North Bristol NHS Trust

Southmead Hospital

Quality Report

Southmead Hospital Bristol
Southmead Road
Westbury-on-Trym
Bristol
BS10 5NB
Tel: 01179505050
Website: www.nbt.nhs.uk/our-hospitals/southmead-hospital

Date of inspection visit: 7, 8 and 18 May 2015
Date of publication: 17/07/2015

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.

Ratings

Urgent and emergency services	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this focused inspection to follow up on the concerns identified in a Warning Notice served in December 2014, following our comprehensive inspection of the trust in November 2014. The warning notice related to a failure to comply with Regulation 9 (1) (a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Care and welfare of service users (now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 : Safe Care and Treatment).

Compliance with the Warning Notice was required by 26 January 2015. The action plan supplied by the trust, detailing how compliance would be achieved, indicated full compliance would not occur until 1 April 2015.

The inspection was conducted on 7, 8 and 18 May 2015 and was unannounced.

Our inspection focused on the issues identified which occurred in the following areas:

- Emergency Department (ED) which provides emergency care and treatment to adults with serious or life threatening emergencies. The department has facilities to treat children, although most paediatric care is provided at Bristol Children's Hospital and this is where ambulance borne patients would attend.
- The Minor Injuries Unit (MIU) which provides care and treatment for adults and children with illnesses or injuries that are not life threatening but still need prompt attention.
- The Ambulatory Emergency Unit (AEU) which provides urgent assessment, diagnostic investigations, observation or treatment for adults who do not require a bed for assessment/treatment and who are not expected to require an overnight stay.

Our key findings of the inspection on 7, 8 and 18 May 2015 were as follows:

- Patients arriving by ambulance requiring care and treatment in the corridor area known as 'crossroads' which led into the majors area did not always receive a timely assessment of needs in line with College of Emergency Medicine guidelines and trust policy.
- Patients presenting at the emergency department with serious and potentially life threatening conditions did not always receive rapid assessment and treatment in line with College of Emergency Medicine guidelines and trust policy.
- Shift coordinators of the emergency department did not have full oversight of the activity within the department. Patients were not being proactively managed by the shift coordinators. Consequently, patients were not receiving appropriate care and treatment in a timely manner.
- The number and skills of staff on duty were not flexed in relation to known fluctuations in numbers of patients expected in the emergency department at different times and on different days.
- The release of beds to the emergency department did not appear to take account of known or expected fluctuations in the numbers of patients being admitted to the emergency department and Ambulatory Emergency Unit.
- Patients admitted to the emergency department and the Ambulatory Emergency Unit were not admitted to wards in the hospital in a timely manner.
- Patients were not protected from the risk of harm caused by pressure damage within the Ambulatory Emergency Unit. Whilst risk assessments were available to staff within the hospital, risk assessments were not carried out in line with trust policy.
- Patients waiting in the corridor (crossroads) area of the emergency department did not always receive timely or effective pain relief from emergency department staff.
- Patients were not always afforded privacy and dignity whilst waiting in the corridor (crossroads) area of the emergency department.
- The corridor (crossroads) area of the emergency department remained cold whilst patients were waiting to receive assessment, care and treatment.

Summary of findings

- Improvements had been seen in the management of patients within the reception area and minors' area of the emergency department.

The Warning Notice dated 17 December 2014 has not been fully met. We are working with the Trust Development Authority, NHS England and Commissioners to improve services within the trust and are considering our regulatory response. A Risk Summit was held in June 2015

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	Inadequate 	The areas within the warning notice had not been fully met. At times, services were found to be unsafe. Patients did not always receive an assessment and response to risks identified. Staffing levels were not increased to reflect predictable activity surges. Patients did not always receive timely analgesia. Staff deployed to the emergency department to support in times of overcrowding in the crossroads area did not always have the skills or experience required. Access and flow was poor. Performance against the four hour target remained consistently below the 95% standard. Patients did not have their individual needs met. Governance was not effective. Whilst processes existed, concerns raised in the Warning Notice issued as a result of the inspection in November 2014 continued to occur. Whilst the executive team were seen as being supportive, there was little support from the wider division management team. Some improvements were seen. Environmental changes had improved the visibility of patients in the reception area and additional staff to triage minors patients had improved the time to triage.

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 the Frenchay hospital site into this new building.

Our inspection team

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

The inspection team comprised of two CQC inspection managers, one CQC inspector and three specialist advisors including: Two senior emergency department nurses and a consultant in emergency medicine.

