue to facilitate regular 'Wellbeing Wednesdays' sessions where ED staff were invited to take part in various wellbeing activities, seek support and given the opportunity to discuss any personal concerns with senior management. Internal and external support agencies will continue to be invited to deliver on various topics from workforce, wellbeing and personal advice.	IHC Director of Therapies/Associate Director of Workforce IHC Director of Therapies/Associate Director of Workforce Head of Nursing EQ /Directorate General Manager EQ /Clinical Director EQ	30th June-2026 30th June-2026 29th May 2026
5.	Governance oversight is improved and ensures staff wellbeing risks and patient safety concerns were	Governance and Leadership – Culture	Staff wellbeing will be a standing item on the local people and culture committee meeting. A report will be compiled and forwarded to the Senior Leadership Team meeting.	IHC Director of Therapies/Associate Director of Workforce	21st May 2026 onwards

	routinely monitored, escalated and acted upon at senior level.		Increased visibility of trade union representatives, culture change leaders and wellbeing champions will be supported within the department. Regular meetings will be held with the local People Business Partner in order that good practice and items for escalation can be raised through the Associate Director of People Services to the Senior Leadership Team and IHC Directors.	IHC Director of Therapies/Associate Director of Workforce	31st August 2026
			The people actions from this plan will be monitored through the local People and Culture Committee.	IHC Director of Therapies/Associate Director of Workforce	Monthly from 18th June 2026
			Workforce representative to regularly attend the monthly Directorate ED Governance meetings to ensure appropriate support and guidance in relation to workforce governance.	IHC Director of Therapies/Associate Director of Workforce	30th June 2026
			Patient safety incidents to continue to be reported via the Datix system and discussed daily (Monday-Friday) within IHC daily Datix review meetings,	Associate Director of Nursing/Site Medical Director	30th June 2026
			Issues of significance; initial harm level moderate or above or relating the themes within the ED relating to corridor and waiting room care and timely moves out of the ED discussed at a corporate level through the daily	Associate Director of Nursing/Site Medical Director	30th June 2026

			integrated concerns review meeting to ensure oversight on occurrence of rapid reviews of such incidents. All rapid reviews were considered at Associate or Director of nurse/medical level as a minimum, submitted thereafter once approved to the Patient Safety Team and presented for discussion and shared learning in IHC led Integrated concerns operational panel (ICOP) Incidents of high concern to be discussed with the Executive team in a weekly Executive Integrated concerns operational panel (EICOP). Bi-weekly oversight from the clinical executive in the EICOG meeting of the ED quality data which includes data on patient safety incidents and impact on staff well-being because of the impact on crowding in ED's. With discussion and investment on support and solutions, including collaborative working opportunities across the organisations three ED's.	Associate Director of Nursing/Site Medical Director Associate Director of Nursing/Site Medical Director Associate Director of Nursing/Site Medical Director	30th June 2026 30th June 2026 30th June 2026
Findings:	We observed the paediatric emergency department and noted that: • The paediatric emergency department was left unattended by medical and nursing staff, while patients were present. Staff suggested this may have occurred because staff were required to escort a patient to another department, instead of the staff from those areas collecting the patient from ED. • Following the triage of a paediatric patient, it was noted that they were returned to the paediatric waiting room, when				

enhanced monitoring would have been more appropriate and cannulation had not yet occurred. Upon raising this concern with staff, the patient was subsequently moved to a paediatric room, however monitoring equipment was not attached.

- Due to current staffing levels in the paediatric ED, there was not a paediatric trained nurse present. It was reported that two paediatric trained nurses were scheduled to start their duties in September 2026
- A male, likely a patient from another unit and carrying a flower, entered the ED by following a staff member who had swiped access into the department. When challenged by the inspector and triage staff, they gave an excuse and left. The incident was escalated to the nurse in charge and security. Staff later confirmed that the patient was detained under the Mental Health Act (MHA) for assessment and should not have left the adjacent unit.
- As a result of a broken suction unit in one paediatric ED room, the paediatric resuscitation trolley was moved into this room. Later, we noted a patient being assessed in this area, which meant the paediatric resuscitation trolley was not readily available in an emergency.
- A paediatric patient who was reported to use cannabis daily was admitted to the paediatric ward; however, we could not locate the related safeguarding documentation.

As a result, we were not assured that the safety of patients within the paediatric emergency department was being maintained.

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	The health board must ensure that:				
6.	Arrangements are in place, so the paediatric ED is attended by clinical staff when patients are present.	Safe Care	Patient Transfer Standard Operating Procedure to be revised to ensure clear guidance is in place for maintaining clinical cover in the area whilst also facilitating patient transfers out of the department. Re-circulate to staff and include signatory list for staff to sign to confirm they are clear on the process.	Head of Nursing EQ Head of Nursing EQ	31st May 2026 19th June 2026

			Communications to be shared with nursing and medical teams to reinforce with all that the paediatric area must always remain staffed, with a responsibility on all staff groups to support this. Estates work to be completed to remove lock on internal paediatric door to enable parents/family members further open access to all clinical staff present in the department.	Head of Nursing EQ/ Clinical Director EQ DGM EQ	31st May 2026 29th May 2026
7.	Children assessed as requiring enhanced observation are placed in appropriate clinical areas with timely cannulation and monitoring equipment attached.	Safe Care	Establish a specific observation area within the Paediatric Clinical Space that will increase the availability of clinical observation space in the paediatric area to ensure a line of sight for patients requiring enhanced observations. ED Clinical Management to undertake monthly audits of patient records to monitor enhanced observations compliance.	Head of Site and DGM EQ Nurse Consultant ED	29th May 2026 30th June 2026
8.	The department urgently mitigates risks arising from the absence of paediatric-trained nursing staff until planned appointments commence.	Safe Care	Scope availability of paediatric trained nurses through other providers (agency) as a short-term measure. ED Head of Nursing & Matron to further progress the development of the Paediatric Nursing Competency Framework for Adult Trained Nurses. To explore the rotation of inpatient paediatric nursing	Head of Nursing EQ Head of nursing EQ / Children and Young persons Head of Nursing EQ	1st June 2026 31st July 2026

			staff to support the children's emergency department. Secure paediatric trained nurses (2) through student streamlining process. Review remaining vacancy position post streamlining recruitment and if able, undertake recruitment process for further paediatric trained nurses. Monitor compliance through e roster and report issues of significance or concern to the IHC nursing workforce group.	 Head of Nursing EQ Head of Nursing EQ Head of Nursing EQ	30th June 2026 31st July 2026 31st July 2026 31st July 2026
9.	Staff reinforce door access procedures and staff awareness to prevent unauthorised entry and ensure immediate escalation of security breaches.	Safe Care	Tailgate awareness training with staff with support of Security/Health & Safety Team. Lockdown assessment simulation session facilitated by Security/Health & Safety Team. Additional and refreshed signage to be displayed regarding tailgating and zero tolerance.	Matron ED Head of Site and EQ DGM Lead manager EQ	31st August 2026 31st August 2026 29th May 2026
10.	HIW is informed of the actions it will take to ensure that inpatients detained under the Mental Health Act are accounted for and do not	Safe Care	Strengthening Supervision in Communal Areas: A review of staffing deployment within the activity room and communal areas will ensure a staff member is consistently present to maintain observation and awareness of patient movement.	Head of Nursing, Central Mental Health	13th May 2026

	leave the mental health unit unescorted.		Environmental Controls – Access and Egress: Consideration will be given to environmental modifications, including a potential airlock or controlled entry-exit system to reduce the risk of patients leaving unescorted and prevent tailgating. Reinforcement of Observation and Relational Security: Ward teams will be supported to maintain appropriate line-of-sight observations and dynamic risk assessment informed by patient presentation. Staff Awareness and Boundary Management: Reminders will be provided regarding prevention of tailgating and management of patient movement across boundaries between clinical areas.	Head of Nursing, Central Mental Health Head of Nursing, Central Mental Health Head of Nursing, Central Mental Health	30th June 2026 13th May 2026 29th May 2026
11.	The paediatric resuscitation equipment is always functional and readily available.	Safe Care	Broken suction unit to be reported and replaced. Nurse in charge checklist to be revised to ensure all mandated safety check are completed. Matron monthly quality and safety audit to be undertaken to support assurance that check is completed in line with standard. Audit results to reported to the EQ Patient, Safety and	Matron ED Matron ED Matron ED Head of Nursing EQ	18th May 2026 1st June 2026 30th June 2026 31st July

			Quality meeting for assurance and monitoring.		2026
12.	Safeguarding risks are consistently identified, documented and communicated when children with known vulnerabilities are admitted.	Safe Care	Health Visitor Liaison Service review all paediatric attendances for any un-noted safeguarding concerns. Health Visitor Liaison report provided to the EQ Patient Safety and Quality Forum and IHC safeguarding forum for assurance. All staff to achieve compliance with level 1 and level 2 safeguarding training for children (85%). BCU designated lead for safeguarding children to provide additional training to senior ED clinicians (face to face). Band 7 nursing staff and Consultants to undertake safeguarding children level 3 training (85%).	Head of Nursing EQ Head of Nursing EQ Clinical Director EQ / Head of Nursing EQ Clinical Director EQ /– Head of Nursing EQ Clinical Director EQ / Head of Nursing EQ	18th May 2026 31st July 2026 31st August 2026 31st August 2026 31st August 2026
Findings:	During the inspection, we noted that at some stage each day, the waiting area was at full capacity. All available seats were occupied, and additional seating was arranged to accommodate the high number of patients awaiting assessment. This overcrowding was particularly evident on the first night of the inspection. Among those waiting were numerous unwell patients, with some present on Day 1 remaining by the afternoon of Day 2. The patient cohort included those with complex medical conditions, elderly and frail individuals and one patient in police custody who was restrained by handcuffs and positioned between two elderly patients. It was believed that several of these patients should not have remained in the waiting room, but rather in an area where staff could properly and safely monitor their condition. The following examples included:				

- Patient who had a cardiac event
- Patient with a serious head injury
- Patient with a potential fractured neck of femur
- Immunocompromised patients who were kept waiting with the general public and subjected to extended waiting times, potentially compromising their health.
- Patient who subsequently collapsed.

