# University Hospitals Bristol and Weston NHS Foundation Trust

# UHBW Bristol Main Site

**Inspection report**

Bristol Royal Infirmary
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## Ratings

| Overall rating for this service | Not inspected |
|---|---|

# Our findings

## Overall summary of services at UHBW Bristol Main Site

Not inspected

We carried out a focused inspection of Bristol Royal Infirmary urgent and emergency care service for adults (also known as accident and emergency – A&E) on 1 February 2021 as part of our winter pressures programme. As this was a focused inspection, we only inspected parts of three of our key questions: safe, responsive and well led. We did not inspect effective or caring on this visit, but we would have reported on them if we found areas of concern. At our previous inspection in 2019, caring was rated as outstanding. Effective was rated as good.

For this inspection we considered information and data and the concerns this raised over the ability of the department to respond to patient need (also known as performance) of the department and the wider trust in relation to responsive care (around timely patient flow) and waiting times for patients. We were also concerned with delayed and lengthy turnaround times for ambulance crews.

# Urgent and emergency services

**Requires Improvement** 

The Bristol Royal Infirmary is a teaching hospital run by University Hospitals Bristol and Weston NHS Foundation Trust for people living in the southern, central and north-west parts of Bristol. The Bristol Royal Infirmary urgent and emergency care service is for adults and some young people (although this has recently been changed and 16 to 18-year olds are now attending the children's emergency department to help with capacity). The service is provided in the adult accident and emergency department (referred to in this report as the 'emergency department'). It is based in the centre of the city of Bristol and is one of two NHS emergency departments serving the Bristol area and South Gloucestershire. The other is at Southmead Hospital, run by North Bristol NHS Trust and serving the rest of the catchment area. The service at the Bristol Royal Infirmary is part of the division of medicine. The trust also runs an emergency department within the Bristol Eye Hospital, located close to the Royal Infirmary, and the emergency department at Weston General Hospital.

The trust has a dedicated children's emergency department as part of Bristol Royal Hospital for Children located adjacent to the adult service and managed as part of the women's and children's division. Although the two departments are next to each other, they are physically independent of each other and do not share reception, waiting or treatment areas. On this visit, we inspected just the adult service.

The emergency department accepts patients transported by ambulance or those who arrive independently. It is open 24 hours a day, seven days a week for patients who require emergency treatment.

The emergency department is a designated trauma unit, one of seven in the south west, and supports the city's major trauma centre at Southmead Hospital. As a trauma unit, the emergency department will provide initial stabilising treatment and some specialist care before a patient with certain major traumatic injuries or illnesses is transferred for major trauma care.

From January to December 2020, the adult emergency department saw 62,355 patients. This was around 5,200 patients per month or around 170 each day on average. This was down by around 12,000 patients over typical patient annual attendance due to the national fall in patient numbers during the months of the first lockdown and notably April, May and June 2020.

During the COVID-19 pandemic, the department has changed. The majors' and minors' areas are now located separately, although joined by an internal corridor. The minors' area, reception and triage (for less serious injuries or illnesses) remains in the original A&E location. The majors' area (for more serious injuries or illnesses) has been established in a newer part of the hospital with a much larger more spacious treatment area.

The department has created blue and amber areas for patients to minimise the risk of the COVID-19 infection spreading. Amber areas are for those patients whose COVID-19 status is unknown and awaiting results, and blue areas are for patients with suspected or a confirmed positive test for COVID-19.

The emergency department has 16 majors' bays and a further eight cubicles. The amber and blue resuscitation areas each has space for four patients. There is also an eight-bed observation room. The minors' area has seven cubicles and two consultation rooms.

# Urgent and emergency services

Our inspection had a short announcement (around 30 minutes) to enable staff to arrange to meet with us and for us to carry out our work safely and effectively. Due to the narrow focus of this inspection, we did not change the rating of the service at this inspection. Our overall rating of the urgent and emergency care service therefore stayed the same as requires improvement.

We found:

- Given the current pandemic, efforts had been made to protect patients and staff, but the design and use of some parts of the premises did not always keep patients safe. We were concerned with the condition of the patient waiting area in the minors' area. There were several damaged chairs which could not be cleaned effectively, and there was a lack of safe social distancing measures. There were some lapses in infection prevention and control practices among staff we observed and areas we visited.
- The service did not have enough medical staff to meet the recommended guidance for the type and size of the department or to be able to expand the service. The department was not able to have consultant cover in the week until midnight as recommended. It was unable to fully establish a same-day emergency care service when this would have improved patient flow. Some middle-grade doctor rotas were not always covered at night.
- Although there were significant efforts made to keep them safe, patients did not always receive care and treatment promptly. Pressure from high demand, COVID-19 restrictions, a lack of beds in the rest of the hospital available for patient transfer, and patients being more unwell meant patients did not get seen in a time considered safe and responsive to their needs. Patient handover from ambulance crews and waiting-time performance for onward admission to the hospital was worse than NHS national standards. It is well understood how these delays cause harm to patients and lengthen response times and delay ambulances needed in the community. However, staff were actively looking for improvements and short and long-term solutions, both internally and externally with system partners. Also, there were few delays in the decisions taken around onward patient care. The department had resolved several flow problems which were in its own control but was limited by external factors.
- The trust senior leadership were perceived by some staff as not having been present enough in the department to provide assurance and support, demonstrate recognition and awareness of the risks and struggles staff were managing. They were not sufficiently visible and approachable for some staff.
- We had serious concerns about the growth in violence and aggression to staff from patients and staff felt they were not adequately trained and protected.
- Although leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, these were not always revisited in times of crisis.