How we carried out this inspection

The inspection was conducted unannounced. We visited on 7, 8 and 18 May 2015. We spoke with nursing and medical staff, ambulance personnel, support staff, patients and relatives, the divisional management team and the executive team. We reviewed information provided by the trust requested during the inspection. We also spoke with the Trust Development Authority and South Gloucestershire Clinical Commissioning Group prior to the inspection and reviewed the information we hold about the trust.

Facts and data about Southmead Hospital

Southmead Hospital has 1024 beds, approximately 7,600 staff who provide healthcare services to the residents of Bristol, South Gloucestershire and North Somerset which

Detailed findings

has a combined population of around 900,000 people. Specialist services are also provided 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 2013/2014 the trust had over 97,600 inpatient admissions, including day cases, 360,000 outpatients attendances (both new and follow up) and 103,202 attendances at emergency and urgent care.

Bed occupancy for the trust ranged from 91.1% in the third quarter of 2013/2014 to 84.8% in the first quarter of 2014/15. This reduction was due to the move from the previous two hospitals to the new Brunel building on the Southmead site in May 2014 when the amount of elective procedure work was reduced in order to manage the move. The overall occupancy rate is above the England average (85.9%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

CQC inspection history

North Bristol NHS Trust has had a total of 12 inspections since registration. Five of these have been at the old Southmead Hospital site. In May 2011 a themed inspection was undertaken specifically looking dignity and nutrition the outcomes inspected were met although there were some areas for improvement identified. In September 2011 a routine inspection minor concerns were found relating to safeguarding people who use services from abuse, staffing minor concerns and in 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 related to the management of medical records, this was followed up in July 2013 and was found to be meeting the standards required.

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 patients within the Emergency Department and Ambulatory Emergency Unit. We served a Warning Notice in December 2014 regarding this.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	N/A	Inadequate	Requires improvement	Inadequate
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

Safe	Inadequate
Effective	Requires improvement
Responsive	Inadequate
Well-led	Requires improvement
Overall	Inadequate

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 consisted of a number of areas, co-located in the purpose-built Brunel building. These were the Emergency Department (ED), the Acute Assessment Unit (AAU), the Minor Injuries Unit (MIU) and the Ambulatory Emergency Unit (AEU) also known as the Seated Assessment Area. As a major trauma centre and regional specialist centre for burns and plastic surgery, the hospital was served by a helipad. An operations centre provided a central point of access for telephone referrals and all admissions. The ED 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 MIU provided

treatment for illnesses or 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 ED 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 Ambulatory Emergency Unit (AEU), had 16 reclining chairs to accommodate patients who required an urgent specialist opinion, rapid assessment, diagnostic investigations, observation or treatment, but were not expected to require an overnight stay. Patients were referred to this unit by GPs or other community providers through the operations centre. There was space for patients to queue in the 'crossroads' area of the ED. This space was effectively a corridor, entering the major area, designed as a signposting area where patients would be directed to a ward or the appropriate part of the Emergency Zone. It was not designed as a clinical area for patient care. Adjacent to the ED 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 CT, plain x-ray and ultrasound.

Urgent and emergency services

Summary of findings

The warning notice had not been met in full. At times, services were found to be unsafe. Patients did not always receive an assessment and response to risks identified. Staffing levels were not increased to reflect predictable activity surges. Patients did not always receive timely analgesia. Staff brought in to the department to support in times of overcrowding in the crossroads did not always have the skills or experience required. Access and flow was poor. Performance against the four hour target remained consistently below the 95% standard. Patients did not always have their individual needs met. Governance was not effective. Whilst processes existed, concerns identified in the warning notice issued as a result of the inspection in November 2014 continued to occur. Whilst the executive team were seen as being supportive, there was little support from the wider division management team.

Some improvements were seen. Environmental changes had improved the visibility of patients in the reception area and additional staff to triage minors' patients had improved safety of patients within that area.

Are urgent and emergency services safe?

Inadequate

Incident reports demonstrated an ongoing occurrence of overcrowding and high levels of patient activity in the crossroads area, with incidents occurring as a result. Opportunity to safeguard vulnerable adults was missed. Patients were not promptly assessed and risk assessments were not conducted. Nurse staffing levels were not increased to reflect predictable activity increases. Patients often experienced delays in receiving specialty review.

Triage within the minors' area had been improved and environmental and staff changes within the reception area meant staff had a better visibility of patients who were at risk of deteriorating in that area.