Supervision of the waiting area was the responsibility of two nurses, one registered nurse and one HCSW, who were stationed in a small room by the entrance to the waiting room. At times, patients sat in department wheelchairs in front of this room's window, obstructing the nurse's line of sight into the waiting area. Even after relocating these patients, clear oversight remained limited. On the morning of Day 2, a floating nurse was temporarily assigned to the waiting area and was able to maintain clear visual supervision of all patients, demonstrating that this approach could offer a more effective model of oversight.

Patients who required pain relief had to queue to speak to the waiting room nurse. Their names were manually recorded on a piece of scrap of paper to document medication provided, with the intention that this information might later be transcribed into their clinical records. Notably, one patient was observed waiting for over an hour to receive pain relief.

During a cardiac arrest incident in the waiting area, staff were unsure about the location where the emergency bell had been activated. Most staff were heading to the resuscitation area, while the arrest itself occurred in the waiting room. A healthcare inspector witnessed the event and assisted the nurse, who was alone with the patient at the time.

On the evening of the first inspection day, patients were not offered nutritional snacks or provided with hydration. In contrast, a drinks and snacks trolley was made available in the waiting area during the second and third days of the inspection.

Overall, we were not assured that the safety, wellbeing, care, dignity and respect of patients was being maintained whilst in the waiting room.

Improvement needed		Standard / Regulation	Service action	Responsible officer	Timescale
	The health board must ensure that:				

13.	Capacity, flow and escalation arrangements are reviewed so patients are not required to remain in the waiting area for prolonged periods, particularly overnight.	Safe Care	YGC Site Escalation and Capacity plan, current plan to be reviewed with amendments made to the site action cards in support of operational levels leading to effective escalation. Hospital Full Plan – Review implementation triggers and update associated action cards. Actions and accountability to be reviewed within the plan and actions associated with de-escalation to be formalised. "Your Next Patient" Forward Wait SOP – Continue to embed the forward waiting SOP to ensure continuous flow. Utilisation to monitored through daily site meetings and bi-weekly Executive Integrated Concerns Oversight Panel. Delivery of Central IHC UEC 90-day plan to support improvement in flow.	Head of Site/IHC Director of Operations Head of Site/IHC Director of Operations Head of Site/IHC Director of Operations Central IHC Programme Manager/ Head of Site/ IHC Director of Operations	30th June 2026 30th June 2026 30th June 2026 31st July 2026
14.	Patients with high clinical risk (e.g. cardiac events, head injury, frailty, immunocompromised) are promptly moved to monitored clinical areas.	Safe Care	Use Site Teams chat to support immediate escalations. Site team to document escalations and associated actions.	EQ Lead Manager Deputy Head of Site	29th May 2026 29th May 2026

			ED to launch organisation SOP for care in undesignated spaces that has clear clinical criteria for patients who should not be cared for in undesignated spaces. Nurse in Charge and Emergency Physician in Charge to monitor SOP utilisation through ED safety huddles 2 hourly. Escalate unresolved issues through site safety huddles and to Clinical Site Team out of hours with a response to be expected as per the site escalation process	DGM EQ/ Clinical Director EQ/ Head of Nursing EQ Clinical Director EQ/ Head of Nursing EQ Clinical Director EQ / Head of Nursing EQ	15th June 2026 30th June 2026 30th June 2026
15.	A visible, dedicated "floating" nurse role to maintain continuous oversight and early identification of deterioration is implemented.	Safe Care	Allocation plan as part of the nurse rostering, to be reviewed, to ensure allocation of appropriate nursing staff to the key areas in the department. Key role and responsibilities of waiting room staff to be reviewed and recirculated. Monitor patient feedback of waiting room experience through CIVICA and report any required associated actions and improvements to the IHC patient experience group. PEARs team to undertake independent reviews of patient experience in the waiting room with staff visibility to be included.	ED Matron ED Matron Head of Nursing EQ C-IHC Director of Nursing	30th June 2026 30th June 2026 31st July 2026 31st July 2026

16.	A robust, real-time system is implemented for recording pain relief and ensure timely access to analgesia without excessive queuing.	Safe Care	Patients to have pain scores assessed at first point of contact (triage), to be audited through the RCEM pain audit. Patients pain score to be reassessed post pain relief and recorded. This will be completed through the Pain Audits in line with RCEM Quality Improvement guidance to monitor compliance of timely pain relief administration. Review of Patient Group Directions to ensure that they are supportive on ongoing pain management	Matron ED Matron ED IHC Director of Pharmacy and Medicines Management	31st July 2026 31st July 2026 31st August 2026
17.	Emergency alarms are clearly identifiable, and staff are trained to respond immediately to incidents occurring within the waiting area.	Safe Care	Estates to prioritise re-programming of location titles on emergency alarm system. Circulate communications to team in interim period to ensure all are cited on current names of locations to remove cause for confusion.	Head of Site and DGM EQ DGM EQ / Lead Manager	18th May 2026 18th May 2026
18.	Staff maintain consistent provision of hydration and nutritional support for patients waiting for extended periods.	Safe Care	Catering to confirm the current arrangement for provision of nutrition during daytime hours. Overnight patients will be supported with hydration and where required, snacks.	Central IHC Catering Manager Matron ED	29th May 2026 29th May 2026

			Patient feedback will be monitored through Civica returns monthly and reported to the IHC patient experience group.	Head of Nursing EQ	31st July 2026
19.	Seating arrangements, supervision and management of patients in police custody is reviewed to ensure dignity, privacy and safety for all patients.	Safe Care	Communication to all team members to remind them of the importance of considering the privacy and dignity of patients when assessing them as suitable for care in the waiting area	Matron ED	29th May 2026

Findings:

We reviewed the resuscitation equipment in the Majors area, and we noted that the MyKitCheck digital system had been implemented to replace the previous paper-based checklists. This system was being used to record checks of the resuscitation trolleys. Despite these checks being evidenced, we found several significant deficiencies: the trolley was missing defibrillator pads, bag-valve masks and contained incorrect syringes that could not be used in practice.

We reviewed the medications and equipment within the ED, and we found several items that were either out-of-date or improperly stored, as highlighted below:

- In the majors B treatment room, two bags of potassium were found to be out of date since August 2025 and were also in a room accessible to patients.
- A bag of sodium chloride was left out and was not in its original, complete packaging.
- The gastro grab bag included a Percutaneous Endoscopic Gastrostomy (PEG) adaptor repair kit, which had expired in 2020.
- A feeding adaptor was found that had expired in 2023.
- Two Enteral feeding tubes that expired in 2024.
- pH kits were present and had expired in 2023.
- Fluids had been stored in an area (now removed) where staff without appropriate access should not have been able to retrieve them.

Further concerns were identified and included:

- Entries in the controlled drugs register from 14 March 2026 to the present date were reviewed. The health board policy stated

these should be checked daily, however, in the resuscitation area, four instances were found where checks had not occurred daily.

- Metronidazole was stored in the intravenous fluid room when it should have been kept in the medication room.
- Both the Welsh Ambulance Service University Trust (WASUT) and the ED dirty utility room doors were left open, one of these doors could not be locked and had been reported but not addressed. Chlor-Clean tablets were stored in both areas and needed to be secured in a control of substances hazardous to health (COSHH) cupboard.
- The ED shift leads daily checklist had not been evidenced as having taken place on 17 occasions between 1 March and 30 April 2026 this included drug fridge temperatures and resuscitation trolley checks.
- In addition, the fridge was overfilled, which prevented proper air circulation.

Overall, we were not assured that all risks to health and safety were managed appropriately. Potentially compromising patient and staff safety.

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	The health board must ensure that:				
20.	Staff review and strengthen checking processes to guarantee all resuscitation trolleys contain the correct, complete and in-date equipment.	Safe Care	Designated staff responsibility for resuscitation equipment checks in place, with monitoring through daily Nurse in Charge checklist. Monthly Matron Quality and Safety Audits to provide assurance regarding checks. Audit outcome to be reported to EQ Senior Governance Meeting	EQ Matron EQ Matron Head of Nursing EQ	1st June 2026 30th June 2026 31st July 2026

21.	Staff implement robust stock control to ensure expired or improperly stored medications and equipment are promptly removed and safely replaced.	Safe Care	Pharmacy staff have processes to regularly check and replenish all medication in designated areas of medication/fluid storage including automated cabinets, fridge and fluid stores. These checks are documented.	Head of Nursing EQ/ Hospital Pharmacy Operations Manager	1st June 2026
			All medications and intravenous fluids are stored in designated areas. Evidenced by completion of monthly medication safety audit, which checks appropriate storage of fluids and medications. Compliance to be monitored by Medicines Safety Practice Group.	Head of Nursing EQ/ Hospital Pharmacy Operations Manager	30th June 2026
			ED staffing establishment to be reviewed to identify opportunity for enhanced medicines housekeeper role supporting stock management, stock rotation and medicines management security support.	Head of Nursing EQ	30th June 2026
22.	Staff reinforce routine environmental and medication audits, with clear accountability for acting on identified risks.	Safe Care	Environmental and medication audit to be captured in monthly medication safety audit.	Head of Nursing EQ	1st June 2026
			Compliance to be monitored by Medicines Safety Practice Group.	Meeting chair (Clinical Director)	30th June 2026
			Identified risks to be escalated via reporting to the IHC Quality Operational Delivery Group.	Meeting chair (Clinical Director	31st July 2026

