North Bristol NHS Trust

Southmead Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this focused inspection to follow up the concerns identified in the warning notice served in December 2014, therefore rating of the service as a whole did not change. A further follow up inspection of North Bristol Trust is scheduled for December 2015 where the ratings for the service will be reviewed.

Our key findings were as follows:

- The warning notice was fully met although there were some areas which required improvement. During our inspection the department was under significant pressure due to a higher number of ambulances arriving than usual and also because the hospital computer system had an intermittent fault and was not working properly. This had an impact on the ability of staff to swiftly assess and treat patients within the department. Despite this staff coped well with the challenges and provided care as promptly as possible.
- Patients were seen to have a prompt assessment on arrival and were prioritised for treatment, although we did see a smaller number of patients who were not assessed and treated within the department within 15 minutes of arrival.
- The majority of patients had their needs met in a timely manner. We saw one patient who did not receive antibiotics when they should have.
- Patients in the seated assessment area, who were waiting for extended periods of time, had appropriate clinical risk assessments carried out.
- Patients requiring mental health assessments, still remained in the department. However, they were situated in the most appropriate location. The department had increased the hours that the mental health liaison team provided support. Further improvements in this were required.
- Privacy and dignity had been improved within the department. However, the inherent risk of privacy and dignity not being maintained when patients are waiting in the corridor remained.
- Staffing levels were increased at times the department knew that it was likely to be busy. As a result of this additional staff called down from wards were not asked to do anything beyond their skill or experience. Nurse practice educators had been employed within the department to support new and existing staff.
- Performance against the 4 hour target had greatly improved and was consistently just below the 95% target. The target was achieved during the months of June, July and August 2015.
- The flow within the emergency department and emergency zone was much improved. Further improvements in patient flow throughout the hospital are needed to support the department in maintaining and improving performance.
- Governance was effective. Risks were properly managed and evaluated and learning was shared. Information was effectively cascaded to the board and the managers felt well supported.
- Relationships had improved greatly which reduced the pressures on the emergency zone.

However, there were also areas where the trust needs to make improvements.

The trust should:

- Ensure that all care records are completed appropriately and filled in at the time of completion to contain an accurate record of care.
- Ensure that there is adequate visibility of all patients in the waiting room to manage unpredictable risks.
- Ensure that there is continued focus on improving flow throughout the hospital to support the emergency department in maintaining and improving performance.
- Ensure that all patients receive an assessment in line with Royal College of Emergency Medicine guidance and that this is clearly documented.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		The warning notice was fully met although there were some areas which required improvement. Patients were seen to have a prompt assessment on arrival and were prioritised for treatment. Staffing levels were increased at times of predictable increases in activity. As a result of this additional staff called down from wards were not asked to do anything beyond their skill or experience. Performance against the 4 hour target had greatly improved and was just below the 95% target. The target was achieved during the months of June, July and August 2015. Patients had their needs met. Privacy and dignity had been improved within the department. However, the inherent risk of privacy and dignity not being maintained when patients are waiting in the corridor remained. Governance was effective. Risks were properly managed and evaluated and learning was shared. Information was effectively cascaded to the board and the managers felt well supported. Relationships had improved greatly which reduced the pressures on the Emergency Zone.

Southmead Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Southmead Hospital

North Bristol NHS Trust is an acute trust located in Bristol providing hospital and community services to a population of around 900,000 people in Bristol, South Gloucestershire and North Somerset. In addition specialist services such as neurosciences, renal, trauma and plastics/burns are provided to people from across the South West and in some instances nationally or internationally.

In May 2014 the Brunel building on the Southmead Hospital site opened. This was a significant event with the majority of services moving from the 'old' Southmead Hospital and Frenchay Hospital sites into this new building.

Our inspection team

Our inspection was led by Catherine Campbell and Amanda Eddington, Inspection Managers, Care Quality Commission.

The inspection team comprised of two CQC inspection managers, two CQC inspectors and one specialist advisor. The specialist advisor was a senior emergency department nurse.

How we carried out this inspection

The inspection was conducted unannounced. We visited on the 12 and 13 October 2015. We spoke with nursing and medical staff, ambulance personnel, support staff, patients and relatives and the service management team. We reviewed information provided by the trust requested during the inspection. We also reviewed information we hold about the trust.