However:

- Staff understood how to protect patients from abuse and acted on any concerns. They recognised when abuse might be occurring and were trained in how to deal with their concerns to keep patients safe.
- Staff kept detailed and comprehensive records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- Patients had an assessment of their infection risk and other clinical risks on arrival at the department. The department had a system for monitoring patients who were either at risk or found to be deteriorating. This included patients who were waiting on ambulances to be admitted to the department when demand was high or patient flow out of the department was blocked or slow.

# Urgent and emergency services

- The pressures of COVID-19 meant the service struggled at times to have enough nursing staff, but measures were taken to ensure staff were brought in where possible to reach safe levels. This was addressed and reviewed on a regular basis by the senior nursing team.
- Leaders in the emergency department demonstrated the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible, supportive, caring and approachable in the service for patients and staff.
- Staff in the department felt respected, supported and valued by their colleagues. They were focused on the needs of patients receiving care. There were strong examples of staff feeling able to speak up and raise concerns without fear.
- There were many good systems to recognise, report and understand performance and a live performance dashboard available to staff to be able to track performance. Following our inspection this was being updated to include the number of patients remaining on trolleys for 12 hours or more.

## Is the service safe?

**Requires Improvement** 

**Safeguarding**

**Staff understood how to protect patients from abuse and acted on any concerns.**

Staff we spoke with were clear how they would identify patients they felt were at risk of abuse. A range of staff from different grades and disciplines were able to clearly describe what the signs were of suspected abuse that would worry them. This included patients who were anxious, had marks of possible injury, such as bruising, or were withdrawn or scared. We heard of some unexpected advantages created by the COVID-19 restrictions for patients who were at risk of abuse. For example, before the pandemic, patients who were suspected of being subject to abuse were often accompanied when staff were with them and sometimes seen to be reluctant to seek help. With the restrictions of COVID-19 meaning they had to be unaccompanied when being treated, patients were able to be more open and ask for and accept help.

Staff knew who they should inform either in the department or within the trust with concerns. There was a trust-wide team of higher-level trained safeguarding staff who had the responsibility to investigate any safeguarding concerns. These were raised with the relevant local authority who had the statutory duty to act on allegations of abuse. Staff we asked said the safeguarding practitioners were very supportive and approachable with any anxieties they might raise however small they might seem.

Staff told us they received regular training updates and training was delivered to all new staff at their induction as a mandatory subject. Those staff we met had been trained to various levels in accordance with their role. They all felt the training was of a good standard to enable them to protect patients from abuse. In the most recent integrated performance report for the trust (January 2021 board paper, December 2020 statistics), the uptake of safeguarding training for the trust was at 89% against a trust target of 90%.

**Cleanliness, infection control and hygiene**

# Urgent and emergency services

**In most aspects, the department controlled infection risk well and it was visibly clean in areas we visited. Most staff wore the right personal protective equipment (PPE) most of the time to keep themselves and others safe from cross infection. However, we did see some lapses in practice around PPE and hygiene.**

Most staff used equipment and control measures well to protect patients, themselves and others from infection. We observed staff wearing the correct personal protective equipment depending on where they were working. Staff said they had not encountered any shortages of PPE since the start of the pandemic and they had been well provided for. In the blue area resuscitation bay, we observed staff were in full PPE to protect themselves from patients who had or were suspected of being COVID-19 positive. Staff told us they had received effective training in putting on (donning) and removing (doffing) PPE safely to prevent the risks of cross infection. They said they were regularly checked by the trust's infection prevention and control team to ensure their practice remained safe and effective. We did note a few occasions when staff were wearing their masks under their nose, which they corrected when this was pointed out. We also observed a cleaner enter the amber resuscitation area without a mask. This was addressed quickly when this was pointed out by one of the nursing team. When we visited the ambulance crews waiting outside the hospital, we were well supported by one of the doctors to ensure we had the right PPE to join them on their patient assessment rounds.

If staff were carrying out a more high-risk process, such as one which may generate aerosols into the atmosphere (known as an AGP), signs were placed at the doors of any room being used to alert all staff to the process. They should then not enter unless wearing full PPE. However, we observed a procedure carried out in the amber resuscitation area and this did not happen in practice that time. There was also a discussion about the clinical procedure being proposed and a member of the nursing team stepped into the discussion around the safety of the procedure. This was then undertaken more safely as a direct result of this intervention.

Staff entering the blue resuscitation area, which had a clear sign designating it as an AGP area, were observed using the agreed buddy system to ensure PPE was put on safely and in accordance with required standards. We were told the blue areas had wipeable keyboards for prevention of the spread of infection, although these had not been provided to the staff work areas or other clinical areas. However, there were large quantities of antibacterial wipes available for staff to use, although we did not see any being used when observing practice. A member of staff we asked said they did not think the more basic processes such as cleaning a keyboard were audited or checked.

There were many paper advice and guidance leaflets in the minors' area for patients to take away. Some electronic alternatives were available, but this was limited. In this time of pandemic crisis, as there were large quantities of these leaflets, they did not appear to have been replaced regularly or kept in limited numbers for reasons of infection control. The department remained using paper records for patients which was also not ideal in a pandemic due to infection risk.

Nevertheless, the premises were visibly clean in those areas we visited. Surfaces including floors and desk areas were visibly clean as were beds and the equipment around them. There was a well-understood regime for clinical cleaning in the department with some more technical cleaning of equipment being undertaken by the nursing team. The more general cleaning was carried out by the domestic team. The cleaning team of domestic staff were placed to work in the emergency department all the time, and a senior nurse said this meant they were "part of the team". We were told they were more aware of the protocols for the department as they worked there regularly and were experienced in the routines expected of them.