23.	Ensure daily controlled drugs checks are completed consistently and monitored by staff.	Safe Care	Designated staff responsibility for resuscitation equipment checks in place, with monitoring through daily Nurse in Charge checklist. Monthly Matron Quality and Safety Audits to provide assurance regarding checks. Audit outcome to be reported to EQ Senior Governance Meeting Pharmacy and nursing undertake CD audits on a six-monthly basis, with results reported to Patient, Safety and Quality meeting. Compliance and identified risks to be monitored by Medicines Safety Practice Group and escalated via PSQ report.	ED Matron ED Matron ED Matron Head of Operations, Pharmacy/ Head of Nursing EQ	29th May 2026 30th June 2026 31st July 2026 31st July 2026
24.	All dirty utility room doors are secure and functional, with timely resolution of reported defects.	Safe Care	Estates to facilitate repairs requested and timeliness of responses to be monitored via the ED, Facilities & Estates weekly working group. Housekeeping staff in ED to undertake weekly environmental checks to ensure that estates issues are recognised and escalated.	EQ Lead Manager/Head of Estates EQ Matron	29th May 2026 29th May 2026
25.	Medications, intravenous fluids and COSHH substances are stored in designated, secure areas with restricted	Safe Care	Monitoring of COSHH compliance through Monthly Matron Quality and Safety audits. Ensure all COSSH risk assessments are up to date and	Matron ED Matron ED	30th June 2026 31st July

	access.		reviewed as part of a regular cycle of business. All staff to have completed Health and Safety mandatory training in line with Health Board compliance levels (85%).	 DGM EQ/Clinical Director EQ/Head of Nursing EQ	2026 31st August 2026
26.	Staff implement conduct the daily checklists daily including resuscitation trolleys and daily drug fridge temperature monitoring, using data loggers, maintaining records and ensuring fridges are not overfilled.	Safe Care	Designated staff allocated per shift to complete checks. All checks must be documented with a sign-off by the Nurse in Charge (NIC), ensuring accountability and traceability. New fridge to be ordered. Stock has been reviewed to ensure quantities do not exceed fridge capacity. Monitoring through monthly matron audits Reporting through to EQ senior governance meeting	ED Matron ED Matron ED Matron Head of Nursing EQ	29th May 2026 29th May 2026 30th June 2026 31st July 2026

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan was actioned.

Service representative: Gareth Evans

Name (print): Gareth Evans

Job role: IHC Director **Date:** 18th May 2026

The initial improvement plan submitted by the health board was not accepted in relation to several areas. As a result, the health board submitted additional improvements on 22 June 2026 and actions that are listed below:

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	The health board must ensure that:				
	To strengthen the model in place to support assurance, oversight and delivery of a safe service for patients and staff.	Governance and Oversight Framework	**Daily** Increased senior leadership through the splitting of the vacancy acute director of operations post with immediate appointment Director of the Day on site rota Site safety huddles (3x daily minimum) ED safety huddles (2-hourly) Daily incident review meeting **Weekly** Operational performance and safety review meeting Workforce and wellbeing oversight	IHC Director IHC Director Site Manager ED Leadership Team Associate Director of Nursing IHC Director of Operations IHC Director of AHPs/Associate Director of	Complete Complete Complete 8th June 2026 Complete Complete Complete

				Workforce	
			HMT and IHC Director Huddle	IHC Director	Complete
			IHC Integrated Concerns Oversight Panel	Associate Director of Nursing	Complete
			Monthly ED Governance Meeting	ED Leadership Team	Complete
			Quality Operational Delivery Group	IHC Director of Nursing	Complete
			People & Culture Group	IHC Director of AHPs/Associate Director of Workforce	Complete
			Executive Oversight: Integrated Concerns Operational Panels (weekly)	Executive Director of Nursing / Executive Director of Medicine	Complete
	To establish a psychologically	Culture and	Implementation of Director of the Day role providing	IHC Director	Complete

	safe, responsive and accountable leadership culture	Leadership	visible senior decision-making Daily senior leadership huddles to review risks and actions Culture diagnostic (June–July 2026) followed by co-produced improvement plan and metrics Behavioural expectations framework for all leaders Management development programme focused on compassionate leadership	 IHC Director IHC Director of AHPs/Associate Director of Workforce IHC Director of AHPs/Associate Director of Workforce IHC Director	 8th June 2026 15th July 2026 30th June 2026 31st July 2026
	Promote staff wellbeing and resilience to reduce risk to patient care.	Wellbeing and Staff Support	Clear communication of wellbeing support pathways Regular wellbeing sessions and proactive welfare checks Daily leadership presence and “walk-rounds”	ED Leadership Team ED Leadership Team Hospital Management Team	12th June 2026 Complete Complete

			Ongoing engagement with staff and trade unions	IHC Director of AHPs/Associate Director of Workforce	Complete and ongoing
	Ensure staff concerns are acted upon promptly, transparently and consistently	Staff Concerns and Psychological Safety	Promotion of the speak out safely route and staff guardians Centralised logging of all concerns (Speak Out Safely and alternative routes) Weekly review group with escalation to IHC Directors Feedback loop to staff within defined timeframe Named senior contacts for escalation within ED and HMT	Workforce Team Workforce Team IHC Director of AHPs/Associate Director of Workforce IHC Director of AHPs/Associate Director of Workforce Hospital Management Team	Complete 12th June 2026 12th June 2026 Comple Complete
	Ensure patients are assessed, monitored and treated in safe clinical environments without	Patient Flow, Safety and Waiting Area	Implementation of “Your Next Patient” SOP Deployment of a dedicated floating nurse in waiting area	Site Manager ED Leadership	Complete 30th June

	prolonged waits.	Risk		Team/Site Manager	2026
			Real-time escalation via site team and safety huddles	Site Manager/ Hospital Management Team	Immediate
			Review and strengthening of escalation and capacity plans	Site Manager	30th June 2026
			UEC 90-day plan to completed in cycle time	IHC Directors	30th June 2026
			Key interprofessional standards to be upheld • time to speciality review (within 60 minutes) • once accepted by a speciality team, patients are not to be referred back to ED • all specialties referrals direct from primary care must be accommodated as per appendix 2 of the IPS	Hospital Management Team	Immediate and ongoing
	The health board must ensure that:				
	Ensure paediatric patients receive safe, continuously supervised and appropriately skilled care.	Paediatric Emergency Care Safety	Minimum staffing model (including paediatric-trained nurse)	IHC Director of Nursing	Complete

			Dedicated paediatric rostering and oversight	Associate Director of Nursing	12th June 2026 (complete in part)
			Creation of designated observation area	Head of Nursing, EQ	Complete
			Safeguarding supervision and real-time reviews	Safeguarding Lead	8th June 2026
			Recruitment and interim mitigation (agency, rotation)	Head of Nursing, EQ	12th June 2026
	Ensure all clinical environments, equipment and medicines are safe, compliant and consistently monitored.	Safety Systems, equipment and medication Management	Daily safety checks with named accountability	Matron, ED	Complete
			Weekly and monthly audit programme	Matron, ED	Complete
			Strengthened pharmacy oversight	Lead Pharmacist, ED	Complete
			Immediate removal of expired or unsafe items	Matron, ED	Complete
			Secure storage compliance (COSHH and medicines)	Matron, ED	Complete
	Ensure safe, secure and controlled clinical	Security and Environmental	Tailgating prevention and staff awareness training	ED leadership team	30th June 2026

	environments.	Safety	Improved signage	ED leadership team	Complete
			Estates response escalation tracking	ED leadership team	Complete
			Strengthening of access control in high-risk areas	ED leadership team	30th June 2026
	Ensure all safeguarding risks are identified, documented and managed appropriately.	Safeguarding	Real-time safeguarding supervision	Safeguarding lead	Complete
			Dedicated safeguarding liaison support within ED. Available Monday to Friday	Safeguarding lead	Complete
			Training compliance programme	ED leadership team	31st July 2026
			Review of all paediatric attendances to assure no missed opportunities	Safeguarding liaison nurse	Complete
			Senior clinical review of paediatric did not waits	ED consultant	Complete

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative: Gareth Evans

Name (print): Gareth Evans

Job role: IHC Director **Date:** 18th May 2026

Appendix C – Improvement plan

Service: **Emergency Department (ED) Ysbyty Glan Clwyd**

Date of inspection: **5 – 7 May 2026**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they were taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Extended waiting times were a dominant theme in patient feedback. Many patients described waits of more than 12 hours, with some reporting waits of over 30 hours before admission or discharge. Delays were not limited to initial assessment but occurred throughout the patient journey, indicating wider system of flow challenges linked to capacity pressures and delays in onward care.	The health board must take urgent whole-system action to reduce excessive waits, improve patient flow and minimise delays in assessment, admission and discharge.	Timely care	An UEC improvement plan is in place which is monitored via 90-day cycles. The initial 90-day cycle ran from March to July 2026, the second is currently ongoing. The focus of the plans are: • ED redesign – UTC, core ED and speciality waits area to improve crowding, risk and flow within in ED • Implementation of an acute medical model to better manage the	Acute Director of Operations, IHC Centre	30/09/2026 01/11/2026

				emergency admissions • Integrated discharge hub to reduce delays at discharge • Acute Frailty Unit in ED to support timeliness of assessments • Improved board round, TTOs, length of stay and better information to reduce delays in Hospital to ensure people get home quicker. Work with NHS Wales Performance and Improvement to align to updated escalation levels (OPEL) and actions		16/10/2026 31/10/2026 31/10/2026 31/10/2026
2.	Patient feedback identified significant concerns about dignity and the provision of basic care, particularly for elderly and vulnerable patients.	The health board must: a. Ensure all patients, including those in non-clinical areas, consistently receive food, drink, toileting	Dignified and respectful care	**2.1.** Continue with the ED wellbeing team model, and recruitment of a further 5 HCSW's to support patient care.	Head of Nursing, EQ	31/10/2026