The inspection focused on the issues in the warning notice served in December 2014 therefore rating of the service as whole did not change. A further follow up inspection of North Bristol Trust is scheduled for December 2015 where the ratings for the service will be reviewed.

Detailed findings

Facts and data about Southmead Hospital

Southmead Hospital has 1,024 beds and approximately 7,600 staff who provide healthcare services to the residents of Bristol, South Gloucestershire and North Somerset which has a combined population of around 900,000 people.

CQC inspection history:

North Bristol NHS Trust had a total of 13 inspections since registration. Five of these had been at the old Southmead site. In May 2011 a themed inspection was undertaken specifically looking at dignity and nutrition. The outcomes inspected were met although there were some areas for improvement identified. In September 2011 a routine inspection identified minor concerns relating to safeguarding people who use the service from abuse, staffing, and informing CQC of notifiable issues. In March 2012 a themed inspection was undertaken specifically looking at terminations of pregnancy and the trust was found to be meeting the required standards. In January 2013 a further routine inspection was undertaken and concerns were identified relating to the management of medical records which was followed up in July 2013 and showed compliance with the standard.

A new style comprehensive inspection of the hospital was undertaken in November 2014. Concerns were identified in relation to the safe care and welfare of patient within the Emergency Zone and the Ambulatory Emergency Unit. We served a Warning Notice in December 2014 regarding this.

A focused follow up inspection of the Warning Notice was conducted in May 2015 which found that the Warning Notice was not met in full.

Urgent and emergency services

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

Urgent and emergency services were provided to people across Bristol, South Gloucestershire and North Somerset 24 hours a day, seven days a week in the emergency zone at Southmead Hospital. Managed within the trust medical directorate, the emergency zone opened in May 2014. The service consists of a number of areas, co-located in the purpose built Brunel Building. These were the emergency department, the acute assessment unit, the minors' area, and the seated assessment area which was due to become the emergency department observation unit on 4 November 2015. As a major trauma centre and regional specialist centre for burns and plastic surgery, the hospital had a helipad. An operations centre provided a central point of access for telephone referrals and all admissions. The standard operating procedure expected to provide emergency care and treatment to about 103,000 adults with serious and life-threatening emergencies a year.

There were six resuscitation cubicles (including one for children) and 14 major cubicles. The minors area provided treatment for illness and injuries that were not life threatening, but still needed prompt treatment. This included minor head injuries or suspected broken bones. There were 11 'see and treat' cubicles in this unit.

The paediatric emergency department at Bristol Royal Hospital for Children was the centre for the treatment of children with major injury or illness. Southmead Hospital provided only a minor injury service for children, seeing approximately 360 children a month. Seriously injured or unwell children who presented at the department were seen and, if appropriate, transferred to Bristol Royal Hospital for Children.

The seated assessment area had 16 reclining chairs to accommodate patients who required an urgent specialist opinion, rapid assessment, diagnostic investigations, observations or treatment, but were not expected to require an overnight stay. There was space for patients who had been assessed in the emergency department to wait in an area known as 'the corridor', previously known as 'the crossroads'. This area was a corridor with six cubicles and seating space for patients who had been assessed by a doctor in the emergency department and where ambulance crews offloaded patients entering the department. Adjacent to emergency department was a 64-bed acute assessment unit (AAU) for the assessment and stabilisation of acute medical patients for the first 24 hours of their stay.

There was a dedicated imaging suite providing plain X-ray, CT and ultrasound.

Urgent and emergency services

Summary of findings

The warning notice was met in full although there were some areas which required improvement.

At the time of our inspection the emergency zone (EZ) was under extreme pressure. We found that there was a spike in activity from both patients walking to the emergency zone and from ambulance admissions. The computer systems were not working properly throughout the day. This resulted in it taking longer for staff to assess, diagnose and treat patients. However, we found that the department coped with this well.

We found that patients were receiving assessment in a timely way. Patients were prioritised as they entered the department and those who presented with greatest risk were seen swiftly. Patients were receiving timely analgesia which was regularly reassessed during their time in the emergency zone. Staffing was increased during predicted increases of activity with additional staffing introduced during peak times in a timely way.

Access and flow within the emergency zone were much improved from our inspection May 2015. The number of 4 hour breaches had significantly reduced. However, further improvements in flow throughout the hospital were needed to support the emergency zone.

