

## Appendix 2:

### **Ensuring safe and high quality care: a spotlight report on recent collaborative discussion on mitigating risk during extended ambulance waits at hospital.**

The Healthcare Inspectorate Wales (HIW) conducted a review and subsequently published their findings into concerns identified with long handover delays during a previous Welsh Ambulance Service (WAST) local review carried out in 2019-20. HIW explored what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity during the period between 1 April 2020 and 31 March 2021. The report set out the findings and recommendations for improvement with expectation that the recommendations were considered at a system level and taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.

More recently, CTM UHB came together with WAST and other health boards in a collegiate response to some of the key recommendations made by HIW to further understand the context to the issues at a local level as well as to workshop potential solutions. Using a sample of the recommendations as a framework, this briefing document will set out to reflect the issues as experienced within Cwm Taf Morgannwg University Health Board (CTM UHB) as well as to outline the collaborative work now underway in order to provide immediate mitigations where there are concerns for negative impact on quality of care and experience for our patients and services users.

**WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being**

As part of the review, HIW considered communication with patients' relatives/carers noting a clear divide, with half of respondents, stating that relatives were kept updated, and half-stating they were not. Comments indicated that ambulance crew communicated well with relatives, to update them on what was happening. However, only half of the survey respondents said they were kept informed about how long the wait on board the ambulance would be. Overall, it was deemed that communication, once the person was admitted to hospital, was experienced as variable. HIW conducted interviews with ambulance crews indicating that they always endeavour to engage with and build a positive rapport with patients. However, they said that during periods of long delays, there are limitations to the number of times they can apologise

to patients and their loved ones, either for the delays they experience whilst waiting for an ambulance in the community, delays outside the hospital, or at both locations.

Guidance from Welsh Assembly Government (WAG) issued in 2016 is clear, that when delays occur patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.

As part of the workshop, there was debate from participants on the potential contributory factors associated with the communication issues. There was consensus of the need to establish the understanding on the expectations that appropriate candour was carried out as well as:

- a) Guiding principles on expectations and processes for ambulance staff and UHB staff on expected communication with patients, their carers' and loved ones.
- b) A commitment from UHBs' and WAST to seek compatible digital solutions to sharing live information on flow and clinical risk.
- c) Shared principles on the approach to practitioner led information sharing to patients and relatives to reassure and clearly realign expectations from within the community and acute setting.

WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly. made in resolving them.

HIW reported on a number of views being expressed from people in the public survey regarding ineffective diagnoses made by both ambulance and ED staff, which included dissatisfied comments about ineffective diagnostics and treatment of conditions once admitted.

*"If there's a documented history of sepsis. Surely the sepsis protocols could be followed."*

Furthermore, HIW made reference to comments from ambulance crew relating to the delays in treatment and diagnosis for patients by ED staff. The comments included concerns where a patient's health could deteriorate whilst on board the ambulance, such as a patient experiencing chest pain. WAST staff were of the opinion that diagnostics should commence whilst the patient is waiting on board the ambulance, such as blood tests and x-rays. However, there were also concerns as to the contradictory position when compared to narrative being provided by UHBs' who confirmed diagnostics where instigated whilst in the ambulance, which then suggested inconsistency of approach across the healthcare system. The workshop membership was relatively consistent with the view that a delay in being

offloaded from the ambulance shouldn't be a barrier to appropriate care and diagnostics, however, individual UHBs' did have reservations as to issues of accountability.

The workshop membership agreed:

- a) No patient should be disadvantaged owing to the delay in being offloaded from the ambulance.
- b) There should be an agreed and consistent set of shared principles on how and when diagnostics are accessed for patients delayed in ambulances irrespective of the UHB they are aligned to.
- c) WAST and UHBs' should seek where available digital solutions to sharing clinical information once diagnostics are carried out, particularly where patients are transferred to other centres as a result of the diagnostic outcomes.

**Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.**

In their report, HIW advised that overall, patients' were very positive about their experience waiting on board an ambulance due to delayed handovers with very positive feedback about ambulance crews, particularly in relation to their kindness, overall communication and managing of distressing situations being expressed during the review. Patient comments included:

*"The ambulance service went above and beyond." "They were excellent, really helped with my mother-in-law's anxiety and kept us fully informed throughout."*

Furthermore, HIW went on to observe that nearly all who engaged in our public survey said they were treated with dignity and respect by ambulance crew, and felt safe and cared for, and that staff were knowledgeable. However, as a dichotomy to the patient feedback, where staff did not feel positive in relation to their ability to maintain patients' dignity during delayed handovers with 78% of emergency department (ED) staff content that patients were well cared for on board ambulances, only 68% said that the patient's privacy and dignity is maintained. Furthermore, only 62% of ambulance crew were felt that patient privacy and dignity is maintained. The comments from staff included:

*"Patients never provided with reason as to why they are waiting on an ambulance or have to endure the indignity of using a commode on an ambulance."*

*"The biggest issue I have come across resulting from patients waiting for many hours on the back of an ambulance is that comfort and dignity is compromised. The ambulance stretcher is not designed for patients, especially elderly patients with thin skin to be laying on them for hours. Also, during long waits patients often need to go to toilet and as a result of very poor mobility end up soiling themselves. So to preserve their dignity we clean them up as best we can with very limited items as it's an ambulance and not a hospital ward."*

One area of concern consistently highlighted by ambulance crew, was the difficulty in facilitating patients to access a toilet during their wait. Whilst most patients told HIW they were able to access a toilet, some patients reported they did not have access to facilities, which was supported by some of the feedback from ambulance staff during the review.

The discussion and feedback during the workshop session was particularly united on this topic in that there was full agreement that any patient requiring the facilities on any UHB should be offered the use of the facilities where appropriate. Furthermore, there was discussion and agreement that:

- a) The fundamentals of patient care is applicable to all caring disciplines and the training should seek to address this.
- b) UHBs' should seek to identify and agree core, shared principles on the mechanisms for ensuring adequate support to WAST staff in maintaining dignity and privacy where practicable.
- c) Individual EDs' should substantiate processes and procedures to enable the use of their facilities by patients in ambulances where clinically appropriate.

**During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.**

The Health and Care Standards 2015 clearly highlights that people should be helped to look after their skin, and every effort should be made to prevent people from developing pressure and tissue damage. In acknowledgement of this, HIW conducted reviews as to the standards throughout the emergency care journey between WAST and UHBs'. In response to

the survey carried out by HIW, ambulance crew raised concerns around the suitability of ambulance stretchers for patients who experience long handover waits. In particular, for patients who are immobile and lying on a

trolley on board an ambulance are at an increased risk of sustaining skin tissue pressure damage.

*"Patients are regularly suffering due to excessive handover delays. Ambulance stretchers are not designed for prolonged use and vulnerable patients are being put at risk of pressure sores and other tissue viability issues despite the efforts of ambulance staff to turn and adjust their positions."*

*"Often waiting outside with a patient for extended hours anywhere from 2 to 12 hours with a patient on an ambulance stretcher that is not designed for. Hard to give pressure relief to patients especially the heavier ones."*

The workshop membership talked extensively on the concerns regarding potential risk for some of the most vulnerable patient groups within our communities. The consensus was that:

- a) UHBs' should seek a collaborative approach to identifying risk of pressure ulcers and skin integrity issues after and as an adjunct to emergency care triage.
- b) Both WAST and UHBs' should seek to establish a set of agreed principles on priority of assessment, equipment availability and resources for those patients identified at significant risk.
- c) WAST and UHBs' had an obligation to ensure appropriate training for emergency care staff looking after patients for extended periods of time, particularly where traditionally such services were set up for patients requiring short term emergency care prior to more medium and long term care options being available.

Many of the issues discussed in the workshop as outlined above in evidence from the HIW review clearly were as a result of extended waits at the front door of the ED. There was shared frustration and concern that many of the measures discussed as cited within this summary documents could be negated by a better system of flow and decision making.

That said, there was common appreciation for the need to look at the current measures in place to ensure we are providing the best and safest care possible for our patients waiting for extended periods of time in ambulances and E.Ds'. Furthermore, is the need for a consistent approach from UHBs' working with WAST to remove the challenges associated with individual organisational barriers and to truly advocate and lobby for improved digital solutions to improve on the availability of information on emergency flow and care priorities to ensure we have the resource of ambulance practitioners in the community and adequate flow through our emergency departments.

A thread throughout the national discussions is the importance of acknowledging the whole system in terms of improvements at our front door services. The importance of engagement with universal services, primary and community care, and significantly, in relation to discharge arrangements, care package provision and social care arrangements cannot be underestimated. Sustainable improvements can only occur within the context of wider multi-agency stakeholder context.