	Many respondents described being cared for in corridors or waiting areas for extended periods, with limited privacy and inconsistent access to food, drink and toileting support.	support, privacy and basic care b. Minimise corridor care and ensure clear mitigating actions are in place where it cannot be avoided c. Take immediate action to address overcrowding, cleanliness and patient comfort d. Strengthen communication with patients and provide regular, clear updates on waiting times and next steps.		Ensure robust intentional rounding takes place, to be audited daily and reported through EICOP bi -weekly		04/09/2026
				2.2. Implement SOP for the care of patients in undesignated areas Provide assurance with compliance through regular audit cycles to be monitored through the EQ patient Safety meeting Ensure robust intentional rounding takes place for each individual patient which will be audited daily and reported through EICOP bi-weekly.	Head of Nursing, EQ	01/09/2026
				2.3. A SOP for forward waiting is implemented (your next patient) .	Head of Site	04/09/2026

				Adherence monitored through daily flow meetings and reported fortnightly to the EICOP. Ensure robust intentional rounding takes place for each individual patient which will be audited daily and reported through EICOP bi-weekly.	 Head of Nursing EQ	 01/09/2026
				2.4. Signage in all undesignated areas to speak to nurse/clinical team if you have any concerns or queries. Wait times displayed and updated regularly, a patient information booklet will be produced explaining the emergency pathway to patients.	Head of Nursing, EQ Patient Experience Team / DGM – EQ	04/09/2026 31/10/2026
3.	Feedback suggested that the principal causes of poor patient	The health board must ensure staffing and senior	Safe and effective care	Implementation ED Business Case in full to	Clinical Director/Head	31/03/2027

	experience were systemic and operational rather than attributable to individual staff performance.	clinical oversight are aligned to demand, with clear executive accountability for improvement and measurable outcomes.		support appropriate staffing levels Director of UEC under the leadership of the Chief Operating Officer will lead on the delivery of the health board major change programme to ensure improvement trajectories are meet in line with WG requirements with key indicators being, Handover 45 Time to clinician Time to decision Time to ED outcome or decision to admit.	of Nursing/DGM EQ UEC Director	 04/09/2026
4.	Whilst no verbal concerns were raised about care quality, improvements were needed in managing patient expectations regarding waiting times and promoting appropriate service use, prior to attending the ED.	The health board must ensure: • Carers accompanying patients in the department are offered appropriate support,	Health promotion	4.1. Carer details added to symphony at reception and any requirements noted and support given as required, and will be measured through CIVICA pt experience survey.	DGM – EQ	30/09/2026

		particularly when they are unable to leave the patient		Develop a patient and carer information board within the Emergency Department Patient and carer feedback will be used to assess the effectiveness of the resources and inform ongoing improvements through quarterly reviews Develop a “Welcome to ED leaflet”	People’s Experience Service	04/09/2026 04/09/2026 01/09/2026
		• Information is displayed on appropriate use of the ED and signposting to alternative services as appropriate.		**4.2.** Information Board at reception advising patients of alternatives has been installed.	DGM, EQ	01/09/2026

5.	Fewer patients were receiving care in corridors than on previous inspections. Staff told us this followed implementation of an SOP, which limited corridor care to 12 patients and supported improved oversight. Despite this improvement, maintaining privacy, dignity and patient comfort remained challenging. Prolonged waits in chairs continued, including overnight stays and elderly or vulnerable patients were not always able to rest comfortably. Blankets were not always readily available, particularly in corridor areas. It was a concern to find immunocompromised patients were in open public areas, such as the corridor and waiting room. Moreover, they were not prioritised for isolation or care in a more appropriate environment. This increased	The health board must ensure: • The dignity and respect of patients is maintained wherever they are in the ED • Immunocompromised patients are cared for in appropriate areas away from public spaces to minimis their risk of exposure to infection.	Dignified and respectful care	**5.1.** See Action 2.2. In addition, staff to ensure the delivery of EDs daily blanket and linen quota from hotel service and will be monitored daily by nurse in charge	Head of Nursing EQ	01/09/2026
				5.2. Communications have been issued to all shift leads to ensure they prioritise the isolation of immunocompromised patients. Intentional rounding to be undertaken and compliance monitored through audit and reported bi-weekly to EICOP , immediate escalation of concerns to nurse in charge Review, develop and embed standardised direct access pathways to Cancer services for	Head of Nursing EQ Head of Nursing, EQ Cancer Services Leadership team/EQ	01/09/2026 31//10/2026 30/11/2026

	their risk of exposure to infection.			inpatient admission of immunocompromised patients (forward waiting)	leadership team	
6.	We were told the removal of the Red Cross volunteers had contributed to longer stays for some medically fit patients, as these volunteers had previously supported transporting patients' home with equipment. Delays were now linked to the availability of hospital transport.	The health board must review discharge support and transport arrangements for medically fit patients, including the impact of changes to volunteer support, to ensure patients are discharged safely and without avoidable delay.	Dignified and respectful care	Patients who require transport are booked via NEPTS and transferred to the Discharge Lounge, discharge lounge utilisation is monitored and audited and reported at EICOP . Communication to team sent to advise of pathway	DGM – EQ	01/09/2026
7.	Patient survey responses indicated that around half reported positive experiences in relation to communication and involvement in their care.	The health board must improve communication between staff and patients, so patients feel informed, listened to and involved in decisions about their care.	Individualised care	Awareness sessions around communication in care will be facilitated with staff. Strengthen our approach to shared-decision making by designing a shared decision-making improvement toolkit, including training, policies and documentation for use	People's Experience Service	30/09/2026 31/10/2026

				across the department, based on established NHS best practice. Quarterly monitoring against compliance with agreed standards. Non-compliance will be flagged and mitigated via iterative improvement work.		From 30/11/2026
8.	Ambulance staff also described working relationships with ED staff as generally positive, respectful and supportive. However, they also reported that handover practice varied depending on the senior staff member or nurse in charge on duty. Some patients remained in ambulances for prolonged periods due to departmental pressures. Decisions to transfer patients into the department when it was already at maximum capacity raised safety concerns, particularly	The health board must ensure consistent ambulance handover arrangements and only transfer patients into areas where appropriate space, care ad oversight can be provided.	Timely care	Implement Handover 45 plan and monitor at the weekly UEC group and monthly executive UEC work and through escalation meeting to WG.	EQ Triumvirate Associate Director – UEC Improvement	30/09/2026

	where no designated space or staff oversight was available.					
9.	Although escalation policies and SOPs were in place to manage overcrowding, these were not consistently followed in practice. Incidents were reported through several mechanisms, but staff indicated the Datix was not being fully used for escalation and wider organisational learning. Reporting was limited to key stakeholders reducing opportunities for learning and improvement.	The health board must ensure Datix reporting is used consistently throughout the ED to ensure risks, incidents and near-misses are reported, investigated and shared for learning.	Timely care	Ensure mechanisms are in place to ensure Datix's are routinely presented to executive EICOP and pan BCUHB shared learning . Thematic reports, significant incidents to be shared at pan BCU ED Learning forum and onward onto the learning repository	EQ Triumvirate	04/09/2026 30/09/2026
10.	We viewed the Ambulance Handover and Management of Patients on Ambulances SOP which was found to be out of date with no indication of review. The Hospital Arrival Screen, intended to support patient tracking and triage, was not observed to be functioning	The health board must work with the Welsh Ambulance Services University NHS Trust (WAST) to review and update the SOP and ensure its requirements are followed in practice.	Timely care	A pan-BCU review of the current Ambulance SOP is underway. Findings from this review will support a strengthened process for Ambulance handovers	Programme Director - Urgent Emergency Care	31/10/2026

	and no alternative system was identified. Overall, findings demonstrated significant gaps between policy and practice, with limited evidence of clinical monitoring, escalation, or documentation for patients waiting in ambulances. These issues indicated weak operational oversight and non-adherence to established procedures, presenting risks to patient safety.					
11.	We also observed that patients were not routinely asked their preferred language at reception, with practice appearing to rely on assumption rather than proactive enquiry. This indicated inconsistent identification and promotion of Welsh language needs and available staff Welsh language skills, despite a proportion of staff being able to speak Welsh.	The health board must ensure: • Patients are asked about their language preference, and this is recorded when they first present at the ED	Communicating and language	**11.1.** Request that ED staff routinely ask patients for their language preference at first point of contact and ensure it is recorded on symphony Support staff with focussed breakout sessions to reinforce responsibilities around language choice,	DGM – EQ Support from Welsh Language Standards to ensure compliancy	04/09/2026

				communication needs and the Active Offer. Information regarding available communication support, including Language Line interpreting services with Digital First resources promoted across the department to support timely communication with patients whose first language is not English.	DGM EQ	01/09/2026
		• Staff who can speak Welsh, or are learning Welsh, wear an appropriate 'Iaith Gwaith' badge.		**11.2.** Welsh-speaking staff, and those learning Welsh, will be encouraged to wear Iaith Gwaith badges to increase visibility of Welsh language skills.	DGM – EQ	04/09/2026
12.	There was no consistent staff identification board in place within the department. Although a staff identification sheet was present in the	The health board must ensure the staff identification, 'who's who,' board within the	Communicating and language	Produce a Who's Who board which will include members of EQ SLT and a uniform poster , this	DGM – EQ	01/09/2026