Incidents

- Staff reported incidents via an electronic incident reporting system and incident reporting was encouraged. We reviewed incidents reported from 1 February 2015 to 20 May 2015 from the ED and AEU and noted a total of 418 incidents reported of which 115 were reported as being of moderate impact and 23 major/catastrophic. We reviewed the content of both the moderate and major/catastrophic incidents and noted 15 out of 23 major/catastrophic incidents described excessive patient numbers or concerns regarding care delivered to patients in the crossroads area. Of the 115 moderate incidents 61 described excessive patient numbers or concerns regarding care delivered to patients in the crossroads area and the AEU.
- Examples of incidents reported identified the capacity issues within the department, identified risks to patients and also identified that patients' privacy and dignity was not always maintained as a result of the capacity issues. These included one on 15 February 2015 which stated: "75 patients in the department at 12:00. This includes a number of patients queuing in crossroads. No capacity within the department and clinically unsafe for the patients." Another on 3 March 2015 stated: "unsafe shift at crossroads due to high number of patients and lack of patient flow through the department…privacy and dignity compromised by lack of space and high numbers of patients and ambulance crews in the area…one neuro patient seen and assessed in corridor

despite protests from emergency department staff, medical doctors expecting clinical procedures to be carried out in crossroads…over 50 patients seen in crossroads today." A third on 7 March 2015 stated: "staffing levels normal but no extra nurses, patients in crossroads reaching 15. SOP nurses called for but unable to bleed/ triage patients…poor communication between majors and crossroads leaving patients in the corridor and not in cubicles that were empty." A fourth on 9 March 2015 described nurses not being able to provide basic care to a patient with Alzheimer's who was waiting in the crossroads area. The patient had soiled themselves whilst waiting and there was no private cubicle available to enable privacy and dignity whilst cleaning them. A fifth incident report on 9 April 2015 stated: "63 patients in the Emergency department, 19 medical patients, 12 expected, 17 patients in crossroads." Another on 19 April 2015 stated: "89 patients in ED. Majors and resus full, 13 patients out in crossroads, 4 ambulances waiting, 17 altogether (only 2 nurses)". These reports indicated that staff were reporting concerns through the appropriate channels in order to escalate concerns within the organisation.

Environment and equipment

- Chairs in the reception area of the emergency department had been turned to face the minors' area to allow better visibility by staff of patients whilst waiting to be seen. In addition, television screens had been switched on to improve the overall patient experience whilst waiting.
- During the inspection in November 2014 we expressed concern that there was not a resuscitation trolley specifically for the minors' area, given that intravenous regional anaesthesia was administered there. The area was seen to have a fully stocked resuscitation trolley in line with the College of Emergency Medicine best practice guidelines (March 2014). We reviewed records which indicated this was checked daily.

Safeguarding

- Vulnerable patients did not receive appropriate care, treatment or support which met their needs. Staff described a good understanding of safeguarding concerns and actions to follow, in the event of a concern being identified. However, during the inspection, one patient was brought to the department by ambulance in an intoxicated state, expressing concerns for their personal safety as a result of alleged domestic abuse. The patient sat in the crossroads to await initial assessment. One hour and thirty minutes later, the patient had still not been clinically assessed and it was at this point that it was noted that the patient no longer appeared to be in the department. Staff described last seeing the patient sitting in the corridor approximately twenty minutes earlier. Following a general search of the department the incident was escalated to the police. Two hours later it was reported that the police had located the patient, who no longer wished to return to the department. The patient was known within the department for attendance associated with domestic violence and alcohol. During the time the patient spent in the department unassessed, opportunity to identify and act on any safeguarding concerns were missed.

Assessing and responding to patient risk

- Patients were not always promptly assessed. Areas within the ED did not meet the standard set by College of Emergency Medicine guidance and trust policy which required patients to be assessed within 15 minutes of arrival. Prompt assessment ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life-threatening conditions are identified or ruled out so that the appropriate care pathway is selected. During the inspection in November 2014 we saw patients waiting in excess of one hour to be seen by the triage nurse. Since the inspection, the triage area had been staffed with an addition triage nurse in the minors' area from 9am to 9pm.
- We reviewed data supplied by the trust and observed practice. Data provided by the department showed performance against the 15 minutes standard for self-presenting patients attending between December 2014 and April 2015 was variable, ranging from 20.4% of patients being assessed within 15 minutes to 64.6% of patients being assessed within 15 minutes. The proportion of minors patients triaged within 30 minutes followed a similar trend, ranging from 36.8% to 82.2%. For both measures a significant upward trend was noted during the month of April 2015 in line with the creation of the second triage nurse post within the minors' area.