We spent some time observing trust staff and ambulance crews coming into and leaving the majors' area where they would book in patients arriving. We were concerned at not seeing an embedded approach to the use of hand gel on arrival in the department at times. This was not helped by some hand gel being placed on desks and workstations in

bottles. Here, and in the incident triage area, staff were required to pick up the bottle to apply hand gel onto their hands, which meant frequent touching of the bottles by multiple people. Otherwise, there was hand gel at all bedsides and in cubicles, along with hand-washing facilities. We observed this being used well, but it was less apparent on entry to the department.

In the female staff changing area in the office area, we found three face masks which had been used which were discarded on top of the shoe rack. Also, due to size restrictions, this and the male changing room was no longer fit for purpose. Both were overcrowded with discarded clothes and shoes and personal effects. This gave rise to a risk of the spread of infection. Also, the waste bin next to the sinks in the female changing room had a defective lid which needed to be raised by hand.

**Environment**

**Given the current pandemic, efforts had been made to protect patients and staff, but the design and use of some parts of the premises did not always keep patients safe.**

The premises used by the department differed between the minors' area, which was located in what was originally the main emergency department, and the majors' area in the newly refurbished building across the other side of the ambulance bay. The move to the new majors' area had resolved some of the problems with the previous older department, and provided more space, light, and a better environment for patients and staff. The environment had mostly been designed to keep patients safe and comfortable within social distancing and infection prevention and control requirements. However, we recognised none of these facilities had been designed to be used in a pandemic and the trust had endeavoured to make them safe for patients and staff.

The new arrangements for the department meant it had become spread out and patient visibility was far from ideal. The majors' area layout, although spacious and better in many ways, was complex and did not easily support an overview of patient flow or risk or allow the opportunity for staff to be able to observe.

As reported above, the relatively new majors' patient care and treatment area had been adapted from a pre-existing treatment area not designed as an emergency department. However, adaptations had been carefully considered and had provided the department with a much larger facility with more beds and cubicles and the ability to segregate patients known to have COVID-19 from others. All patients in the department were seen in areas which, for safety, were behind doors closed to the main atrium and staff workstation area. As described above, there were separate resuscitation areas for COVID-19 positive patients and all others. At the time of the inspection, due to current guidelines, most patients were not permitted to have family, friends or carers with them due to infection risk, and there were limited areas for people to wait. They were able to wait in the minors' waiting area, although this was small with potential for overcrowding, so this was discouraged.

The minors' area had not changed since the pandemic due to the need for the proximity of triage rooms and the adjacent treatment areas it provided. However, the treatment area was small and restricted in how it could enforce social distancing for staff and patients with narrow corridors and small workstation areas. Staff we met in the department were clearly taking steps to keep a safe distance if possible, but this was often unavoidable in the space. Nevertheless, they were all in PPE and all the patients we saw were wearing masks provided to them by the department.

# Urgent and emergency services

Due to COVID-19, some seats in the waiting area had been marked with a laminated sign on the back rest, and a cross in tape across the seat to indicate they should not be used to allow for some social distancing. However, some of the tape and the signs were missing, and one person in the waiting area was sitting on a chair which had been taped. We asked if they had been asked to avoid these chairs when they booked in, but they said they had not been told. Otherwise, there were no specific visible changes made to help prevent the spread of infection.

We saw several of the chairs in the waiting area were damaged, particularly three of those which were pink in colour. They were torn badly on both the seat and the back rest, which were otherwise made of a wipeable fabric. This damage gave rise to a risk of them being unable to be cleaned effectively and prevent the spread of infection. The inner fabric which was exposed would be an area which would possibly harbour infection.

The department had recognised the lack of safety of patients in the waiting room from overcrowding and inability to socially distance was a risk. This was raised on the risk register in July 2020 and graded at a very high-risk classification. However, there were no mitigating actions or updates that suggested this had been further addressed and none of the issues we found on our visit had been recognised. We asked for a risk assessment of the waiting room for COVID-19 safety, but this was not provided.

We were concerned about the safety of the air quality in the confined area outside of the main entrance to the department. Due to the need for ventilation and warmth for patients and staff who were held on ambulances in the bays outside the department, the crews were required to keep the engine of the ambulances running. However, the doors and windows of the ambulances were closed for safety. We visited the outside area, which was surrounded on three sides by high buildings and partially obscured on the fourth side. There was a small road leading to the ambulance bay from the main street outside the hospital. There were six ambulances in the bay with two moving out and another two waiting to park. The air was clearly heavy with fumes from the ambulances and smelled and tasted strongly of petrol or diesel fumes. We asked a member of the ambulance crew and one of the trust staff if they were aware of the quality of the air being tested and one comment made to us was “it’s always like this.” This was directly outside of the main entrance and close to a volunteer member of the ambulance service who was stationed outside and supporting crews.

**Assessing and responding to patient risk**

**Patients had an assessment of their infection risk and other clinical risks on arrival at the department. The department had a system for monitoring patients who were either at risk or found to be deteriorating. This included patients who were waiting on ambulances to be admitted to the department when demand was high or patient flow out of the department was blocked or slow.**

All patients were assessed for their risk of COVID-19 when they entered the emergency department. However, this was delayed by the lack of near-patient-testing facilities for COVID-19 in the department. All tests needed to be sent to the in-house laboratory for processing. The positive side of this delay to the patient admission was the laboratory result being more reliable than some of the quicker test methods.