	paediatric area, it had not been completed at the time of our observations, which limited its usefulness in helping patients and visitors identify staff roles.	department is kept up to date.		will be monitored and updated by the matron.		
13.	Although areas within the department were signposted, navigation could be improved through clearer displays, such as a site map, floor-based directions or identifying markers, to support patients and visitors in finding key areas more easily. Improved signage would also help patients access facilities independently, including washing and shower facilities during prolonged waits.	The health board must ensure: • Signage is improved within the ED to direct patients around the department and to inform patients about self-care and management • Patient communication is enhanced and patients are provided with clear updates on delays and care processes.	Communicating and language	**13.1.** Ongoing work to support new signage on the back of Core ED underway which will include a map and directions for our facilities	DGM – EQ & Estates	01/09/2026
				13.2. Awareness sessions around communication in care will be facilitated with staff. Strengthen our approach to shared-decision making by designing a shared decision-making improvement toolkit, including training,	People's Experience Service	30/09/2026 31/10/2026

				policies and documentation for use across the department, based on established NHS best practice. Quarterly monitoring against compliance with agreed standards. Non-compliance will be flagged and mitigated via iterative improvement work. Develop Welcome to ED Leaflet.		From 30/11/2026 01/09/2026
14.	However, 10 of the 43 staff members who responded to this question reported experiencing discrimination within the previous 12 months. This indicated that further work was required to ensure a fully inclusive and supportive working environment.	The health board must ensure processes are in place to: • Enable all staff to report concerns internally and ensure concerns are appropriately investigated and responded to	Rights and Equality	**14.1.** Clearly visible information (hard copies) reminding staff of their rights not to be discriminated against and informing them of how they can safely report any incidents via Freedom to Speak Up Safely and approach their line manager	Equality Managers	31/12/2026

				immediately where a concern is raised.		
		• Ensure staff are treated fairly and equally, with any instances of discrimination addressed promptly and appropriately.		**14.2.** Compliance with EDI Training for all groups which will be monitored locally by the leadership team and reported into the BCUHB equalities group.	Equality Managers	31/12/2026
15.	Patients who described perceived discrimination across several areas reported these experiences were often compounded by staff attitudes and communication styles, which some described as dismissive or lacking compassion.	The health board must provide HIW with details of how it will ensure patients are treated fairly and equitably, and discrimination is not tolerated and any concerns are addressed promptly and appropriately.	Rights and equality	Monitor completion of mandatory Equality Training – Treat Me Fairly and provide staff time to complete this. Compliance will be monitored by the leadership team and any areas of non-compliance escalated immediately for action. Ensuring that any Patient and Carer feedback where concerns are raised, is logged by staff and reported into PEARS	Equality & Inclusion Manager and IHC leadership team People's Experience Service	31/12/2026 04/09/2026

				for acting on feedback and learning. Actively follow up any concerns and report via Central IHC Patient and Carer Experience Group.	IHC Director	30/11/2026
16.	Overall, feedback highlighted significant and widespread challenges in accessing healthcare services. Whilst many issues reflected wider system pressures, the impact on patients was substantial, affecting safety, confidence and overall experience of care. Addressing these concerns will require coordinated action across primary, secondary and community care services.	The health board must ensure: • It reviews the patient experience feedback highlighted in this report and takes action to address the issues identified, implementing timely and sustained improvement	People engagement, feedback and learning	**16.1.** Review, triangulate and analyse patient, carer and staff experience feedback to identify learning and develop a structured improvement in co-production with ED management and reported in through the community by design board. Monitor progress through governance arrangements and use people's experience strategies to demonstrate sustained improvements in accessibility,	People's Experience Service and IHC leadership team	31/03/2027

				communication, patient-centred care and overall experience. (Stories, Compliments, Feedback, Complaints).		
		• Staff training, accessibility, governance and patient-centred care is strengthened to support equitable, safe and compassionate services.		Implement shared decision-making tool – please see action 7 ED Patient experience data & themes to be reported to the IHC patient experience group with associated improvement plans.	People's Experience Service EQ HON	31/10/2026 30/09/2026
17.	No evidence was provided that regular health and safety audits were being undertaken. Risk assessments relating to identified concerns, including corridor care and delayed transfers of care, were not consistently completed or documented.	The health board must ensure that regular health and safety audits and risk assessments are undertaken across all areas of the ED, with identified risks documented, monitored and addressed in a timely manner.	Risk Management	Annual Health and Safety Audits are completed and stored within a team folder locate in the Matron's office and related actions monitored through the IHC H&S group. Corporate H&S to work with the operational team to develop a robust	Head of Nursing EQ Head of H&S	04/09/2026 30/09/2026

				H&S audit plan to support safe care and mitigate identified risks.		
18.	Although there was an SOP for corridor care, we were told that the maximum numbers set out in in the SOP were often exceeded. We were also told the SOP may have had the unintended impact of affecting ambulance handovers, as described earlier. Where a patient waiting in an ambulance needed to be brought into the department, staff described using a risk-based approach.	The health board must ensure corridor care is delivered in line with the SOP and that any breaches are authorised by senior management and reported through Datix.	Risk Management	Monitoring no of patients receiving corridor care through ED safety huddles and site flow meetings Decision to exceed number of patients receiving corridor care to be agreed with NIC/EPIC as per SOP, will be documented in NIC log. Immediate escalation to site when numbers exceeded for corrective actions. To consider accelerated boarding. Numbers of patients receiving corridor care to be reported to EICOP bi-weekly.	Head of Nursing EQ Head of Nursing EQ Head of Nursing EQ Head of Nursing EQ	04/09/2026 04/09/2026 04/09/2026 04/09/2026

19.	When we spoke with staff about escalation arrangements when the department was at, or close to, capacity, some lower grade nurses were not fully aware of the escalation policy. Senior staff within the unit were able to explain the escalation process but told us they did not believe the health board always responded effectively to escalation concerns or provided additional support when required.	The health board must ensure ED escalation processes are clearly understood by staff and escalation concerns are responded to promptly, with appropriate senior oversight and support.	Risk Management	Work with NHS Wales Performance and Improvement to align to updated escalation levels (OPEL) and actions and cascade to all staff for their awareness and delivery, supporting with training and information as required.	Associate Director, UEC Improvement and ED leadership team	30/09/2026
20.	However, we noted no negative pressure rooms were available, which limited the department's ability to safely manage some airborne infections. Whilst we were informed IPC audits were undertaken, these were only completed when staffing capacity allowed, which limited their consistency and effectiveness as an assurance mechanism. Audit information	The health board must ensure: • Appropriate facilities are available, or clear escalation arrangements are in place, for the safe management of patients requiring isolation for airborne infections	IPC	**20.1.** Negative pressure rooms are available on site. Management pathways are in place for patients requiring negative pressure cubicles for highly infection diseases as part of HCID	Head of Nursing ED	05/09/2026

	provided to us showed 100% compliance in the most recent hand hygiene audit, 100% mattress compliance and an average of 45% compliance in the commode audit. Patient survey responses relating to IPC measures differed to our observations and indicated mixed perceptions of IPC practice. Overall, 63% of respondents believed IPC measures were either followed or partially followed, while 23% felt they were not. In addition, 64% of respondents rated the environment as either fairly clean or very clean. This suggested, while general cleanliness was acceptable, there was scope to improve the visibility, consistency and assurance of IPC practices. Qualitative patient feedback also indicated variable confidence in IPC practices and	• IPC audits are undertaken consistently, with clear oversight, action plans and monitoring where compliance issues are identified • Hand hygiene facilities are clearly visible and accessible throughout the waiting area, particularly at entry points • Cleaning arrangement in high-turnover areas, including waiting room		**20.2.** IP team to support, carry out independent audits and 15 steps approach into the unit to review. IPC audits are undertaken as part of the matron's monthly audit programme. Findings are discussed at LIPG and will form the basis of an ongoing improvement action plan. The IPC team will undertake weekly audits in ED until compliance is maintained	Head of Nursing ED	05/09/2026
				20.3. Review with IPT to ensure adequate sinks and hand gel points available.	Head of Nursing, EQ	01/09/2026
				20.4. Domestic cover to be renewed in line with All Wales Cleaning Standards	Head of Facilities, Central IHC	30/09/2026

	reinforced the need to strengthen visibility, consistency and governance of IPC measures.	seating, are strengthened and clearly documented • Staff respond promptly and appropriately to patients' basic care and environmental needs, including where IPC risks are identified • Learning from patient feedback relating to cleanliness and IPC is reviewed and used to inform improvement action within the department.				
				20.5. Ensure all staff are compliant with IPT training IP risks to be monitored through ED safety huddle process Patients to receive intentional rounding as prescribed, evidenced through regular audit cycle and reported to EICOP fortnightly	Head of Nursing, EQ	30/09/2026
				20.6. Patient feedback in relation to IPC to be provided through CIVICA reports and associated improvement plans to be monitored through local infection prevention group and patient experience group.	Head of Nursing, EQ	04/09/2026