Urgent and emergency services

- Staff described a "huge difference" in their ability to triage within 15 minutes in minors' following the creation of the second triage nurse, whilst a senior nurse told us "staff were very pleased because they could provide a safer service."
- An additional nurse had been employed as a 'streaming' nurse to remain in the reception area from 11am to 11pm. Their role was to remain in the reception area, observing patients who were self-presenting, to stream children appropriately and to stream patients back into primary care where appropriate. For example, to their own dentist or to an advanced nurse practitioner employed by a primary care provider who worked within the department during the day. Newly created at the time of the unannounced inspection, the full impact of the streaming nurse had yet to be demonstrated.
- Receptionists used a red flag system to alert staff of any concerns regarding patients presenting and had received additional training into what presentations required a red flag alert. In addition there was a tannoy system in operation which allowed reception staff to call for clinical staff to attend if they were concerned that a patient required prompt attention. During the inspection we observed this in operation. Staff were quick to attend and see to the needs of an unwell patient within the reception area.
- The time to assess patients within the crossroads area remained a concern. The care and welfare of patients in the crossroads area was of particular concern during the inspection in November 2014. Large numbers of patients were cared for in the crossroads area because there were no cubicles within the majors or resuscitation areas of the department. Ambulance crews were seen queuing to hand over the care of patients, and patients were observed for long periods of time without assessment.
- On arrival at the hospital by ambulance, patients were taken into the crossroads area of the department to the 'pit stop' (reception desk) where they were greeted and checked in by a staff member, usually a receptionist. This area was designed as a checking in area only and was staffed by one registered nurse, one healthcare assistant and a receptionist. Changes implemented as a result of the inspection in November 2014 included the location of a consultant in the area from approximately 11am to 6pm. Outside of those times, medical advice was sought from the majors' area. Busy times in the department tended to be from 6pm onwards into the evening. However, there was not consultant presence in the crossroads area during this time.
- The location of a consultant in the crossroads area allowed for the rapid assessment and treatment (RAT) of patients. RAT involves the early assessment of undifferentiated patients by a senior doctor, allowing them to define a care plan and stream the patient appropriately to ensure emergency investigations and treatment, including pain relief, is not delayed. During our inspection the RAT system was being undertaken on a trial basis and the benefits were still to be evaluated. However, early feedback suggested that patients who received rapid assessment and treatment had timely pain scores and analgesia, timely antibiotics where sepsis was a likely diagnosis and timely investigations such as CT scans. Performance against the time to treatment standard had significantly improved from a median of 48 minutes in November 2014 to a median of 21 minutes in April 2015, though this was a median time devised by amalgamating results from both the minors' and majors' areas of the emergency department.
- During the unannounced inspection, inspectors and specialists placed themselves in the crossroads area to observe the care and treatment being delivered. When the department was not overcrowded, patient flow through the area was effective. However, once the department became busy, the crossroads area became a second majors' area. At one stage, a total of 22 patients were seen to be waiting in this area. The creation of two small cubicles opposite the pit stop desk meant some initial assessments could be undertaken, but we observed several patients waiting unassessed for far longer than their clinical presentation would indicate as appropriate. For example, we observed one patient who had self-presented and been seen in minors triage rapidly. They had been brought through to majors to sit in the crossroads area because there were no majors' cubicles free. The patient described having breathing problems and a severe headache and waited for 45 minutes in the crossroads area to be seen.
- We observed other examples where patient risk was not assessed in a timely way. One elderly patient was brought in having taken a significant overdose. The patient was triaged 41 minutes after attending. They were then brought round to the crossroads area where they remained for a further 29 minutes before being

clinically assessed. Another patient presented with chest pain and was unassessed for one hour and 48 minutes, a third patient with chest pain waited for one hour and 42 minutes (at which point it was established they had left the department unassessed).

- Shift coordinators in the emergency department were rarely seen to leave the majors area. As a result they did not have full oversight of the activity within the department. Patients were not being proactively managed by the shift coordinators. Consequently, patients remained in the crossroads area and were not receiving appropriate care and treatment in a timely manner.
- We raised our concerns to the executive on call who was present in the department on the 18 May 2015. The level of risk that patients were exposed to at that time was acknowledged but not acted upon.
- In November 2014, patients were seen to be remaining in the AEU for longer than six hours without clinical risk assessments. Equipped as a 16 seated assessment unit, the AEU did not have the facilities of a ward. The area was occupied by men and women undergoing assessments or at times awaiting admission following a decision to admit them to the hospital. The area had only one toilet. During our inspection on 7 May 2015 we observed one elderly patient who was unable to walk. They had been seated in a reclining chair. We reviewed their notes and saw no clinical risk assessments had been undertaken to assess the likelihood of pressure damage. They had become hot against the 'leatherette' fabric of the chairs and as a result their relative had placed paper towels under their legs to stop them sticking to the chair. We asked staff of the frequency of risk assessments within the AEU and were informed risk assessments were not undertaken as the area was "not a ward", but that they would be completed if a person remained longer than six hours. At this time the patient had been in the AEU for seven hours. We raised these concerns to the nurse in charge at the time.
- We identified in November 2014 that the AEU was not designed or equipped to provide comfort and privacy for patients who experienced extended stays. Patients were admitted but did not experience ward accommodation. Patients were accommodated fully clothed on reclining chairs, without sheets. There were no processes or protocols in place to monitor pressure area care for patients at risk of developing pressure ulcers. We found this situation remained the same.
- On the evening of 18 May 2015 we reviewed the care of patients in the AEU. At 11.45pm we saw an elderly patient in a reclining chair. They had been in the department for ten hours and forty minutes. A decision to admit onto a ward had been made at 5.25pm. We reviewed their notes for evidence of risk assessments for pressure damage. None had been completed. Their notes contained an untimed entry which read "I have contacted 26B two hourly overnight regarding [patient's] bed but they are unable to take [them] at present…[the clinical site manager] has clarified there are no surgical beds, he has been advised to clear ED as a priority and it is unlikely [patient] will get a bed overnight." The area was brightly lit and not conducive to sleep. We discussed the situation with the nurse in charge and were informed they were considering putting the patient into a treatment room in order to make sleep a little easier. When spoken to the patient told us "I've been here since quarter past twelve and these chairs are not for sitting on long." We saw a second patient who was being administered oxygen for a chest condition which made sitting in a reclining chair difficult. As a result they had requested to sit in an upright chair. This had no pressure relieving cushion in place. The patient was seated furthest from the toilet and did not have immediate access to their call bell. We reviewed the notes and saw they had been admitted to the ED at 11.20am and into the AEU at 1.05pm. A decision to admit to a ward had been made at 1.59pm. No risk assessment had been conducted into the risk of pressure damage for the patient, and they remained in the department on an upright chair. Prior to leaving the department at 1am we contacted the clinical site manager to express concerns regarding both the patients welfare and were informed beds were being made available on a ward.
- Patients who required mental health support and assessment were frequently admitted to the AEU, which was not an appropriate setting. Patients with mental health concerns had a risk assessment completed prior to admission to the AEU. Department guidelines stated anyone with a red risk score should remain within majors for assessment and that only those patients rated amber or green could be transferred to the AEU. Incident reports showed that patients who were risk rated as 'red' were admitted to the AEU on of whom remained in AEU for two nights, awaiting a mental health assessment with only a reclining chair to sleep in

- At 10.30pm we observed one patient admitted to the AEU to await a mental health assessment which would not occur until at least 8am the following morning. We reviewed the incident reports from 1 February 2015 to 20 May 2015 and identified thirteen incidents reported with a moderate impact of patients remaining in the AEU for over twelve hours. For example: one report on 8 April 2015 stated: "86 year old [patient] presented with a low HB on 7/04/15 at 14.10hours. Patient remained in recliner chair for a 24 hour period due to no beds available."

Nursing staffing

- Whilst nursing staff had staggered start times, there was insufficient flex to meet predictable increases in activity within the emergency department. We reviewed the weekly reports produced for the Clinical Commissioning group dated 5 May 2015, 11 May 2015 and 19 May15. In these reports Mondays were described as the worst performing days on each weekly report. Each Monday (with the exception of Monday 6 May 2015 which had only three patients less than the previous day) had the greatest number of patients attending the department and the largest number of patients who were not discharged or transferred to a ward within four hours. This showed that surges in the number of patients and therefore additional staffing required, was predictable. However, staffing levels remained consistent throughout the week despite known increases in demand.
- One registered nurse and one healthcare assistant were allocated to work in the crossroads area each shift. This staff complement had been assessed as being able to care for up to six queuing patients. Staff described the escalation processes for caring for patients in the event of a patient surge or overcrowding. When there were eight queuing patients in the crossroads area, red escalation was declared and assistance sought from elsewhere in the dept. When the number rose to ten patients, black escalation was declared and assistance sought from elsewhere in the hospital known as a SOP (standard operating procedure) nurse. On both 7 and 18 May 2015 we observed the release of the SOP nurse to support the area. However, these were nurses from elsewhere within the hospital and on both occasions neither had worked in an emergency department nor had any emergency department experience. During the evening of 18 May 2015, attendance in the department was so high the matron remained to coordinate and take charge of the crossroads area. They had started work at 8am and had been due to finish at 5pm. They remained in the department, working clinically in the crossroads area until midnight.
- The creation of the streaming nurse in reception had been a new initiative since our inspection in November 2014. It was anticipated this role would be filled for twelve hours a day, every day. However, staff told us this did not always happen. During the unannounced inspection of 18 May 2015, there was not a streaming nurse on duty. Staff told us this was the third day in a row they had been without a streaming nurse in the reception area.
- We were told staffing levels within the Acute Assessment Unit (AAU) was of concern. Staff described a large number of vacancies and a high number of staff who had been qualified under one year and may therefore have limited skills in assessing the acutely ill medical patient. Staff felt this was a cause for surges and overcrowding within the ED as medically expected patients, who would normally be admitted directly to AAU, formed a large number of patients attending the department. We reviewed the staffing levels within the AAU and noted a large number of temporary staff assigned to the area (bank and agency). We reviewed the staffing levels for AAU for the period between 1 May 2015 and 19 May 2015. Of a total of 38 shifts, only 12 were staffed fully with staff from the area. Gaps in the rota were filled by bank and agency staff who amounted to 32% of the total workforce. The area was noted to have a large number of vacancies; eleven registered nurses and eleven healthcare assistants.