Patients had their needs met. Privacy and dignity had been improved within the department. However, the inherent risk of privacy and dignity not being maintained when patients are waiting in the corridor remained.

Senior staff in the emergency zone were well supported by the divisional and executive teams and held weekly meetings to discuss the performance of the department. There were daily emergency zone meetings where the previous day's performance was discussed and lessons learnt shared.

Are urgent and emergency services safe?

Incident reports demonstrated much reduced of overcrowding and subsequent harm to patients compared to May 2015. Opportunities to protect vulnerable adults were identified and acted upon. Patients were promptly assessed and appropriate risk assessments were conducted. Nursing and medical staffing numbers were increased to reflect predictable spikes in activity reducing the waiting times for patients in the department.

Incidents

- Incident reports demonstrated much reduced overcrowding and subsequent harm to patients. Staff reported incidents via the electronic incident reporting system and incident reporting was encouraged. In May 2015 we reviewed incidents from 1 February 2015 to 20 May 2015 and found that of a total of 418 incidents in this time 115 (28%) were regarded as being of moderate impact and 23 (6%) were regarded as major or catastrophic. In October 2015 we reviewed data between May 2015 and September 2015 and found that out of a total of 433 incidents in this time 46 (11%) were regarded as being of moderate impact and nine (2%) were regarded as major. No incidents were regarded as catastrophic.
- Of the nine incidents regarded as major, three were as a result of capacity in the department. Two incidents occurred on 5 September 2015 where there were extensive delays for patients requiring a bed in a secure location under the mental health act. One patient waited for 11 hours, another waited for 14 hours and a third waited for 30 hours for an appropriate bed. On 22 September 2015 it was reported that there were excessive numbers of breaches in the 4 hour target within the emergency department as 15 patients required beds in the hospital.

Environment and equipment

- In May 2015 we found that in the reception area of the emergency department all chairs had been turned to face the minors area of the emergency department to allow better visibility by staff of patients while waiting to be seen. During our first inspection day we found that five chairs were facing away from the minors area. We were told by senior nursing staff that this may had been done during cleaning, as the chairs could easily be

moved, and would be turned back. However, when we visited on 13 October they still had not been moved. Despite this the visibility of patients within the waiting area had improved since November 2014.

Records

- We looked in nine patient records and found that six were completed appropriately. One patient's record had observations written in pencil. This means that they could easily be removed from the record. In a second patient's record we found that there was no time of triage and did not find an observational chart and also found that there were no nursing observations recorded in a four hour period. However, in the remaining seven sets of notes we found comprehensive recording of observations and nurses documentation. In a third patient's record we found that neurological observations were not done in a timely way and that they were recorded retrospectively in the notes.
- These records were highlighted in the daily debrief meeting by senior staff in the department. Support for new staff involved was to be provided by the nurse practice educators within the department.
- The trust had reviewed the documentation for patient episodes in the emergency department and a new format of documentation was being implemented in the week following our inspection. This documentation prompted staff to carry out observations at the appropriate point in time. This had been adapted from the documentation in use at another trust.

Safeguarding

- We observed that when patients attended the emergency zone they were all spoken to on arrival and any concerns were listened to. Staff went back to patients to keep then up dated during their time in the corridor. There was one patient who attended that was intoxicated and the ambulance crew had some concerns about the reasons behind this. This patient was prioritised and was moved into a majors cubicle within ten minutes. This had improved from our inspection in May 2015 where, although staff had a good understanding of the safeguarding principles, we observed one incident where a patient at risk left the department prior to having an assessment. They had been waiting for an assessment for one hour and thirty minutes.