				Evidence needed – CIVICA reports agendas LPG and PEG		
21.	These findings suggested a need for enhanced oversight and reinforcement of safeguarding practice to ensure vulnerable patients were consistently protected, appropriately supervised and supported in a way that upholds their rights.	The health board must ensure: • Vulnerable or confused patients are appropriately assessed, monitored and supervised, with clear escalation where risks are identified • Staff recognise and respond appropriately to situations may require consideration under DoLS or wider mental capacity arrangements • All staff know how to access safeguarding policies and procedures and understand their responsibilities for	Safeguarding As part of huddles – will document as part of risk and highlight actions. Put patients in high visibility areas / eyesight of NIC station. Provision of 1:1 support	**21.1** Enhanced care assessments for patients presenting as vulnerable, confused or at risk of harm. Escalation through ED Safety huddles.	Head of Nursing, EQ	04/09/2026
				21.2. MCA training compliance and additional focused training where required	Head of nursing, Clinical Director, DGM, EQ	04/09/2026
				21.3. Safeguarding level 1 & level 2 training compliance to be above 85%	Head of nursing, Clinical Director, DGM, EQ	04/09/2026

		escalating safeguarding concerns • Safeguarding documentation is completed, retained and readily available for review where risks or concerns are identified.		**21.4.** Increased safeguarding presence in department for supervision. Review of documentation provided to IHC Director of Nursing on a weekly basis for assurance.	IHC Director of Nursing IHC Director of Nursing	04/09/2026 04/09/2026
22.	We found pressure risk assessments and associated wound care documentation were not completed consistently or in a timely manner. There was limited evidence to demonstrate assessments were routinely undertaken, reviewed, or updated during patients' time within the department.	The health board must ensure systems and practice to support pressure ulcer prevention are strengthened including: • Timely and consistent completion, review and updating of pressure risk assessments	Preventing pressure and tissue damage	**22.1.** Risk Assessments to be completed within 6 hours of admission and audited through the ED matrix and reported to EICOP, support from TV team where required with focused training.	Head of Nursing EQ	04/09/2026

	We also found insufficient evidence that appropriate preventative measures were consistently implemented or recorded, including the use of pressure-relieving equipment and regular repositioning.	• Clear documentation of preventative interventions, including repositioning and skin integrity checks		22.2 Pressure relating actions to be documented in Symphony Intentional rounding as per risk category to be undertaken and documented and compliance and action audited.	Head of Nursing EQ	04/09/2026
		• Availability and timely access to appropriate use of pressure-relieving equipment		**22.3**. Repose mattresses are available for all trolleys.	Head of Nursing EQ	04/09/2026
		• Effective oversight and assurance arrangements to monitor compliance and address gaps in practice.		**22.4** Patients at risk of pressure damage or deterioration to have risk mitigating measures documented. Intentional rounding as per risk category to be undertaken and documented and audited.	Head of Nursing EQ	04/09/2026

23.	We found falls assessments were not consistently completed within the expected time. Bed rail risk assessments were also not routinely undertaken where applicable. We identified concerns regarding staffing levels, specifically the availability of HCSWs, which affected the department's ability to safely support patients at risk of falls. There was insufficient staff capacity to assist patients who required support with mobilisation, including access to toilet facilities. This presented a potential risk to patient safety, particularly for patients at increased risk of falls. We also identified HCSWs were undertaking initial risk assessments for falls and skin	The health board must ensure: • Falls risk assessments are completed by appropriately trained staff within the expected time • Preventative actions, including falls prevention measures and the use of bed rails where appropriate, are fully documented • There are sufficient staff available to support patients at increased risk of falls, including those requiring assistance with mobilisation and toileting	Falls Prevention	**23.1.** Patients to have a risk assessment within 6 hours, compliance monitored weekly and reported through enhanced monitoring arrangement, ED matrix , audited and reported to EICOP.	Head of Nursing EDQ	04/09/2026
				23.2. Please see 22.2	Head of Nursing EQ	04/09/2026
				23.3. Patients at risk of falls to have enhanced care risk assessment undertaken Staffing to be provided as per ECRA escalation and monitoring ED safety huddles.	Head of Nursing EQ	04/09/2026

	integrity. This was not in line with expected practice.	• Staff roles and responsibilities for completing assessments and implementing care interventions are clearly defined, understood and followed.		**23.4.** Monitor through Matron spot checks. Reinforce professional standard with all registrants and the delivery of care under the code.	Head of Nursing EQ	04/09/2026
24.	Improvements were needed to ensure provision was consistent during peak periods and prolonged waits and to improve visibility and availability of drinking aids. Patient questionnaire comments presented a mixed picture. Some patients described regular offers of food and drink, while others reported difficulties accessing suitable food, drinks, or dietary alternatives during prolonged waits.	The health board must ensure patients, including those in waiting areas and corridor care, have timely and consistent access to appropriate food, fluids and assistance with nutrition and hydration. This must include arrangements for patients with specific dietary, cultural, allergy-related, or clinical needs and clear processes to ensure food and drink provision is maintained during prolonged waits and periods of increased demand.	Nutrition and Hydration	Recruitment for 5 additional HCSW is in progress to support ensuring patients are all supported with hydration and nutrition and food and fluid charts maintained where required and all non-registrants to be under direct supervision of a registrant who will monitor care delivery. Catering to confirm the current arrangement for provision of nutrition during daytime hours	Head of Nursing, EQ Catering manager, Central IHC	31/10/2026 04/09/2026

				that meets the needs of the patients Overnight patients will be supported with hydration and where required, snacks and monitored by the Nurse in charge. Patient feedback will be monitored through Civica returns monthly and reported to the IHC patient experience group.	Head of Nursing, EQ Head of Nursing, EQ	04/09/2026 04/09/2026
25.	We reviewed six patient records and identified significant concerns regarding clarity, structure and usability of clinical documentation. These issues had implications for patient safety, continuity of care and the ability of staff to make timely and informed clinical decisions.	The health board must strengthen patient record-keeping arrangements to ensure: • Assessments, treatment decisions and escalation actions are documented clearly, promptly and consistently	Patient Records	**25.1. – 25.5.** Clinical staff are to be reminded of their professional responsibility with regards maintaining clear and accurate patient records. An enhanced clinical audit tool, based on GMC professional standards for patient record-	Clinical Director EQ & Emergency Medicine Consultant	30/09/2026

		• Patient records follow a clear and standardised structure supports safe, effective and continuous clinical care • Clinical pathways, including sepsis and deterioration pathways, are followed and clearly evidenced in the patient record • High-risk patients are clearly identified, monitored and reviewed, with risks and actions documented in a timely manner • Records clearly evidence the delivery, review and evaluation of fundamental care.		keeping, will be developed and implemented to enable clinicians to effectively monitor record keeping arrangements, ensuring all key recommendations are being picked up on. Audit fundings will be reported at Clinical Governance meetings, and recommendations for improvement agreed and incorporated into an improvement plan, which will be reviewed at each meeting. Systems will be put in place to ensure non-compliance is managed through professional supervision, with a zero-tolerance approach take to sustained non-compliance.		

26.	The SOP made clear corridor care was not commissioned and should only be used as a temporary risk mitigation measure. It must not become routine practice. The SOP also stated corridor care should cease if fire safety was compromised, staffing levels fell below 16 registered nurses, a corridor patient deteriorated, or any patient remained in the corridor for more than six hours. Due to the pressures within the ED, these conditions were frequently breached. We observed five patients on trolleys in Majors A and three in Majors B and were told some patients remained in corridor areas overnight.	The health board must: • Ensure corridor care is used only in exceptional circumstances and is managed safely, with appropriate staffing, clinical oversight, escalation arrangements and respect for patient dignity • Take sustained action to reduce reliance on work towards corridor care.	Effective care	**26.1.** Care for patients in undesignated areas SOP in place and used and monitored at each safety huddle	Head of Nursing EQ Clinical Director EQ & Emergency Medicine Consultant	30/09/2026
				26.2. An UEC improvement plan is in place which is monitored via 90-day cycles. The initial 90-day cycle ran from March to July 2026, the second is currently ongoing. The focus of the plans are: • ED redesign – UTC, core ED and speciality waits area to improve crowding, risk and flow within in ED	Assistant Director – Urgent and Emergency Care	04/09/2026

				• Implementation of an acute medical model to better manage the emergency admissions • Integrated discharge hub to reduce delays at discharge • Acute Frailty Unit in ED to support timeliness of assessments • Improved board round, TTOs, length of stay and better information to reduce delays in Hospital to ensure people get home quicker.		01/11/2026 30/09/2026 31/08/2026 31/12/2026
27.	We reviewed a range of audits, from 2024 and 2025, including audits relating to chest pain, blood gas, knee assessment, venous thromboembolism risk assessment and appropriateness of ankle X-rays. These audits were	The health board must ensure lessons learned from audit findings are translated into timely improvement action, with clear ownership, monitoring and feedback to staff to	Effective care	• Develop tier 3 audit programme, reflective of the key risks • Monitor completion of the plan through local CEG inclusive of action plans	Acute Medical Director, IHC Central	31/03/2026

	reported through meetings and consistently identified gaps in fundamental clinical assessments. Although these issues had been identified and recorded, they reflected weaknesses in core routine care.	support sustained improvements in practice.		• Arrange appropriate learning events to disseminate findings		
28.	We were told GPs were sending referrals to an email address that was not being monitored. As a result, some patients arrived at the ED without the department having prior knowledge of their referral. We were also provided with information about 29 ED attendances, which showed 15 had been inappropriately referred to the ED by a GP or the community service. In a further 14 cases, there was reported reluctance by specialities to accept referrals from the ED, with some requiring escalation	The health board must ensure: • Referral pathways into the ED are clearly communicated to GPs, community services and other referrers • Incorrect or inappropriate referrals are reviewed with the referring service to support learning and reduce recurrence	Effective care Use AAU model work here as well as IPS and quarterly breech analysis Embed within august induction	28.1 GP and Community services will be part of the Acute medical model task and finish group and communication will be shared once implemented	Clinical Director, EQ	01/11/2026
				28.2. ED GP inappropriate referrals and issues with IPS being captured for discussion, will be through IHC UEC weekly performance meeting	Associate Director, UEC Improvement	04/09/2026