Patients arriving in the minors’ area independently from the ambulance service were triaged by the nursing team and any risks which required them to be seen more quickly were recognised through that process. In order to safeguard patients in the waiting area, of whom the majority were required to be unaccompanied, the department had trained reception staff to recognise mental or physical deterioration. This was an action from our previous inspection which had

been addressed. To provide further effective safeguards for patients, the trust had placed an emergency nurse practitioner within the reception team to oversee the patient booking in. They also took time to walk through the waiting area at regular intervals to check on the welfare of patients. This was arranged 24 hours a day, seven days a week.

Staff used a national early warning score (NEWS) which recorded some patient clinical indicators and required staff to respond when the score reached or passed certain limits. This nationally recognised tool was well-embedded with clinical staff. Those we talked with about it said it was used well and part of the toolkit for responding to risk of patients deteriorating. The latest audit measures on the use of NEWS (December 2020 results) showed 90% or above of all patients in the emergency department had NEWS and vital signs measured when required. The assessments for October and November were also well completed. However, some areas needed attention, which included the need for pain management and electrocardiograms to be undertaken more promptly.

The department had introduced a fairly recent triage process to limit the risks to patients being held on ambulances when they were waiting for a space to be admitted to the majors' area. This system came into effect when there was what was referred to as being "no exit flow in the adult ED". In other words, patients could not be transferred to wards for admission as they were full. An area within the corridor between the minors' and majors' areas with access out to the ambulance bay had been converted to become the incident triage area or ITA. The ITA was a system staffed by the department and the ambulance service to provide a booking area and support to patients and staff waiting to be brought into the department. It came into operation when the department reached the place in the escalation protocol when six ambulances were in the bay outside and the delay in patient transfer had exceeded an hour. The escalation protocol was triggered when certain performance measures fell short of the required standard. This included long waits on ambulances and overcrowding elsewhere in the department.

To address the possibility of patients' deteriorating in the ambulance while waiting, the department relied on the crew to keep the ITA staff or hospital team informed, but equally on its own staff to assess and always monitor the patient. There was a clear and effective standard operating procedure, risk assessment, and ambulance safety checklist in use. From this, the ITA's nurse and doctor would be able to determine if some patients were needing admission more urgently than others or take immediate action if the patient became unstable or critically unwell. The staff we spoke with were clear that patients on the ambulance were immediately entered into the hospital system and deemed the responsibility of the hospital staff. They fell under the safety and governance arrangements of the emergency department.

We were concerned that some patient handovers to ward staff were given over the telephone and without any paper record. The nurses told us this was perhaps not the best approach as there were times when the patient was then taken to the ward by another member of the team who had not completed the telephone handover. The patient could then be handed over to a member of staff who also did not have the information and a handover needed to be repeated. We recognise there was a need to reduce the use of paper for reasons not least of infection prevention and control. However, this was not the reason for this system and there was no form in use or electronic alternative to make this function more efficient and less repetitive at times for staff.

**Nurse staffing**

**The pressures of COVID-19 meant the service struggled at times to have enough nursing staff, but measures were taken to ensure staff were brought in where possible to reach safe numbers. The trust and the nursing leadership were aware of the critical position for nursing staff and it was under constant review.**

# Urgent and emergency services

The COVID-19 pandemic has brought pressure to all hospitals in the country due to staff either becoming infected, being required to self-isolate after contact with a positive person, or from the usual sickness which afflicts staff at times. There was also pressure from patients needing more care, PPE taking time to apply and remove, and a reduction in the availability of temporary staff. This was coupled with a national shortage of nursing staff before the pandemic.

The trust was under pressure in other departments and wards and struggled to redeploy nursing staff to the emergency department. There were also requests at times for the emergency department to redeploy staff to other parts of the organisation when wards became unsafe in terms of numbers of nurses or the skill mix. However, in the emergency department, staff sickness among the nursing team had been low and nurses we met said their wellbeing and safety was highly regarded and protected as much as possible by the leadership team.

Staff told us there were times when the nursing staffing was “not great” or “really grim”. However, they said the senior team focused on this as soon as it became apparent and did everything possible to bring in additional staff. Senior staff returned to frontline duties at any time it was needed. The number of nursing assistants was increased to support nurses in some of the general tasks and with additional patient care. A nurse told us how support from other specialists within the hospital, such as the tissue viability nurse, helped reduce the demands of patient care and could save valuable time. However, staff said it was hard for them when they were asked to be moved to help support a struggling ward, and they missed the continuity of patient care. Nevertheless, they said they entirely understood why this was needed in the COVID-19 crisis.

Across the wider organisation, the heads of nursing had reviewed all clinical areas and established a revised nurse to patient ratio (increasing the number of patients for each nurse) in order to redeploy nursing staff to support other teams. Recruitment had been stepped up and there was a fast-track system to allow staff who had retired to return if they wished. All non-essential training was cancelled as was non-essential clinical activity, including some non-emergency surgery.

**Medical staffing**

**The service did not have enough medical staff to meet the recommended guidance for the department or be able to expand the service. There were insufficient numbers of consultants employed and some middle grade rotas were not always filled overnight.**

The Royal College of Emergency Medicine (RCEM) recommends (RCEM Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK, February 2019) consultants are on duty in the department from 8am to midnight in all medium and large systems. With usually more than 60,000 but fewer than 100,000 patient attendances each year, the adult emergency department at the Bristol Royal Infirmary would be classed as medium sized. This would require 18-25 whole-time equivalent consultants specialising in emergency medicine to be employed to cover the rota. The department had 14 at the time of our inspection and two starting shortly, but the numbers would still remain short of the recommended safe level. A business case to expand the service in the department to include a same-day emergency care service, if accepted, would increase the required consultant base to 20.