Assessing and responding to patient risk

- Improvements had been made in the assessment and prioritisation of patients entering the emergency zone. This was as a result of a change in the flow of patients arriving by ambulance through the emergency zone. Rather than patients waiting in the corridor to be assessed and treated in the majors area, patients were greeted by the nurse in charge of the corridor area and swiftly guided through into the majors area. We saw that patients coming to the hospital by ambulance, were seen quickly during the day. Patients who were at risk were moved to the most appropriate area. For example, we saw one patient who was pale and in obvious pain. They were quickly moved to the acute assessment unit for further observations. When the department got busier nurses talked with the ambulance crews and the patients on arrival to prioritise those at greatest risk.
- All patients arriving in the department by ambulance had an initial undocumented assessment by the nurse in charge in the corridor. This was to ensure that the patients were appropriately prioritised for treatment. We observed that most patients were swiftly moved into the majors' area. Between 10 August 2015 and 4 October 2015, 81% of patients arriving by ambulance were handed over to emergency department or acute assessment unit staff within 15 minutes. Data for the two months prior to our inspection identified that 75% of patients attending by ambulance had a formal documented assessment within 15 minutes of arrival in the department and all patients were triaged within one hour of arrival. This was an improvement on the timeliness of patient assessment.
- There were no more than seven patients awaiting triage at any one time during our inspection. This was during the period of time that the computer system was not working. In May 2015 there were at one point 22 patients awaiting handover and triage in the corridor area. This was as a result of the improved flow through the department.
- We saw some delays in the assessment and responding to patient risk. For example, one patient had their antibiotics delayed because there were delays in taking observations. Despite a high temperature, they were not reassessed. This resulted in an hour delay in their treatment. In another patient's record it was recorded by the ambulance team that the patient's blood glucose was high. It was not repeated or recorded in the patients

notes until two hours after their arrival. This was highlighted in the daily debrief meeting and nurse practice educators were to provide support to the members of staff involved.

- Patients who had been assessed and treated in the majors area and were considered safe were moved into the corridor. Although this had improved since our inspections in May 2015 and November 2014, the two cubicles used, did not have any access to call bells or oxygen and visibility to the nurses station was obscured. If a patient required assistance they would have limited means of communicating this to staff. However, nursing staff walked past this area and observed patients regularly, attending to them as necessary.
- There was clear assessment and monitoring of patient risk at regular intervals throughout the corridor, majors and resus areas of the emergency department. In contrast to our inspection in May 2015, we saw that shift coordinators were regularly walking around each area to identify where patients could be moved. We saw an example where two patients in the corridor required majors cubicles. Discussions were had as to who could be moved out and quickly a decision was made. One patient went into the seated assessment area and another went into a crossroads cubicle freeing up the space for the unassessed patients. All of these decisions were appropriate based on the risk posed to the patient at that time. Senior doctors led reviews of the patients within the corridor, majors and resus areas, to monitor and prioritise patients on a regular basis. The frequency of this increased during busy periods, although staff were hampered by the failure in the computer system.
- We observed a tannoy system in operation where staff were required to attend a particular unit or patient. This was regularly used to update all staff as to the ongoing situation with the computer system failure.
- In November 2014 patients spent long periods of time in the seated assessment area without clinical risk assessments. In May 2015 we saw that this was still ongoing. In October 2015 we found that as a result of the acute assessment unit receiving medically expected patients straight from the ambulance crews capacity was greatly freed up in the seated assessment area. We reviewed three sets of records and found that they all had appropriate risk assessments, which were repeated if necessary. Patients we spoke with said they were well looked after by the staff and were regularly offered food and drink. We also observed consultants doing a board round there. There were clear plans in place for the development of the seated assessment area into the emergency department observation unit from 4 November 2015, which would further improve the monitoring of patient risk within the department.
- We saw that patients were no longer waiting for extended periods of time unnecessarily in the seated assessment area. When we arrived at 1pm all 15 chairs were in use. By midnight all patients who were awaiting a bed were transferred out and the area was being used as an observational area for emergency department. There was only one patient who was waiting overnight in this area, but this was the patient's choice and monitoring was in place.
- In October 2015 we found that the protocols regarding mental health support were being followed and patients were appropriately placed within the department. There had been an improvement in the timeliness of mental health assessment, although further improvement was required. The hours that mental health services were going to be delivered were to be extended to between 7am and 9pm. In the records we looked in all patients who required a mental health assessment had the appropriate matrix risk assessment.
- During the inspection May 2015 the introduction of a 'streaming' nurse who would remain at the reception area to redirect patients to primary care if necessary was introduced. However, the impact was not assessed. In October 2015 this role has changed to a 'hello nurse'. On the days of our inspection this post was not filled as staff were required elsewhere. We were also told that during periods of heightened activity this person was usually the first to be moved as it posed the least risk to the patients.
- Receptionists used a red flag system to alert staff of any concerns regarding patients presenting and had received additional training in this. We observed a receptionist getting the attention of nurses when a patient presented at reception who was unwell and needed immediate medical attention.
- There were two triage nurses in the minors area of the department. This was working effectively and ensured that all patients were seen in a timely way to maintain the good compliance with the target seen in May 2015.