	to an ED consultant. This placed additional pressure on the ED, increased demand on triage and contributed to delays for patients who required emergency care.	• Speciality teams respond promptly to appropriate ED referrals to support patient flow and avoid unnecessary delays • Unmonitored referral routes are closed or clearly re-directed and referrers are informed of the correct process for making referrals.		28.3. Internal Professional standards to be adhered to and escalated to the clinical director where there is deviation and is to be monitored through IHC UEC weekly performance meeting. 28.4 Email sent to primary care medical director confirming email address not in use.	Associate Director, UEC Improvement Clinical Director EQ	04/09/2026 04/09/2026
29.	We were told staff were sometimes reluctant to direct patients from triage to SDEC because this was not perceived as usual practice and because SDEC capacity was often limited. Staff told us patients deemed suitable for SDEC would be accepted where capacity allowed. These	The health board must ensure: • The use of the SDEC is reviewed to ensure it is appropriate, safe and aligned with its intended function	Effective care	**29.1.** A review of SDEC pathways and the acute medical model is currently underway. SDEC dashboard to be utilised to monitor performance trends	Clinical Director EQ	31/10/2026

	findings indicated a need to strengthen staff understanding and consistent use of the SDEC pathway.	• Any overnight use of SDEC is reviewed to ensure patients are cared for in an appropriate environment that maintains safety, privacy and dignity • Staff are provided with clear guidance and training on the SDEC pathway, including referral criteria and escalation arrangements.		**29.2** Work with NHS Wales Performance and Improvement to align to updated escalation levels (OPEL) and actions.	Clinical Director EQ	30/11/2026
				29.3. Once the review is complete, revised information will be provided to staff verbally, at staff meetings and handovers, and will be made accessible on the YC ED SharePoint site/ Team channel for ease of reference.	Clinical Director EQ	31/10/2026
30.	Overall, systems intended to support safe patient flow were not consistently applied. This created significant risks linked to inconsistent governance, limited clinical oversight and persistent operational pressures. Staff survey	The health board must ensure patient flow arrangements include clearly defined accountability, escalation routes and documentation of safety-critical decisions,	Patient Flow	An optimal flow trainer is in post to train and support all wards to improve accuracy of data on the system, identify discharges and patients suitable to move to the discharge lounge.	Associate Director, UEC Improvement	04/09/2026

	feedback strongly reflected these findings. Staff consistently identified patient flow as the most significant operational challenge affecting the department, describing delays in transferring patients to inpatient wards, prolonged ED stays and the routine use of corridor areas as consequences of wider hospital capacity pressures. Staff linked these issues to reduced privacy and dignity, delays in care and increased risk to patients and staff.	with evidence concerns are acted upon and monitored.		A UEC improvement plan is in place which is monitored via 90-day cycles. The initial 90-day cycle ran from March to July 2026, the second is currently ongoing. The focus of the plans are: • ED redesign – UTC, core ED and speciality waits area to improve crowding, risk and flow within in ED • Implementation of an acute medical model to better manage the emergency admissions • Integrated discharge hub to reduce delays at discharge • Acute Frailty Unit in ED to support		01/09/2026 01/11/2026 30/09/2026 01/09/2026

				timeliness of assessments • Improved board round, TTOs, length of stay and better information to reduce delays in Hospital to ensure people get home quicker. Implement pilot of the Health Board Quality Management System to support continuous improvement cycle and assurance in nursing standards.	 Head of Nursing, EQ	31/12/2026 30/11/2026
31.	Overall, whilst a comprehensive suite of patient flow documentation was in place, the contrast between the number of patient flow policies, escalation processes and operating procedures in place and the experiences described by patients and staff, was	The health board must ensure patient flow policies, SOPs and risk assessments are current, complete, regularly reviewed and consistently implemented in practice.	Patient Flow	Work with NHS Wales Performance and Improvement to align to updated escalation levels (OPEL) and actions UEC Recovery Director to renew governance for HB, wide SOPS & Risk	Associate Director, UEC Improvement	31/10/2026

	particularly striking. Whilst arrangements existed on paper, both inspection findings and survey feedback indicated prolonged waits, overcrowding and corridor care continued to be routinely experienced in practice.			Assessments and Policies relating to patient flow.		
32.	During the inspection, we identified examples where patient flow was not effective, which included: • Flow between the ED, the surgical assessment units and the acute medical unit was limited because these areas could not actively transfer patients where no bed spaces were available, despite repeated meetings and escalation. • Demand for inpatient beds exceeded available capacity, including three resuscitation beds being	The health board must ensure: • Patient flow through the ED is improved through clear, measurable and sustained whole-hospital actions • All relevant specialties and hospital teams share responsibility for improving patient flow and reducing waits in the ED • Senior managers outside the ED are responsive to patients	Patient Flow	A UEC improvement plan is in place which is monitored via 90-day cycles. The initial 90-day cycle ran from March to July 2026, the second is currently ongoing. The focus of the plans are: • ED redesign – UTC, core ED and speciality waits area to improve crowding, risk and flow within in ED • Implementation of an acute medical model to better manage the	Associate Director, UEC Improvement	01/09/2026 01/11/2026

	occupied by patients awaiting medical and surgical ward beds • Onward referral and specialty acceptance were delayed in some cases, with staff reporting some patients remained in the ED for longer because the department was perceived as a place of safety.	and staff risks within the ED and actively support improvements across the wider hospital system.		emergency admissions • Integrated discharge hub to reduce delays at discharge • Acute Frailty Unit in ED to support timeliness of assessments • Improved board round, TTOs, length of stay and better information to reduce delays in Hospital to ensure people get home quicker. These are monitored and reviewed at the UEC improvement group weekly		30/09/2026 01/09/2026 30/09/2026
33	Staff comments in the HIW questionnaire reinforced these findings. staff consistently described the department as operating over capacity, with	The health board must strengthen specialty referral and escalation arrangements to ensure patients are reviewed,	Staff Feedback	Update IPS policy through co-design and implement, monitor daily and escalate any incidents of non-	Acute Medical Director	30/09/2026

	poor patient flow identified as a key concern. Comments highlighted delays in moving patients through the department and onto wards, resulting in prolonged ED stays and the continued use of corridor areas. Only 17% of staff agreed patients were assessed within four hours, with the majority disagreeing.	accepted and transferred in a timely way according to clinical need.		adherence to the medical director for action. Develop and implement Acute Medical Model to improved patient pathways, reduction in patients presenting to ED and time to speciality review. Monitor adherence to IPS and embed learnings through weekly performance meetings.	Clinical Director Medicine Associate Director, UEC Improvement	30/09/2026 29/07/2026
34	Of particular concern was the extent to which issues such as overcrowding, corridor care, workforce pressures and delays in patient flow appeared to be viewed by some respondents as normal features of service delivery rather than exceptional circumstances. Staff frequently described feeling unable to provide the standard of care	The health board must: • Ensure operational risks highlighted by staff, including those relating to patient flow, corridor care, staffing levels, skill mix and patient safety, are not accepted as routine practice	Leadership	**34.1** ED risk matrix to be embedded to support identification of key risks and action owners	IHC Director of the day and Site lead for the day	04/09/2026

	they wished to deliver and reported limited confidence concerns raised would consistently result in meaningful action or sustained improvement. Staff feedback described a workforce that remained committed to delivering safe and compassionate care despite significant operational pressures. However, the extent to which longstanding operational issues appeared to have become normalised presented a risk that unacceptable conditions may increasingly be viewed as unavoidable rather than requiring urgent and sustained improvement.	• Demonstrate sustained action to address these issues and provide assurance concerns raised by staff lead to timely review, decision-making and measurable improvement.		**34.2** Measure improvements through weekly performance meetings Implement monthly 2-way feedback meetings with ED staff (Day and night shift) with documented feedback themes and actions	Associate Director – UEC Improvement HMT	04/09/2026
35	Taken together, inspection findings, governance documentation, staff feedback and incident reporting data	The health board must ensure they:	Leadership	**35.1** Review of governance framework to ensure clear pathways for escalation of risk from	HMT	04/09/2026

	indicated a disconnect between governance arrangements as described and the experience of staff working within the department. Whilst structures, meetings and policies were in place, there was insufficient assurance these arrangements were consistently resulting in learning, improvement, staff engagement, or sustained reduction in risk. Persistent concerns regarding patient flow, staffing, corridor care and escalation had been recognised through multiple governance mechanisms, yet many of these issues continued to be raised by staff and reflected in inspection findings.	• Strengthen the implementation, monitoring and evaluation of governance processes to ensure they are effective in practice • Improve communication between senior leaders, managers and frontline staff, including clear feedback on decisions, actions and progress • Promote a positive, open and psychologically safe culture that supports escalation, learning and staff engagement		ED Through the organisational structure.		
				35.2. Monthly 2-way feedback decisions.	HMT	04/09/2026
				35.3 Continue to promote speak out safely and open lines of communication between operational teams and IHC Directors	IHC Director	04/09/2026
				Establish monthly (one day and night) two-way feedback sessions focused on 'you said, we did'.	HMT	04/09/2026

		• Maintain policies and procedures so they are current, ratified accessible and actively used in practice		**35.4** Work with NHS Wales Performance and Improvement to align to updated escalation levels (OPEL) and actions UEC Recovery Director to renew governance for HB, with SOPS & RA's and policies relating to patient flow.	ED operational leads/HMT/IHC Directors	30/09/2026
		• Embed a robust system for documenting, reviewing and learning from incidents, with clear ownership, timescales and evidence of completed actions.		**35.5.** Learning from incidents to be documented and shared through the IHC Integrated Concerns Oversight Meeting (ICOP) All incident reviews to have an associated improvement plan that details action, owner, timescale and evidence of completion. Evidence to support completion of actions to	EQ leadership team/HMT	30/09/2026

				be monitored through the datix system.		
36	The recurrence of similar themes within Datix reports, governance meetings, staff survey findings and inspection observations raised concerns regarding the effectiveness of organisational learning and the extent to which known risks were being mitigated. The persistence of these issues across multiple assurance mechanisms suggested opportunities to translate learning into sustained improvement had not always been fully realised.	The health board must strengthen review and learning from ED Datix incidents, including corridor care, pressure damage, monitoring and documentation, to support sustained improvements in patient safety.	Leadership	All incidents reviewed at daily datix meeting to ensure appropriate level of response , Moderate and above incidents, complaints and mortality reviewed daily at the health board integrated Hub to determine level of investigation required. Focused reviews completed for all pressure damage and falls, and learning taken to harms forum and ICOP and onward to the health board improvement groups for falls and HAPU. ED significant incident reviews presented at EICOP fortnightly to share learning.	ED operational team Associate Director – UEC Improvement IHC Directors	30/09/2026