The consultant clinical lead for the emergency department described how the cover had been difficult for them with a consultant on secondment and another on maternity leave. Cover was provided in the week from a roster of 8am to 10.30pm and 8am to midnight over the weekends. The overnight hours were covered by the junior doctors. Although the

roster was until 10.30pm, we recognised consultants were often in the department later than 10.30pm and staff said they would not leave if there were issues to be addressed. There was a consultant on call for the hours where they were not physically present within the department. With the new staff joining the team, the expectation was to be able to provide the 16 hours of cover recommended by April 2021.

There was a range of differently skilled and experienced junior doctors and trainees. To increase the numbers, there were two advanced clinical practitioners (ACP), who were at the level of a middle grade doctor, and five more in training. The junior doctors covered the overnight shift on a rotation although an ACP was never left on duty on their own. However, evidence we requested showed there was a recognised risk of middle grade doctors being at times alone in the department at night. The size and coverage of the new department required two doctors of this grade to be on duty at night (10pm to 8.30am). However, this was not always achieved and mitigating actions such as the use of locum doctors and consultants staying later were required. This was on the departmental risk register and rated as high risk.

ACPs and speciality doctors had at least 20% of non-patient facing time in their job plans for quality improvement and project work. There was a strong focus on continuous teaching and development with time set aside for education and training at all grades using several forums and opportunities. There were conference facilities in a good-sized seminar room which had enabled additional remote participants to join sessions and increase the multidisciplinary attendance at governance and the reviews of patient mortality and morbidity.

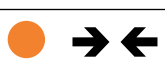
We observed a safe, effective and thorough medical handover. This took place each day at 8am, 4pm and 10pm. Teaching opportunities were used during the handover and staff welfare considered in addition to the safe and timely care of patients. Issues relating to patient management were covered fully and senior staff reviewed patients after the handover as required. The emergency physician in charge (known as EPiC) role was clearly demonstrated in the running of the department and supporting the team of junior staff. They took on the role of coordinating care plans and running the patient review (board round). This supported the department having a strong performance in taking decisions to admit patients in contrast to the four-hour target performance (see below).

**Records**

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and easily available to all staff providing care.**

We reviewed six sets of patient notes. All were of good quality from both the nursing and medical team input. They were clearly written and had timely reviews of patients. The safety checklist was completed each hour for all those patients we reviewed. Medication records we saw showed these were given in a timely manner and charts properly completed.

## Is the service responsive?

**Requires Improvement** 

**Access and flow**

**Patients did not always receive care and treatment promptly. Staff addressed this as much as possible for individual patients, but system factors meant this was a significant risk overall. This was a risk accepted as a trust-wide problem.**

# Urgent and emergency services

Pressure from high demand, COVID-19 restrictions, lacking beds available for transfer, and patients being more unwell meant patients did not always receive care and treatment promptly. Patient handover from ambulance crews and the four-hour performance around patient flow was worse than NHS national standards. It is well understood how these delays can cause harm to patients and lengthen response times and delay ambulances needed in the community. However, staff were actively looking for improvements and short- and long-term solutions, both internally and externally with system partners. Also, there were infrequent delays in the decisions taken around onward patient care. The department had resolved several flow problems which were in its own control but was limited by external factors.

We were not assured as to how the escalation plan for the department (when it was experiencing high demand and pressure) was always effective and had support throughout the trust. There was a clinical standard operating procedure for use when the department was under pressure, but evidence to show it was effective and gave the right results was not apparent. We were concerned as to how it demonstrated to staff it was working as expected and whether the actions were being taken as needed and making a positive difference. For example, it was unclear as to how many escalation beds were available in the whole trust or hospital although there were clear criteria as to which patients were eligible to move to these beds and when. We recognised alongside this there were pressures on other parts of the hospital, particularly in the wards, where there were staff shortages to manage as well as complex patient care to provide.

National performance data showed the trust had struggled to achieve the NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours since at least April 2018. In the first three months of 2020, prior to the first COVID-19 lockdown at the end of March, the department only achieved the four-hour standard for between 66-70% of patients. The national average was around 74%. However, with a significant drop in patient numbers of around 50%, this improved in April 2020 to 91% (better than the 87% national average). This improving picture continued among lower patient numbers in May and June before starting to drop again. However, it was only the month of April 2020 which saw the trust outperform the England average.

The four-hour performance throughout the summer months achieved around 70% of patients on average seen, treated admitted or discharged against an England average of around 85%. The winter months brought a deterioration in performance ending the year at 61.8% against a national average of 72.1%.

In other performance measures, patients in the department had experienced very few delays of more than 12 hours in the year 2019/20, but the winter months of 2020/21 showed a different picture. In November 2020, 66 patients waited more than 12 hours from a decision to admit them to a hospital ward until that happened. In December this rose to 79 patients. The delays were from the lack of available beds in the rest of the hospital in the right or best place.

The number of patients waiting in ambulances had increased as had long delays in patient handovers. This was despite a fall in the number of ambulances arriving due to the pandemic. In 2020/21, our data showed the Bristol Royal Infirmary had around 20 fewer ambulances each day on average that in 2019/20. Due to restrictions on movement and rules around prevention of the spread of infection, coupled with poor capacity in the rest of the hospital to admit patients, ambulances were facing long delays at busy times.

Data from early October 2020 until late January 2021 showed there had been incidences at times of high numbers of ambulances waiting over 60 minutes in any given day. The department was experiencing delays reported as worse than both the South West average and the England average. However, to balance this with days when the department was working well, there were many more of these in the period where there were no delays for ambulances of over 60 minutes.