Medical staffing

- Following the inspection in November 2014, the trust recruited two additional consultants bringing establishment up to 13.5 whole time equivalent staff. This allowed rapid assessment and treatment (RAT) to be carried out between 10am and 5pm on Monday to Friday through the allocation of one consultant in the crossroads area. However, during the inspection we noted this cover was not always provided. For example, we observed the area for 45 minutes from 12.45pm to 1.30pm on 7 May 2015. During this time there were between two and four ambulance patients queuing at

any one time and two self-presenting patients who had been brought through from minors following triage. The doctor responsible for the area was seen to enter the area briefly once during this time.

- Patients waited a long time in the emergency zone for review by specialists. This meant that the planning and delivery of their care and treatment was delayed. Expected patients (urgent admissions referred by general practitioners) were routinely admitted via the ED because there were no appropriate beds in the hospital. Staff described long waits for patients to receive speciality reviews. For example, we noted one incident report dated 28 April 2015 which described an eight hour wait for a patient to be seen by a medical staff member. Another dated 30 March 2015 where a patient had been admitted to the AEU at 3:15pm. Despite referral to the surgical team at 6:25pm on 29 March 2015 the patient had still not been seen at 12:30am on 30 March 2015.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We raised concerns at our previous visit about failure to consistently assess pain and administer pain relief promptly. Performance in both local and national audits is this area had shown this needed to improve. We observed access to adequate pain relief remained a concern, with patients seen to wait long periods of time before pain relief was administered. Staff brought in to the department to support in times of overcrowding in the crossroads did not always have the skills or experience required. Access to food and drink whilst patients waited in the department had improved with better availability of water and the recruitment of a housekeeper who undertook regular 'tea' rounds.

Pain relief

- Patients waiting in the corridor (crossroads) area of the emergency department did not always receive timely or effective pain relief from emergency department staff. However, once patients were taken from the crossroads area into majors or the resuscitation area, pain relief was seen to be administered promptly.
- There had been no internal audits of pain relief since our last inspection. However, a programme of monthly snap shot audits using a number of performance metrics was about to start, led by an ED consultant. Senior staff told us they felt confident the two significant changes in process, improved triage of minors and more consistent use of rapid assessment and treatment processes, would result in improved performance in the delivery of pain relief.
- We reviewed the delivery of pain relief to patients within the department. We saw one patient arrive by ambulance. They were in severe pain and using inhaled analgesia supplied by the ambulance crew. The patient was seen to remain in the corridor on an ambulance trolley for 15 minutes. A relative was heard informing the ambulance crew that the inhaled analgesia was not adequately controlling their family member's pain. During the time we observed them in the corridor, we saw no ED staff approach the patient or move them into a cubicle, which at the time was vacant.
- We observed a second patient arrive in the department at 1.08pm. Pain relief was not administered until 1:50pm, 42 minutes later. The patient's relative was asked to alert staff if their pain worsened. Further analgesia was administered at 3.30pm.
- We observed a third patient with a severe headache who had been waiting for over 45 minutes without the offer of analgesia.
- We saw a fourth patient with abdominal pain in the crossroads area. They were being cared for by a member of ambulance crew who described administering intravenous morphine to the patient from their stocks in order to provide them with pain relief whilst they waited to hand the patient over to a member of nursing staff. They had remained with the patient awaiting handover for over 75 minutes.
- We looked at a set of notes for another patient with a bone fracture. They arrived by ambulance at 10.40am. A pain assessment was recorded at 11am and recorded a pain score of 7. Pain relief was administered at 12.25pm.

Nutrition and hydration

- Water jugs and glasses were available to patients in the crossroads area. In addition, a housekeeper had been recently employed to provide housekeeping support 24 hours a day and seven days of the week. We observed them conduct tea rounds to patient in the majors' area, the crossroads and AEU and patients were seen being offered sandwiches where appropriate. They described a process for obtaining additional sandwiches outside of meal times and also for accessing cooked chilled foods to offer patients in the AEU who had been there for a long period of time a hot meal.

Competent staff

- Nursing staff deployed from other areas of the hospital to the emergency department, to provide additional support in the crossroads corridor area, did not always have the competencies to provide patients with the care and treatment they needed. We observed a nurse from a ward who had been deployed to assist on the corridor as the SOP nurse. As a newly qualified nurse, they had never worked on ED before and were unable to take blood samples or insert cannulas. Other SOP nurses were observed who had the skills to take blood samples or insert cannulas, but had also not worked in the ED before. As a result they were directed to undertake specific tasks on patients, for example to obtain patient's blood samples, rather than to deliver patient centred care as a nurse with emergency department experience would.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

We reviewed the access and flow of patients through the Emergency Zone. Despite a requirement to improve, patients continued to be admitted to and remain within the crossroads area. Performance against the four hour target remained consistently below the 95% standard. The number of medically expected patients admitted to the ED impacted on the department's ability to manage the number of patients presenting. Once in the department, flow out was also restricted. During our inspection, in order to release beds, staff called a critical internal incident late at night. As a result, beds were released and flow improved. Patients within the department did not have their individual needs met. Patients were not always afforded privacy and dignity whilst waiting in the corridor (crossroads) area of the emergency department. Patients were cold whilst awaiting assessment in that area. Patients also remained overnight in the AEU.

Access and flow

- Performance against the four hour target from December 2014 to April 2015 was consistently below the 95% standard, ranging from 83.3% to 86.9%.
- Staff described a high number of medically expected patients attending the department rather than being admitted to the AAU. Incident reports described a high number of medically expected patients awaiting review and transfer to medical wards, for example on 9 March 2015, 24 medically expected patients were admitted to the ED and on 6 April 2015, ten medically expected patients were admitted to the ED. This impacted on the ability of the ED to admit patients into the majors' area and increased the likelihood of patients remaining within the crossroads area for long periods of time.
- Rapid assessment and treatment involves the early assessment of undifferentiated majors' patients by a senior doctor allowing them to define a care plan and stream patients appropriately to ensure emergency investigations and treatment, including pain relief are not delayed. The RAT system was being undertaken on a trial basis within the department and the benefits were still to be evaluated. However, early feedback suggested that patients who received RAT had timely pain scores and analgesia, timely antibiotics for sepsis patients and timely investigations such as CT scans.
- Staff described the process for managing patients once checked in to the ED. We also reviewed the standard operating procedures which stated patients were to be moved from the 'pit stop' to one of two majors cubicles which were designated areas for assessment, often known as rapid assessment and treatment (RAT). Patients entered these cubicles, received assessment and were then moved to other cubicles in order to ensure that the designated assessment cubicles were free for further patients requiring assessment. We observed the flow through these two cubicles and noted that when the department was not overcrowded, they were used as intended. However, during times of surge and overcrowding within the department,

patients were unable to be moved out of the cubicles because there was no other majors' cubicle available for them to be placed into. As a result the planned RAT process ceased.

- Flow out of the emergency department was restricted. For example, we observed one patient in the resuscitation area at 7:30pm. A decision to admit the patient had been made at 1:40pm. However, at 11pm they remained in the emergency department awaiting an appropriate bed.
- We reviewed the escalation status of the department from 1 December 2014 to 7 May 2015 (a total of 145 days, although not all data for this period of time was made available to us). The department was reported as being at 'Red' escalation ("regularly unable to function as normal and verging on unsafe for periods of time") for a total of 51 days and at 'Black' escalation ("dangerous for a sustained period of time (more than two hours) and where normal care is not possible") for 51 days.
- The ambulance service had agreed a process, known as the ambulance standard operating procedure (SOP) which allowed ambulance crews to leave patients in the department if they had been waiting to hand over to nursing staff for longer than 30 minutes. This was enacted on 21 occasions during that same timeframe. Staff told us that the ambulance service did not enact this lightly, and delays were often greatly in excess of 30 minutes before the SOP was enacted.
- At 10:55pm on 18 May 2015 we observed a total of 22 patients in the corridor area. This meant the number of patients requiring majors care was 110% above capacity. There were six ambulance crews queueing to hand over the care of their patients. One ambulance crew had been waiting to hand over for over one hour. At this point a decision to declare a critical internal incident was made. It was the view of the specialist advisor accompanying us that this was appropriate but should have been called at an earlier point in the evening. The executive on call had been present in the department until approximately 10:30pm, at which point they left the hospital to go home despite the high number of patients in the crossroads area. The request to declare a critical internal incident was made to the manager on call who was with the clinical site manager at the time. Over the following hour we observed beds become available and patients moved from the majors' area to wards. It was not clear why these had not been available prior to this point. Patients were also moved from the crossroads area into the AEU to await test results. The ambulance SOP was implemented and at the request of senior clinicians a request was made to the ambulance service to transfer any suitable inbound patient to a neighbouring trust. At 1am (19 May 2015) the situation had greatly improved with fewer than ten patients in the crossroads area.