Nursing and Medical staffing

- During the inspection in May 2015 we saw that there was no consideration of changing staffing levels at times the

department knew that it was likely to be busy. This meant that when demand was at its greatest there were no additional staff rostered to work in the department. We found in October 2015 that additional staff had been introduced during these times including extra twilight staff on a Saturday, Sunday, Monday, and Tuesday. An extra consultant was introduced for a Monday between 4pm and 11pm in a supernumerary capacity. On a Sunday, Tuesday, Wednesday and Thursday two additional consultants were on duty. On a Monday three additional consultants were on duty.

- We looked at staffing data for the six weeks prior to our inspection in October 2015. This was analysed and discussed on a daily basis by the managers of the emergency zone and risk rated as black, red, amber or green. Staffing was rated as green 21 (50%) times, amber 21 (28%) of the time, red 8 (19%) times, and black once. On the one occasion that the department was rated as black they were short of four senior house officers. However, mitigating actions were taken as a result to ensure patient safety.

Are urgent and emergency services effective?
(for example, treatment is effective)

We saw that pain was effectively assessed and that analgesia was promptly administered. We didn't see anyone in the corridor who was in pain and wasn't being appropriately managed. Audits had improved since May 2015 and compliance was consistently high. Staff who were brought into the department to support at times of overcrowding worked responsibly and within their ability.

Pain relief

- Patients who were in pain were quickly assessed and either taken into the emergency department or were given prompt analgesia. We didn't observe anyone in the corridor in pain who was not being appropriately managed. We saw the nurse in charge of the crossroads area, checking that people were not in pain when they arrived in the department.
- We looked at nine sets of patient records and found that they all had their pain charts completed and analgesia administered in a timely way.
- Of the records we looked at patients in majors received effective assessment of pain on average within 12 minutes. These patients were considered at a higher risk so received a prompt assessment and intervention. Patients in the corridor received an assessment on average in 59 minutes. Of these patients 75% did not require any form of pain relief.
- There was a daily audit of five patient records in the emergency department and five patient records in the seated assessment area. Data from 13 July 2015 to 20 September 2015 showed that 93% of patients in the emergency department and 99% of patients in the seated assessment area received pain assessments in under 20 minutes. In the same two month 92%of patients in the emergency department and seated assessment area received analgesia, in under 60 minutes.

Competent staff

- During a spike in activity in the corridor a "standard operating procedure nurse" was requested. This is when the emergency zone requests wards to move one member of staff to the emergency zone to assist. When we inspected in May 2015 the nurse sent did not have the appropriate skills to manage the demands of the department. In October 2015 a standard operating procedure nurse was requested and two supernumerary nurses quickly attended from wards in the hospital. Although, neither of them had much emergency experience they were quickly orientated by a senior nurse and given tasks within their capacity to do safely. These included taking observations, going around the department with the drinks and food trolley, cleaning empty cubicles and beds.
- During the day we saw that an additional nurse from a cardiology ward was assisting in the corridor. This individual was confident in the role they could perform and their responsibilities. This included taking observations and cleaning empty cubicles and beds.
- The trust had employed three nurse educators within the emergency zone to provide training and support to all staff but particularly to newly qualified staff. This was seen to have had a positive impact on the care delivered by staff. It also enabled swift support for individual staff members where care and treatment was not delivered as they would wish.

Multidisciplinary working

- As part of the emergency zone quality improvement action plan handovers were changed in July 2015. Previously handovers were based around the computer

with no visualisation of patients by nurses and doctors in charge. During our inspection we saw that handovers were done at the bedside to ensure this initial contact with the patient was made. This allowed for good multidisciplinary working between nurses, doctors, and the patients and as a result we saw that issues were quickly identified and acted upon. However, we saw that during this time the lead co-ordinator in emergency zone did not attend this.

- We saw a handover taking place in the corridor where doctors, nurses from emergency zone, resuscitation, the corridor, the matron and the on call manager discussed patients individually and decided the best place for them to be and how they would achieve this. This meeting was completed within 5 minutes and highlighted the efficiency of this process.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

We reviewed the access and flow of patients through the emergency zone (and found there were significant improvements since our inspection May 2015. Performance against the four hour target had improved and patients received a timely triage within the department into the appropriate area based on risk. Medically expected patients were moved quickly into the acute assessment unit reducing additional pressure from the emergency zone.

Meeting people's individual needs

- In May 2015 people with mental health problems were waiting too long for assessment under the Mental Health Act 1983. Between December 2014 and May 2015, 79 out of 186 patients (42%) who attended the emergency department with mental health issues spent more than four hours in the department. Sixty eight of these (38%) were delayed because they were waiting for an assessment under the Mental Health Act 1983. This concern was identified on the emergency department quality improvement action plan which stated that a mental health strategy was to be developed by October 2015 however this had not been completed.
- During our follow up inspection May 2015 the corridor area of the emergency department was cold whilst patients were receiving assessment care and treatment. The ambulance doors were frequently open, allowing cold air into department. During our inspection October 2015 we found that the area was warm and patients we spoke to were comfortable with the temperature in the corridor. We observed that as a result of improved flow in the department there were fewer ambulance crews waiting by the doors resulting in the doors remaining closed.
- Occasionally basic observations (taking a patient's blood pressure) were carried out by nurses or ambulance crews in the corridor area. Where more invasive tests were required, for example a blood test, this occurred in one of four private cubicles. Although staff worked to ensure that patients' privacy and dignity was maintained, we observed one patient trying to sleep on a bed in the corridor for over an hour and did not have any screens to ensure privacy.
- Confidential conversations could be overheard in the corridor and patients who were waiting in beds who had been assessed in the emergency department did not have access to curtains and had limited access to screens compromising privacy. For example, we observed that conversations between physiotherapists and a patient in this area could easily be overheard. We also found that conversations at the nurse's station could be overheard by patients sat in the corridor.

Access and flow

- Performance against the four hour target from December 2014 to April 2015 ranged from 83% to 86%. We found this had much improved. In the two month period prior to the inspection the average compliance rate was 94% (an improvement of 8%), just under the 95% national target. On the day of our inspection due to the surge in activity and the issues with computer systems there was a drop in compliance to 82%.
- As a result of the computer issues it was taking longer to triage patients in the minors area. We found it was taking up to 40 minutes to triage a patient as paper records were required. However, the flow through the minors department was greatly improved from that seen in November 2014.
- During our inspection in May 2015 rapid assessment and treatment (RAT) was being trialled in the emergency department with positive results. We saw example in October 2015 where this meant that patients were getting timely assessment, diagnosis and treatment for example getting analgesia quickly or being sent for

computed tomography (CT) scans. Due to improvements in the flow of the department this was used less regularly. It was used during our inspection due to delays with computer systems breaking down. However, as a result of the IT systems breaking it took up to an hour longer to complete this process. One consultant described it as "wading through treacle".

- Flow through the emergency department was greatly improved from that in May 2015. During the day patients were quickly assessed by a competent experienced nurse in the corridor and taken into emergency department where they had further assessment and treatment. As the department became busier there were patients waiting to be assessed in the corridor, but, they were all initially assessed, prioritised and were taken into emergency department in a timely way. Patients who were assessed and were awaiting further investigations were either moved from the emergency department into the corridor if appropriate or into the seated assessment area creating capacity for incoming patients. At any one time there were no more than seven unassessed patients in the corridor. All of which were being monitored either by nursing staff or ambulance crews.
- In May 2015 we reviewed the escalation status for the department between December 2014 and May 2015. The department was reporting red escalation ("regularly unable to function as normal and verging on unsafe for periods of time") 35% of the time and reporting black escalation ("dangerous for a sustain period of time (more than two hours) and where normal care is not possible) 35% of the time. In October 2015 we reviewed the escalation status for the previous two months and found the department was reporting their maximum escalation status during the day as, red escalation 30% of the time and reporting black escalation 40% of the time. The maximum escalation status may have been for a short or long period of time. During our inspection black escalation was called, which was directly affected by IT complications. However, this was managed well and the corridor was quickly brought back to a safe level.
- Between April 2015 and September 2015 there were 10,432 ambulance handovers in the hospital. Of these patients 8853 were triaged within 15 minutes and 21 were triaged after an hour of waiting. During our inspection in October 2015 there was a unusually high number of patients attending the emergency zone by ambulance. In the 2 months prior to the inspection the average number of patients attending in a day had been 69 patients admitted by ambulance. During our visit 83 patients admitted by ambulance. Flow into the appropriate area had improved with 75% of patients being seen within 15 minutes and 93% being seen within 30 minutes.
- The ambulance service had agreed a process, known as the ambulance standard operating procedure which allowed ambulance crews to leave patients in the department if they had been waiting in excess of 30 minutes for handover. Between January 2015 and May 2015 this had been implemented on 21 occasions. Between May 2015 and October 2015 this had happened only 3 times. One of these occasions was during our inspection. The standard operating procedure should be enacted after only four hours of time collectively spent by ambulance crews in the EZ. During our visit it was enacted after 14 hours of time collectively spent in department to ensure the safety of the patients. We were told that it was enacted because the risk to patients waiting for an ambulance was greater than those in the hospital.