# Urgent and emergency services

One of several problems with long delays for ambulances (which the trust reported in its document 'adult ambulance bay pre-alert measures') was the risk to patients held in ambulances on the route into the department. If a patient on one of these ambulances required resuscitation and the entry ramp was blocked, the patient would be unable to be brought quickly to the department.

As some mitigation, the department and ambulance team had reconfigured the way ambulances were stationed to support their 'complete and finish' tasks (such as infection prevention and control cleaning protocols). This enabled crews to complete these tasks away from the main parking bay and not take up valuable space for other ambulances arriving or queueing. The reconfiguration also meant a further two ambulances (now seven) could park safely.

Furthermore, the traffic marshal used in the ambulance bay would direct any ambulance on route with a high-risk emergency patient on board to use the exit lane if the entry lane was blocked. All other ambulances would be held from leaving until the exit was cleared as safe. There was also an emergency option available if needed to divert pre-alert ambulances (those who had called ahead to alert the department of a critically ill patient). This was to use access at another part of the site – although this was recognised as not ideal due to it being complex to then access the emergency department.

Several other initiatives had been set up to help support the department in times of pressure or when recognising the overall deterioration in performance. These included:

- The establishment of the incident triage area as described above.
- The former observation area in the department was established as an overflow area for specific patients meeting certain criteria (principally COVID-19 negative). This was always staffed for use and had capacity for up to eight patients who had a decision to admit to a specialist inpatient wards.
- A facility for primary care clinicians to provide direct access to senior clinical staff in speciality teams to give guidance and advice and potentially avoid an admission for patients. This was established with five speciality teams and available 9am to 4pm in weekdays. The calls were routed through the 111 service and direct contact would be arranged between clinicians.
- Due to COVID-19 pressures, from 8 January 2021, patients aged 16-18 years were diverted to the children's emergency department to alleviate pressure on demand for the adult service. There was a standard operating procedure (SOP) to outline how this should happen in practice.

Staff told us the adult mental health liaison team were responsive to requests for support, although the number of patients with mental health problems and being more unwell was growing. We met one of the mental health team who said cover during the day was good and they had effective engagement with the emergency department team. However, those patients requiring a mental health bed often had long delays and there was increasing pressure on community services. As a result, more patients with mental health problems were coming to the emergency department for support and there was difficultly in arranging follow-up at times due to the pressures on external services. This was on the departmental risk register rated as a high risk.

There were regular huddles where senior staff including the emergency physician in charge, senior nurses, and clinical site managers discussed and proactively planned patients moves and discharges. The department had established a new flexible overflow patient holding area which was used according to the need at the time. At the time of our visit it had adequate oversight and support from the team.

However, the trust was yet to introduce the 'same day emergency care' service (known as SDEC) which had been a national directive from the Royal College of Emergency Medicine and NHS England and NHS Improvement for establishment by April 2020. This care model was designed to minimise and remove delays for patients allowing them to receive care and treatment in the same day and avoid hospital admission. The NHS had recognised how most growth in unplanned admission to hospital was for patients who spent one or two days in hospital. It had been recognised how many of these patients could be safely and effectively assessed, diagnosed and treated in the same day. It was recognised by the clinical team as a significant opportunity for the trust and the department. The main restriction for the department was the shortfall in consultants to support the service. A business case had been submitted to the division to establish an SDEC and an area of the majors' department set aside for the service. The department was planned to be run with joint working with medical colleagues and operate as a seven-day advanced care practitioner and emergency nurse practitioner-led service with full support from consultants.

External support to the department came from other specialities in the trust to whom patients would be referred for further clinical opinion or admission to their care. There was an effective process with the medical division, with nurse-to-nurse referrals entirely accepted, but this was not considered as effective or responsive with other specialties. We found frustration among the senior team and the clinical site team that the ease of referral in the medical directorate was not replicated with the surgical directorate and other specialities. They felt this process did not have executive or non-executive director sponsorship to support the recovery and the future for the emergency team.

Other areas of concern which added to patient delays at times included:

- The lack of COVID-19 testing with a fast turnaround from a rapid antigen test. The department had not been able to use its rapid analyser system due to technical difficulties in the early days of the pandemic which had not been resolved. This was insufficient for a busy emergency department and impacted on patient delays at the start of the episode of care.
- Some delays were caused by capacity to perform diagnostic tests on some patients, such as computerised tomography (CT) scans. These were particularly reduced in capacity at night when one scanner was in operation for the whole hospital. Furthermore, the department was required to arrange for some patients to have diagnostic tests and scans before they were able to be admitted to specialty teams, when the result of the scan was unlikely to change the decision to admit the patient. This caused further delays. We asked about the range of timings of results from diagnostics and staff said a good day would have fast results of around 20 minutes. A bad day would see results in up to four to six hours.

The reception team and triage nurses were committed to, and effective in safely diverting patients to other services if they did not require emergency care.

We met with several of the ambulance personnel who were on site waiting to handover their patient. They told us if they were concerned about a patient, they would either alert the clinical team on site or a senior member of their own staff who was on site at busy times to monitor the situation. These were hospital ambulance liaison officers or HALOs. We met with the HALO when the incident triage area was opened in the afternoon to manage ambulances who were queuing in the holding bay outside. They felt their role was of benefit to the crews, the patient, and the rest of the department in their liaison work. They also felt it gave them a better understanding of the pressures the department was under to be able to bring some balance to the concerns of delayed crews. They also supported the crew with getting breaks and being able to end their shift on time as much as possible.