				Incidents and learning to be discussed at the ED learning forum to ensure sharing across the Health Board.		
37	Staffing levels across nursing and medical teams were a significant concern, particularly at weekends. Staff reported gaps in rotas, with middle-grade doctor shifts frequently filled by locum staff. Some consultants confirmed these concerns had been escalated, but requests for additional staffing had not been approved. Staffing levels were not aligned to patient acuity, including resuscitation areas where high acuity patients were being managed with limited staffing and limited paediatric-specific provision. Awareness of escalation processes varied, senior staff were able to describe	The health board must ensure: • All staff understand escalation policies and procedures	Skilled and enabled workforce	**37.1.** Escalation of nurse shortages and risks identified via safety huddle and safe care process, attended by HON/ Matron and ED Manager of the day. NIC to join site nurse meeting every morning to escalate any concerns Drs & Nurse staffing concerns tracked 3 times at site safety huddle and through ED safety huddle. ED staffing business case approved at Board	Head of Nursing – EQ Matron ED ED Lead Manager	04/09/2026

	escalation arrangements, while junior staff were not always clear about the process. Although escalation policies were in place, staff reported organisational responses to escalation were not always effective.			in June and is now being implemented. Staffing to monitored through the newly developed ED metrics.		
		• Escalation concerns are recorded on DATIX where appropriate		**37.2.** staffing concerns datix to be monitored through daily datix meeting. Monthly staffing datix report reviewed by DON for identification of themes and significant trends.	ED Matron IHC Director of Nursing	04/09/2026 04/09/2026
		• Organisational responses to escalation are documented and communicated to staff.		**37.3.** All staffing datix to have feedback provided to reporter.	ED Matron	04/09/2026
38	Despite workforce planning processes and escalation mechanisms being in place, we found evidence of sustained staffing shortfalls, particularly	The health board must ensure:	Skilled and enabled workforce	**38.1.** ED staffing requirements within recently approved ED business case to be fully implemented.	Head of Nursing EQ /Clinical Director EQ/DGM EQ	31/03/2027

	at weekends. Staffing levels and skill mix were not sufficient to consistently meet patient demand, with ongoing reliance on locum and agency staff and gaps in paediatric provision. Staff survey responses consistently highlighted concerns regarding staffing levels and skill mix.	• ED staffing levels and skill mix are reviewed against patient demand, acuity and activity				
		• Staffing reviews are undertaken at least quarterly and result in clear actions where gaps are identified		**38.2.** Quarterly staffing reviews will be undertaken for nursing using the NSA triangulated methodology	Head of Nursing EQ/Associate Director of Nursing	31/12/2026
		• Paediatric nursing provision is strengthened to meet the needs of children attending the ED		**38.3.** Recruitment plan developed to support appointment of RN Child nursing staff to ED Ensure minimum of 12 ED RN (adult) undertake competency framework programme.	Head of Nursing EQ	30/09/2026
		• The availability of practice development, education and professional support arrangements within the		**38.4.** All staff must have protected mandatory training, evidenced through compliance with Health Board standards.	Head of Nursing/Clinical Director/DGM EQ	30/09/2026

		ED is reviewed to ensure staff can access mandatory, specialist and developmental training in a timely manner.		Current Band 7 in PDN role to facilitate training **.**	Head of Nursing EQ	31/08/2026
39	Just over half of staff reported having appropriate training, while others indicated training was only partially sufficient or insufficient. Free-text responses identified a lack of structured training support, including the absence of a dedicated practice development role and difficulty accessing mandatory or specialist training.	The health board must ensure: • Mandatory training, including face to face training is completed in a timely manner	Skilled and enabled workforce	**39.1.** Mandatory training compliance Medical weekly training events Current Band 7 in post responsible for delivering training to staff including RCN framework adult trained nurses caring for paediatric patients current rolling programme.	Head of Nursing EQ /Clinical Director lead for medical team/ OD	30/09/2026
		• Staff can access protected time, appropriate educational support and practice development resources to complete mandatory,		**39.2** ED SharePoint site used to support learning Two weekly SIM training to be implemented for all staff from the clinical and RN	Head of Nursing EEQ /Clinical Director /OD	30/09/2026

		specialist and developmental training.		team. The SIM training suite and education area is being utilised for all staff. **39.3**		
40	Outdated Putting Things Right (PTR) guidance was still displayed and we found no clear evidence of the new NHS Wales complaints process, Listening to People, visible within the department. Although information on how to provide feedback was displayed across the department, including in waiting and clinical areas, signposting to Llais, the independent advocacy body, required improvement. There was also no visible evidence demonstrating to show how patient feedback had led to service changes or improvements.	The health board must ensure: • Patient feedback, including actions taken in response, is clearly displayed in the ED • Signposting to Llais is displayed prominently in the ED • The new NHS complaints process, Listening to People, replaces outdated complaints guidance	People engagement, feedback and learning	**40.1.** Establish a "You Said, We Did" approach to demonstrate learning from patient feedback and provide assurance that feedback is routinely reviewed, acted upon and communicated through governance and patient-facing channels via ED meetings and communications.	People's Experience Service	04/09/2026
				40.2. To include Llais information on PES Board.	People's Experience Service	04/09/2026
				40.3. Review and refresh all patient feedback information within the ED, ensuring Listening to People & PEARS	People's Experience Service	04/09/2026

		and is displayed throughout the ED.		information is prominently displayed.		
41	While communication measures showed some improvement, the overall trend indicated increasing pressure on patient experience. We found no clear evidence of a structured response or improvement plan aligned to the Listening to People framework.	The health board must ensure patient feedback is reviewed, acted upon and monitored through a structured improvement plan with clear measures of progress.	People engagement, feedback and learning	Develop and implement a structured Emergency Department Experience Improvement Plan aligned to the NHS Wales Listening to People framework and the People's Experience Framework (using People's Experience Self-assessment tool). ED staff will be supported by PES, PEARS and the Concerns Team to routinely review patient, carer and staff feedback, including complaints, concerns, compliments, Civica feedback, patient stories, PEARs reviews and engagement activity. This work should be triangulated and	People's Experience Service	31/12/2026

				translated into measurable improvement actions by ED staff. Progress, learning and outcomes to be reported through governance arrangements, (PSQ/IHC PCE/ED Governance meetings) to demonstrate sustained improvements in people's experience.		
42	Free text responses highlighted concerns regarding limited engagement with frontline staff and lack of consultation on changes. Staff morale was widely described as low, with some comments referencing a negative or unsupportive culture.	The health board must develop and implement a staff engagement and psychological safety improvement plan for the ED. This should include actions to improve leadership visibility, staff engagement, confidence in raising concerns, feedback mechanisms and organisational responsiveness, with progress reported through	People engagement, feedback and learning	A report has been collated following our cultural intervention of listening to staff which has been reported back to the IHC Directors (22.07.2026) alongside identified opportunities for improvement. Next steps will be to present the findings to the ED leadership team.	Workforce & Organisational Development Team Director of AHPs – IHC Centre	04/09/2026 04/09/2026

		established governance arrangements.		This will then be followed by further engagement sessions with the wider ED teams to share the themes and to build on the actions looking ahead so that future developments and solutions are co-produced. This will include appropriate training for staff and senior managers to support and embed change. Staff who have raised issues through speak out safely will receive appropriate feedback in relation to these actions. A cultural assessment will take place at a future date once the actions identified above are in place and embedded.		30/09/2026 30/09/2026 31/03/2027

43	The wellbeing team reported they felt supported by most nurses in charge, which enabled them to provide this level of patient-centred care. Overall, the service was had a positive influence on patient wellbeing during extended waits and was supported by local management.	The health board must review the wellbeing support team model to ensure it is delivered consistently and learning from the initiative is used to inform wider improvements in patient experience and dignity.	Quality improvement initiatives	HCA recruitment drive to support patient wellbeing x 5 HCA vacancy to support and ensure there is consistent cover to support patients' wellbeing and formal review and evaluation once all posts are appointed to.	Head of Nursing EQ	30/11/2026
44	Patient and staff feedback both highlighted wider system challenges beyond the ED itself, including difficulties accessing primary care, delays in specialist review, discharge delays, limited community capacity and challenges accessing social care support. Collectively, these factors contributed to increased attendance at the ED and delays in progressing patients through the wider healthcare system.	The health board must work with system partners to reduce discharge delays, improve access to community, reablement and social care services and strengthen weekend discharge arrangements where these affect patient flow.	Partnership working and development	System wide Development of integrated discharge hub in partnership with local authorities across the Health Board. Director of UEC to lead on the discharge /flow improvements in line with the reaccommodation's from WG intervention team and the major change improvement programme	Acute Director of Operations, IHC Centre and HB UEC Director	11/10/2026 04/09/2026

				Continue to embed new LLOS process to reduce delays. Support shared purpose through regional alignment group.		31/10/2026

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan was actioned.

Service representative:

Name (print): Clara Day

Job role: Executive Medical Director **Date: 14th August 2026**