Are urgent and emergency services well-led?

We found a positive and reflective process for managing risk and governance in the department. Daily meetings took place to review performance and lessons learnt were shared. Information was escalated appropriately to the board. We observed strong leadership and staff were informed of proposed changes to the seated assessment area. Staff we spoke with were positive about working in the Emergency Zone.

Governance, risk management and quality measurement

- Performance within the department was reported weekly to the Bristol and South Gloucestershire Clinical Commissioning Groups. Activity and clinical governance was also reviewed at divisional and board level performance meetings.
- Performance was reviewed daily by the clinical lead, matron, and ward manager and a daily debrief chart was filled in. This chart examined four hour performance, ambulance turnaround times, the number of patients in crossroads, internal escalation levels as a

result of flow through the department, staffing levels, transfers and the results of daily audits conducted. This was then risk rated (as black, red, amber or green) to provide an overall performance score for the previous day. This is was then reflected upon and lessons were learnt and shared.

- During this meeting three individual patients were discussed to be at risk as a result of waiting for long times in the corridor. Where a concern was identified it was actioned that a root cause analysis should be conducted.
- Information from the daily meetings was fed into a weekly acute flow meeting where the performance was presented and discussed. Selected members from the board attended this meeting. This information then fed into trust board meetings.
- Since May 2015 a quality action plan had been implemented based on the concerns in the warning notice. This was regularly updated and each item had a responsible person and a timeframe to complete the action. Of the 17 actions 11 had been completed and the remaining 6 were in progress.

Leadership of service

- Leadership within the emergency zone remained strong and the clinical lead, matron and ward manager worked cohesively. They were visible throughout the spikes in activity and when the computer systems failed and were seen to be supporting others well. The on-call manager was present when the computer systems failed and she stayed assisting in the department until late at night.
- Staff were confident that the proposed changes to the seated assessment area were going to have a huge benefit on patient safety and flow. Staff were well informed by managers of these changes and the progress with them. Plans which were due to come into effect in November 2015 included a six seated step-down area and four cubicles being introduced to this area, further reducing the pressure on the majors' area. Managers told us about the predicted benefit of this and felt it would have a significant impact on flow through the department during the winter period.

Culture within the service

- When we inspected in May 2015 we saw that staff continued with resilience and professionalism whilst working in challenging conditions. Staff were supported by an open culture within the department which welcomed change. We found in October 2015 that staff were feeling that things had improved significantly in the last few months. One member of staff said "I used to hate coming to work but now it is so much better".
- Managers discussed that relationships had greatly improved within the hospital and that there was more dialogue. This led to the workload of the emergency zone decreasing and getting greater support from specialities and medics throughout the hospital.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should ensure that all care records are completed appropriately and filled in at the time of completion to ensure an accurate record of care.
- The trust should ensure that there is adequate visibility of all patients in the waiting room to manage unpredictable risks.
- The trust should ensure that there is continued focus on improving flow throughout the hospital to support the emergency department in maintaining and improving performance.
- The trust should ensure that all patients receive an assessment in line with Royal College of Emergency Medicine guidance and that this is clearly documented.