# Urgent and emergency services

Within the delays in ambulance handovers in the department, was the consequent delay in releasing that crew to help other patients who were waiting for an ambulance in the community. The staff we met said they were very aware of the risks and it did heighten the anxiety they felt at times.

## Is the service well-led?

**Good** 

**Leadership**

**Leaders in the emergency department demonstrated the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible, supportive and approachable in the service for patients and staff. However, the trust senior leadership were perceived as not present enough in the department to provide assurance, demonstrate awareness of the risks and struggles with performance, and be visible and approachable.**

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. They were innovative and looking to find solutions to problems directly. They prioritised staff education and wellbeing. We found a team who had a clear view of the departmental approach and their own role, as well as the key issues both currently and longer term. This was consistent among the people we spoke with. The teams met each week, and this had become better attended since options to call in virtually were arranged. We were told the meetings had good challenge and discussion and concluded with defined outcomes.

There was effective and supportive management of the department by the emergency physician in charge and the nurse in charge. This was undertaken well and with regular reviews of each patient in their charge to check on safety and progress.

There were numerous routes for communication within the department. This included emails, alert posters from the Royal College of Emergency Medicine, and the use of intranet workspaces with all guidelines visible and updated. The emergency department leadership team also ran a regular question and answer group on a multimedia platform for the whole department. The ‘Happy App’ was also made available to all staff for anonymous feedback to the leadership team, but this was underutilised with just two entries per week on average and at times a slow response.

We were concerned that many staff we met could not recall seeing trust executives or non-executive directors in the department or at team meetings to support better care for patients. The trust provided us with a list of executive visits to the department and the medical director did visit when on call. The chief operating officer visited each week and when on call. The chief executive had been in the department before Christmas and met with the senior team. The non-executive directors had not been on site in accordance with recent national guidance in relation to COVID-19 but had not set up any virtual calls with staff to seek a focus on performance and departmental pressures. There were no visits recorded for the previous chief nurse, although a new chief nurse recently joined the trust.

# Urgent and emergency services

Urgent and emergency care is the only service in the trust which is rated below good. This is down to long-standing concerns around safety, some of which have been resolved, but long-term problems remain with patient access and flow. Although some visits had been undertaken, as reported to us by the executive team, it was the case that staff perceived a lack of executive visibility in the department and support, recognition and understanding with them of pressures and demands on the service.

**Culture**

**Staff in the department felt respected, supported and valued. They were focused on the needs of patients receiving care. There were strong examples of staff feeling able to speak up and raise concerns without fear. However, there were serious concerns about the growth in violence and aggression to staff from patients and staff felt they were not adequately trained and protected.**

There were strong examples of a resilient and committed culture in the team. Those staff we talked with said they felt valued by the leadership in the department and the directorate. They felt there was effective team working and support. There was a strong wellness culture and the department had its own website around wellness for staff. There were 12 staff trained as TriM practitioners. TriM is a trauma-focused peer support system to help staff who have experienced a traumatic or potentially traumatic event. A psychologist was available to emergency department staff and was in regular contact.

We heard numerous examples of strong cultural behaviours and values, including:

- All patient interactions we observed were seen to be caring, kind and empathetic.
- We witnessed a junior-grade member of the nursing team being firm with colleagues where they felt a process about to be undertaken was not safe.
- Despite growing activity during the day, the department remained calm and professional throughout.
- We were told the team had thrived despite the pressures of the job. The majors' department was moved in just one day to the new location despite A&E being fully open throughout. We were told the staff were willing and supportive to help.
- Nursing staff telling us about how rotas were organised by one of the senior nurses to take account of their personal lives and circumstances as much as possible. One nurse said how it was ensured, when possible, they had a break between shifts so they could take time out to "recover my mental strength."
- Staff said they were 'swapped out' from high risk areas to give them a break from the pressure they can exert.
- Staff said department managers and leaders were happy to listen to any suggestions and acted on those which would make a difference and in their gift.
- One of the newer members of the nursing assistant team told us staff were "really friendly and supportive" and "there are lots of 'thank yous' at the end of a shift".
- Staff endeavoured to ensure rough sleepers were given a hot meal before they left the department.

As a somewhat unintended consequence of patients needing to be held on the ambulance for safety in the pandemic, staff said the absence of patients queuing in the corridor had reduced their anxiety over growing demand and delays. Staff were open and honest with patients and told us they were quick to apologise when a patient was unintentionally delayed or perhaps relocated.

# Urgent and emergency services

The Happy App (see above) had limited use in the department. However, some of the comments we picked at random included:

- "[two named staff on reception] are absolutely fabulous. Always have a good shift with them…"
- "I've been working at ED as an agency nurse for the last [two months]. Great team, made to feel welcome. No complaints. Everyone supports and helps each other."
- "I'm new to the team here in ED and I would just like to thank everyone for being so welcoming and supportive! Everyone works together as a team no matter how busy the department is. So nice to be part of a lovely team so thank you."
- "New to the trust and department, everyone in department has been very welcoming and supportive. I am also very excited about the training opportunities that are available here and the ease to book myself onto the study days."

One area of serious concern was with the growth in violence and aggression to staff by patients, and the response to this from the trust. We contacted the trust shortly after the inspection and asked for urgent action to be taken in this matter. Although we recognised several actions had been taken already, and this was on the trust risk register, several staff we met said they were anxious about their ability to respond effectively to an assault by a patient. One said they were "scared at times and felt vulnerable". They said they had been given limited training on protecting themselves from assault.