Meeting people's individual needs

- Patients with mental health problems continued to wait too long for an assessment under the Mental Health Act 1983. Between December 2014 and May 2015, 79 out of 186 patients (42%) who attended ED with mental health problems spent more than four hours in the dept. Sixty eight of these (38%) were delayed because they were waiting for an assessment under the Mental Health Act 1983.
- The corridor (crossroads) area of the emergency department remained cold whilst patients were waiting to receive assessment, care and treatment. The ambulance doors were frequently open, allowing cold air into the department. Patients were seen waiting in this area in nightwear.
- Patients were not always afforded privacy and dignity whilst waiting in the corridor (crossroads) area of the emergency department. For example, we observed one patient have their chest examined whilst in the crossroads area. Some patients were seen waiting in nightwear and conversations could be easily overheard.

Are urgent and emergency services well-led?

Requires improvement

Concerns raised in the warning notice indicated a need to review the governance and leadership of the department and division. Governance and risk management within the Emergency Zone was not effective. Whilst processes existed, concerns raised in the warning notice issued as a result of the inspection in November 2014 continued to occur. Whilst the executive team were seen as being supportive, there was little support from the wider division management team.

Governance, risk management and quality measurement

Urgent and emergency services

- Performance within the department was reported weekly to the Bristol & South Gloucestershire Clinical Commissioning Groups. Activity and clinical governance was also reviewed at divisional and board level performance meetings.
- Despite high levels of concern raised by staff and continuing poor performance against targets, concerns were not being fully addressed at divisional and board level. This indicated either a shortfall in the governance system, which resulted in significant concerns not being alerted to the board, or an acceptance of the concerns raised as events which were common place. For example, the department risk register (up to 20 May 2015) contained only six recorded risks. This risk register covered risks identified in all areas of the emergency zone (ED, AEU and AAU) and identified continuing concerns which we had raised in our inspection in November 20414. One entry (undated but for review on 3 June 2015) described the risk to patients within the crossroads area and stated “Patient may have a life threatening condition that is sub-optimally managed leading to serious harm. Patients don't have privacy and dignity whilst on hospital trolleys in Crossroads. Patients care is potentially suboptimal whilst in crossroads area.”
- There were plans in place to implement quality outcome audits, where staff were to review the case notes for all attendances during a 24 hour period each week. This had yet to commence at the time of our inspection.
- Staff described having developed the action plan for improvement following our previous inspection with no input from the divisional management team. Following its creation, the department leads had presented it at trust level and reported on progress at divisional meetings.

Leadership of service

- There was a newly appointed (in December 2014) clinical lead in post with responsibility for the ED. However, since appointment they had not had a one to one meeting with their line manager. Support received from executive level was described as good.
- Following our inspection in November 2014, the trust had commissioned an external review of the EZ against the actions identified in the warning notice. External reviewers visited the departments on 23 and 30 April 2015 and 1 May 2015. The report acknowledged that they had been unable to test the service at a time of overcrowding. Ongoing concerns were raised regarding the use of AEU with the report stating “limited evidence that it is being used effectively at the moment particularly there is no single accountable clinical and managerial lead or a clear definition of its role. The tensions and conflict characterised as “turf wars" around the ambulatory care pathway requires executive team leadership and action to resolved.” Staff told us systems for the use of AEU had undergone minimal change with the exception of some ‘hot clinics’ being moved to mornings. The AEU was felt to have a ‘confused identity’ with senior medical staff wanting to use the area for a variety of speciality work. The area was led by the clinical director for the medical division who also had responsibility for the whole Emergency Zone.
- Leadership within the ED was seen to be strong. The clinical lead, matron and ward manager worked cohesively, were visible and supportive. However, there was little engagement with the divisional management team who continued to be directive and lacked a supportive approach.
- Release of beds on declaration of an internal critical incident on 18 May 2015 indicated ongoing practices that supported the belief that overcrowding in the ED was a problem for ED and not the trust as a whole.

Culture within the service

- Staff continued to demonstrate resilience and professionalism whist working in challenging conditions. One staff member stated being able to cope “only because I’m part time.” This was supported by an open culture within the department where staff welcomed change to improve the service.

Outstanding practice and areas for improvement