A member of staff had sustained an injury just prior to our visit and others had bandages from patient attacks. We were told staff were worried how the incidents of violence and aggression on staff were impacting on staff recruitment and retention.

There were concerns around the quality and experience of the security staff, who were mostly agency staff used for security work in, for example, nightclubs and large venues. They were also not always available as they were covering the whole site at times. Staff were concerned about their skills in preventing violence from escalating or defusing tension. We were told very few emergency department staff had face-to-face de-escalation training.

Although this was listed on the departmental risk register at a very high-risk classification, the adequacy of controls was recorded as 'inadequate'. There was also no reference to how this might be a risk factor not just for staff but also for patients.

We were also concerned that staff members were wearing identity lanyards around their necks which only had one break point in the strap. This was at the back of the neck. If a patient or member of the public was to grab the strap of a lanyard at the back of the neck, and hold the break point, the lanyard would not break as intended and could be a possible ligature risk for staff.

We asked for further information on how this had been recognised and reported on by the department leadership team. A report had recently been produced which recorded how "organisational actions previously agreed to help mitigate the risk this poses to staff have yet to be fully implemented, with unclear timescales for implementation." The areas which remained outstanding included de-escalation and control and restraint training for staff. It was recognised by us, the senior leadership in the department, and in a following conversation with the trust executive team how the current pandemic had added complexity to the delivery of the actions. There was a significant rise in violence and aggression from patients attending with mental health, drug and alcohol issues and with the closure or limitation of community services, these had significantly increased. However, the response to dealing with that increasing risk and its effect on staff safety and wellbeing had not been adequately addressed.

# Urgent and emergency services

**Managing risks, issues and performance**

**Although leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, these were not always revisited in times of crisis. However, there were many good systems to recognise, report and understand performance.**

There was a departmental risk register and risks were reviewed and reported on through an assurance report to the division. Although the risk of delayed care and treatment was recognised on the departmental and the trust risk registers, it was rated as 15 out of a possible score maximum of 25 when this was among the highest known performance issues for the department and the trust. This entry had been made to the risk register in July 2015. The way the risk register was used did not show how this risk had changed over time, but we recognise it had become significantly worse of late with the emergence of long waits for patients in ambulances and trolleys while awaiting transfer within the hospital. Following our inspection, the trust was updating the performance dashboard in the emergency department to show the number of patients waiting for more than 12 hours on a trolley.

The use of paper records for patients created a reduced opportunity to automate processes, audit records, systems and processes quickly, and be more responsive to safety and flow issues.

The emergency department leadership team had developed a comprehensive analysis of the CQC and ED consultant-designed Patient First conversation document. This was a document produced by CQC in late autumn 2020 and designed to be used by clinicians and departmental leads to support practical solutions to support good, efficient and safe patient care. It was almost ready to present to the trust board. The department had also been assessed through an NHS England and NHS Improvement 'getting it right first time' (GIRFT) report. However, the action plan had not been prioritised alongside the findings in this study. It had not been updated since September 2019. Early actions may have otherwise led to reductions in the trust reporting such high 12-hour waits and ambulance queues.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**The urgent and emergency care service must:**

- Have safe and sufficient numbers of all grades of medical staff to meet the recommendations of the Royal College of Emergency Medicine. The department did not have enough consultants to meet the recommendations for caring for the number of patients it saw and the expanded size and footprint of the environment. There were insufficient numbers to be able to expand into a fully operational same-day emergency care pathway to reduce demand for overnight beds. There were some night shifts where the junior doctors' rotas (primarily middle grade) were not fully covered and this required the use of locum doctors if available and consultants to remain past their shift or start earlier than planned. Regulation 18 (1)
- Provide care and treatment in a safe way for patients by ensuring there is flow through the emergency department. In growing and unprecedented numbers in this organisation, patients were waiting on ambulances in queuing systems which had the potential to be unsafe. Some patients were waiting on trolleys for more than 12 hours after a decision had been made to admit them to a hospital bed. Regulation 9 (1) (a) (b)

# Urgent and emergency services

- Take action to protect staff and other patients as much as possible from incidences of violence and aggression. Ensure staff feel fully trained and have the tools, experience and support to be able to feel safe and protected. Staff said they felt scared and anxious about their safety at times and the experience and skills of those around them to deescalate or prevent violence and aggression. Regulation 17 (2) (b)
- Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding. Regulation 15 (1) (a) (c) (d) (e) (2)

**The urgent and emergency care service should:**

- Consider how to address the perception in the staff team in the emergency department that there was limited executive visibility, recognition, understanding and support. Look at options for more virtual contact with staff teams if executive or director visits are on hold during the pandemic.
- Address with staff the failures and lapses in practice around infection prevention and control we identified. This included the failure to wear or have masks covering the face at all times, a lack of good hand cleansing at all times, and the safe disposal of clinical waste in staff areas.
- Revisit the handover process for nurses when patients are transferred from the emergency department to a ward. These was no paper record of a patient handover which sometimes meant it would need to be repeated or recreated if different staff were involved in the final move of the patient.
- Check and risk assess the quality of air and vehicle emissions in the area where ambulances are required to wait. As ambulances are required to leave their engines running for their crews and patient safety and comfort, this causes emissions into a very built-up small area with little opportunity for the polluted air to dissipate. Act if possible, should the air quality be considered as a risk to people.
- Undertake a review of the safety of identity lanyards worn by staff to determine if these meet health and safety requirements or pose a ligature risk.
- Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.

# Our inspection team

The team that inspected the service comprised a CQC inspection manager and two specialist advisors. The inspection team was overseen by Amanda Williams – Head of Hospital Inspection.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Diagnostic and screening procedures | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |