The Regulation and Quality Improvement Authority

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Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust

9 to 11 December 2014

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and inspections are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our inspections are carried out by a team of inspectors, who have the relevant experience and knowledge. Our reports are submitted to the Minister for Health, Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

RQIA wishes to thank those people, including patients, their families and HSC staff, who facilitated this inspection through participating in interviews or providing relevant information.

Executive Summary

This report outlines the findings of a second follow-up inspection by the Regulation and Quality Improvement Authority (RQIA) to the Royal Victoria Hospital (RVH) Emergency Department (ED) on 9 to 11 December 2014. The purpose of the inspection was to review progress in implementing the recommendations of an RQIA inspection which took place on 31 January to 3 February 2014.

Inspectors found that there had been good progress made to address the recommendations of the previous inspection. The following judgements were made.

- **17 recommendations have been addressed**
- **3 recommendations have been addressed in principle**
- **5 recommendations have been partially addressed**

There has been significant improvement in nurse and consultant medical staffing levels. Staff commented that senior management were more visible, supportive and engaged positively with staff. Inspectors found that staff training has been ongoing and staff have received induction, supervision and appraisal. The provision of support services to ED has improved.

There has been a trust wide effort to improve unscheduled care pathways. These measures should improve the flows through the ED although it is too early to assess their full impact. A new trust wide escalation plan has been developed.

Difficulties continue in relation to staffing by middle grade doctors, especially at weekends, with further recruitment taking place at the time of the inspection. There has been some difficulty in maintaining the full nurse staffing complement with long time periods for recruitment and significant hours lost to sickness absence. Reception staff and patient trackers raised specific concerns in relation to staffing levels and working patterns with inspectors.

Inspectors identified areas where further action is recommended. These included: operation of the ED internal escalation plan; ensuring effective security arrangements for ED; continuing to emphasise that clinical need must take priority over action to avoid waiting time target breeches; patient documentation; and ensuring that pain assessment is carried out and recorded.

The current RVH ED environment continues to present challenges with overcrowding leading to difficulties in delivering personal care. However inspectors observed that staff generally tried to maintain patient privacy and dignity. Inspectors sought the views of patients and cares through interviews or questionnaires. Results indicated that patients were generally happy with the overall care provided.

The report highlights an improving picture in the RVH ED, with significant work carried out to address previous recommendations. 12 new recommendations have been made in this report as a result of this inspection.

Contents

1.0 Introduction and Background to the Inspection

On 9 to 11 December 2014, RQIA conducted a further follow-up inspection to the Royal Victoria Hospital (RVH). This reviewed progress in implementing the recommendations made as a result of the RQIA's previous inspection on 31 January to 3 February 2014. The inspection was based primarily in the ED.

The initial inspection was carried out for the following reasons. On the evening of Wednesday 8 January 2014, a major incident was declared at the RVH, due to the large number of patients within the Emergency Department (ED). The major incident was declared after a period of sustained pressure in the ED.

RQIA received a letter, on 28 January 2014 signed by eight doctors working in the Acute Medicine Unit (AMU) at the RVH, requesting that RQIA investigate an important aspect of the acute medicine service at RVH. The issues raised included the level of medical staffing within the AMU team and the "system's inability to consistently code and track patients correctly as they are moved within and across hospitals within the BHSCT network." The doctors stated: "The situation is worsening and it is our belief that our ability to stand over the quality and safety of many patients under our care is critically compromised through an organisational inability to track and allocate patients to clinical teams in a sustainable and safe manner". The letter was immediately escalated to the chief executives of the Belfast Trust, the Health and Social Care Board and to the Department of Health, Social Services and Public Safety.

On 30 January 2014, RQIA was asked by the Minister for Health, Social Services and Public Safety to carry out an "inspection of the Emergency Department and Acute Medical Unit of the Royal Victoria Hospital at the earliest opportunity". This inspection took place from 31 January to 3 February 2014. A follow-up inspection took place on the 12 to 14 May 2014.

A preliminary report was provided to the Minister on 12 February 2014, and the final report, and the follow-up report for the 12 to 14 May 2014 are all available on RQIA's website www.rqia.org.uk.

2.0 Methodology and Approach

This follow-up inspection was carried out by inspectors from the same RQIA team involved in the initial inspection. Details of the inspection team can be found in Section 3.0 of this report.

The inspection focused on the 25 recommendations relating to the ED, and a spot check was undertaken to Acute Medical Unit (AMU).

For ease of reference in the quality improvement plan, progress made against recommendations have been colour coded. The recommendations were judged to be either:

- **addressed**
- **addressed in principle** (this means that a recommendation has been addressed, but the outcomes have yet to be fully realised)
- **partially addressed** (not all areas have had the appropriate action taken)
- **not been addressed**

The inspection approach included:

- talking to staff, either on an individual or group basis
- talking to patients and patients' families
- periods of observation in the departments and wards
- observation of team meetings in relevant departments
- consideration of documentation shared with the inspection team
- review of patient care records

The Royal Victoria Hospital ED was visited on:

- Tuesday 9 to Thursday 11 December 2014

A spot check visit took place to the AMU during the inspection

Following this inspection, RQIA inspectors provided feedback on the inspection to the Belfast Health and Social Care Trust's (Belfast Trust) senior management team and a range of staff representatives. At this meeting RQIA described the interim findings of the inspection, and provided recommendations for immediate consideration, to ensure patient safety.

3.0 RQIA Inspection Team

RQIA Inspection Lead	**Liz Colgan**
Medical Director	**David Stewart**
RQIA Inspector	**Sheelagh O'Connor**
RQIA Inspector	**Thomas Hughes**
RQIA Inspector	**Margaret Keating**
RQIA Project Manager	**Helen Hamilton**

4.0 Inspection Team Findings

The ED at the Royal Victoria Hospital is a 24-hour, seven day a week comprehensive emergency service. It is the Level 1 Trauma Unit for the greater Belfast area. It is also the Regional Trauma Centre, which accepts trauma transfers from other EDs in Northern Ireland, reflecting the regional specialist services provided on the RVH site.

RQIA's inspection on 31 January to 3 February 2014 resulted in 25 recommendations for the Emergency Department of the Royal Victoria Hospital (RVH). A team of RQIA inspectors undertook a further inspection of ED on 9 to 11 December 2014. The inspection reviewed the recommendations that had been made in the following four themes in ED:

- staffing issues for nursing and medical staff
- safety
- the environment
- the patient experience

The following judgements were made:

- **17 recommendations have been addressed**
- **3 recommendations have been addressed in principle** (this means that action has been taken to address the recommendation but has not been fully completed.)
- **5 recommendations have been partially addressed**(not all areas have had the appropriate action taken)
- **0 recommendations had not been addressed**

In addition 12 new recommendations were made.

4.1 Staffing Issues

RQIA Inspectors' Findings

Inspectors noted the improvement in staffing levels. The recruitment process for all new posts has been completed. However, due to natural attrition, there has been some difficulty in maintaining agreed staffing levels. All vacant posts, as they arise are submitted to the scrutiny panel and approved by return. The lead in time and the lengthy recruitment process can result in delays between nursing staff leaving and appointments being made; this issue was also raised by medical staff. To improve retention, staff will be asked at interview if they wish to work in ED to provide retention of staff.

The review of nurse staffing was completed in February 2014 and recruitment completed in May 2014. There has subsequently been a further review using the Baseline Emergency Staffing Tool (BEST) methodology in June 2014 and an objective validation carried out by the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) using the BEST methodology in October 2014. Inspectors were informed that there were difficulties with the data collection methods used for this review; therefore this is to be repeated.

The ED Senior Sister/Charge job description has been reviewed by HR and Trade Unions in line with the national AfC. The outcome of this job matching process was that the grade of the post remains unchanged, i.e. band 7 although they have the opportunity to appeal this decision. Currently one of the senior sisters is working in the commissioning role for the new ED and the other senior sister's role focuses on quality improvement within the ED (KPIs, audits etc.).

Inspectors found that there are issues with nursing leadership of the department and the trust is currently working with Royal College of Nursing to explore the roles and responsibilities of the band 7 sisters. There is a band 6/7 sister on duty 24/7 who oversees the clinical practices of the nursing team, providing support, supervision advice and guidance. There has been a change to band 6/7 sister's rota to enable 2 Sisters/Charge Nurses to be on duty until 2am. The trust has changed the band 6 sister's uniform to the royal blue uniforms similar to the band 7 sister's uniforms. This decision was made to increase visibility of leadership within the department for the general public.

The staffing levels have improved as outlined in the tables below. In January 2014 the ED planned minimal staffing levels were:

Table 1: ED planned minimal staffing levels January 2014

	AM	PM	Evening	Night	Twilight
Monday and Tuesday	12 RN 2 HCW	14 RN 2 HCW	14 RN 2 HCW	8 RN 2 HCW	1 RN 1 HCW
Wednesday to Sunday	11 RN 2 HCW	13 RN 2 HCW	13 RN 2 HCW	8 RN 2 HCW	1 RN 1 HCW

Inspectors were provided with the current ED planned minimal staffing levels noted below.

Table 2: ED planned minimal staffing levels December 2014

	AM	PM	Evening	Night	Twilight
Monday to Sunday	13 RN 2 HCW	16 RN 2 HCW	16 RN 2 HCW	10 RN 2 HCW	1RN 1HCW

The ED intend to have 11 RNs on each night, but to date this has not been achieved on a regular basis. The trust is currently engaging with staff side to achieve this as this will require staff undertaking more than their 4weeks days and 2 weeks nights.

Inspectors were provided with the ED duty rota for the week commencing, 17 November 2014, and the week of 8 December 2014.

Table 3: Staffing Levels week from the 17 November 2014

	AM	PM	Evening	Night	Twilight
17 Nov 2014	14 RN 1 HCW	15 RN 2 HCW	16 RN 2 HCW	10 RN 2 HCW	2 RN 1 HCW
18 Nov 2014	14 RN 2 HCW	16 RN 4 HCW	17 RN 4 HCW	11 RN 3 HCW	1 RN 1 HCW
19 Nov 2014	15 RN 2 HCW	16 RN (1 sent off ill) 1 HCW	17 RN 2 HCW	10 RN 3 HCW	2 RN 1 HCW
20 Nov 2014	16 RN 1 HCW	15 RN 3 HCW	16 RN 4 HCW	11 RN 3 HCW	2 RN 1 HCW
21 Nov 2014	13 RN 2 HCW	16 RN 2 HCW	18 RN 2 HCW	11 RN 5 HCW	1 RN -
22 Nov 2014	14 RN 3 HCW	15 RN 6 HCW	14 RN 5 HCW	13 RN 4 HCW	1 RN -
23 Nov 2014	13 RN 2 HCW	15 RN 2 HCW	16 RN 3 HCW	12 RN 3 HCW	1 RN 1 HCW

*** RN- Registered Nurse**
*** HCW- Health Care Worker**

Table 4: Staffing Levels week from the 8 December 2014

	AM	PM	Evening	Night	Twilight
08 December 2014	16 RN 2 HCW	15 RN 4 HCW	16 RN 4 HCW	10 RN 3 HCW	1 RN 1 HCW
09 December 2014	10 RN 3 HCW	13 RN 2 HCW	13 RN 1 HCW	11 RN 3 HCW	2 RN 0 HCW
10 December 2014	12 RN 4 HCW	14 RN 4 HCW	15 RN 2 HCW	12 RN 3 HCW	1 RN 0 NA
11 December 2014	13 RN 0 HCW	14 RN 1 HCW	13 RN 2 HCW	12 RN 2 HCW	0 RN 1 HCW
12 December 2014	15 RN 3 HCW	15 RN 3 HCW	14 RN 3 HCW	13 RN 1 HCW	0 RN 0 HCW
13 December 2014	12 RN 2 HCW	13 RN 1 HCW	14 RN 1 HCW	13 RN 3 HCW	1 RN 0 HCW
14 December 2014	14 RN 1 HCW	16 RN 2 HCW	15 RN 3 HCW	12 RN 3 HCW	1 RN 1 HCW

*** RN- Registered Nurse**
*** HCW- Health Care Worker**

The duty rota indicates an increase in staffing over all shifts, particularly on night duty. In addition there are usually two Emergency Nurse Practitioners, (ENP), on duty from 0800 to 2100, and one extra on two evenings per week.

The duty rotas, particularly during the week of the inspection, showed some reduction in numbers. Inspectors were informed that over the month of November 2014 there was 471.5 hours lost to sickness of registered nurses and 320 hours lost to sickness of HCAs. These shifts were submitted to the bank and agencies, 61 per cent of registered nurses shifts and 80 per cent of healthcare workers shifts were filled.

Some staff who spoke with the inspectors stated that staffing levels are good when there is no sickness and all posts are filled. A recent audit carried out by the Trust's HR team in relation to management of absence was positive Some staff advised inspectors that they felt that sickness absence could be managed more effectively.

Staff commented that senior management staff were more visible, supportive and engaged positively. Staff also praised the support provided by the clinical educator and clinical coordinator.

Inspectors were informed that maintaining staffing levels of one to one in resuscitation, and agreed staffing levels in focused assessment, remains a challenge at times. However, staff will be moved from other areas of the department to mitigate any shortages/needs.

Staff informed inspectors that the new build for the ED has only four resuscitation beds.

To mitigate this, plans are in place to upgrade five cubicles within the major's area of the new department to resuscitation level.

Inspectors determined that sufficient work has been done to improve nurse staffing levels to judge the recommendation in relation to staffing levels as addressed. There will be ongoing issues with natural attrition; the new recommendations will assist in the overall management of staffing levels.

Staff Training

Inspectors found that staff have received a full induction and supervision and appraisal and other staff training has been ongoing.

NIPEC was commissioned by the Chief Nursing Officer (CNO), to conduct a review of how the Manchester Triage System (MTS) cascade training is organised within Emergency Departments across the five HSC Trusts in Northern Ireland. The findings of the review would suggest that the BHSCT has in place a number of robust locally developed processes and procedures to support the delivery of MTS cascade training.

BHSCT ED nursing staff are to contribute to an initiative to develop a regional framework aimed at supporting the five HSC Trusts to move toward full compliance with the Advanced Life Support Group (ALSG) standards/criteria and MTS Approved Centre Status.

All staff in the ED have received Aseptic Non-touch Technique Training (ANTT). This training was initially facilitated for ED staff by the department Nurse Development Lead. A number of ED staff have now been nominated as ANTT assessors who provide training and skills assessment of ANTT procedures within the ED.

Five ED staff attended resilience training on the 25 November 2015. The training is a mechanism to equip staff with the skills they need to identify and maintain healthy levels of stress, and to quickly recover from challenging situations if and when they arise within the ED. Further training in this area is planned for all staff.

Management of Actual or Potential Aggression (MAPA) training level 3 is provided for all new staff. Over 50 per cent of all staff have either completed this training or have been given a date to attend. ED staff are trained in personal safety and disengagement, which means break away skills and low level restraint. Security staff are all trained to Level 4, including their managers, which means break away skills and high level restraint. Inspectors were informed that the reason ED staff are not trained to perform high level restraint is because they are taught to withdraw from higher level violence and call security staff who have these skills.

Inspectors determined that sufficient work has been done to improve nurse training to judge the recommendation as addressed.

Support services to ED

The provision of support services to ED has improved, security was the only area raised by most staff that still required improvement. Staff stated that when they need an immediate response from security staff, there are too many questions to answer before security come down. Staff advised that there are at times when security could respond more promptly. When security staff arrive in the department, their presence is often enough to quell difficulties.

Security staff are supposed to do an hourly walk round. Staff were unsure if this happens, as they rarely seem to observe security staff within the central areas of the department.

Inspectors were informed that the trust are exploring a number of options to manage access to the department. Throughout the three days of the inspection, there was unrestricted access to the ED from level 1 of the main hospital. Staff also stated that visitors are allowed to enter the department without being accompanied.

Staff stated that the zero tolerance policy for abuse in the department needs to be followed consistently by all staff. A zero tolerance risk assessment was undertaken in August 2014. This assessment seeks to manage the risks associated with abuse from patients, their relatives and carers, towards clinical staff. An action plan has been devised but no timescales have been set.

Inspectors spoke to the patient trackers. The trackers have been instrumental in piloting and trialling new approaches to tracking patient flow within the unit. They contribute to the management meetings and their feedback is valued by the other staff. The trust aims to provide a 24/7 service between RVH and the Mater Hospital. Currently the patient trackers work a 12 hour shift along with the nurse in charge, which they state provides continuity. Nurses state that they prefer to have the tracker working alongside them.

The patient trackers advised that a revised rota has been proposed to commence in January 2015. They are concerned that this may reduce the effectiveness of their role if this goes ahead.

The reception staff specifically asked to speak to the inspectors. They stated that they are currently short of staff and that shifts that had previously been covered by agency staff have now been stopped. They are often working with two staff instead of four.

Reception staff commented that this situation is causing them personal stress; however their main issue is that there can be a delay in the registration of patients arriving in the department. If there are only two staff on duty, one can be away from reception registering an admission and one registering ambulance patients. On these occasions there may be no staff at the reception desk to observe patients on arrival.

The ED has recently moved to an updated Symphony system (updated one month ago) which now is recording live data. Reception staff commented that they find it difficult to keep this up to date when short staffed. Staff are responsible for inputting all the data, addresses and DOB etc. Individual staff members are responsible for ensuring that information is accurate. Reception staff are concerned that if an error occurs it will be them who will be held responsible. When they are not able to keep the live system up to date they can often have patients who are showing as breaches but they cannot get onto the system to say they have now left the department.

Reception staff stated that there is no waiting time display within the reception area. If the reception staff cannot leave the desk to check a patients waiting time, they often need to send the patient into the main ED to ask staff the waiting time.

The reception staff had previously filled in incident reporting forms highlighting safety concerns but had stopped as they didn't receive any feedback; they commented that they feel like they are a lost cause.

Inspectors determined that sufficient work has been done to improve the other areas regarding support staff to judge the recommendation as addressed.

There are new recommendations related to the findings of this inspection.

Staff meetings and feedback from incidents

Inspectors reviewed the minutes of various staff meetings. Agenda items include feedback to staff from Serious Adverse Incidents (SAI's), IR1's, complaints, patient compliments and staffing developments. The information from results of the trend analysis for incidents highlighted violence and aggression, trolley waits and staffing as the main issues. The minutes stated that the senior sister welcomes staff to approach her if they have concerns regarding an incident and provide feedback on individual incidents. The meeting minutes are posted in the staff room and they are also saved on the 'T' drive for staff to access electronically.

A team brief takes place two to three times per day to accommodate shift patterns. The brief will be led initially by the manager/sister in charge.

A quarterly staff newsletter was designed and issued in September 2014.

Inspectors determined that sufficient work has been done to improve this area to judge the recommendation as addressed.

Staffing Issues: Medical

The Health Social Care Board (HSCB) has increased funding for a total of 16 WTE Consultants; staff have been appointed to all consultant vacancies. The trust stated that they will all be in post by the end of 2014.

Middle Grade staffing continues to be problematic, especially at weekends. Recruitment to middle grade positions is ongoing and a recent round of recruitment closed during the inspection, with a number of interested applicants. The recruitment of these middle grade doctors will assist in balancing the skill mix of shifts, and reduce the need for locum staff.

There are also two trainee advanced nurse practitioners (ANP) in post who are trained in line with the Regional ANP programme which will help with the middle grade rota.

The consultants informed the inspectors that they were involved in the initiatives to improve the onward movement of patients from ED to the wards and felt things had improved in the last few weeks, although progress was slow. However, they remained concerned about the ability to maintain this during the winter pressure period. The lack of space within the department, and somewhere to examine patients in private when the department is very busy, remains a concern.

Inspectors determined that sufficient work has been done to improve this area to judge the recommendation as addressed.

The new recommendation in relation to the appointment of middle grade doctors will assist in balancing the skill mix of shifts and reduce the need for locum staff.

Specialty Triage decisions

The inspection team was informed that that there can still be difficulties and delays in getting assessments from some medical specialities such as neurosurgery and at times cardiology. Consultants felt that they still did not have full decision making authority to admit to all specialities.

Inspectors were informed of the trust plans to open a Medical Clinical Decision Unit (CDU). Until this opens the AMU team will conduct specialty triage in the ED. The pilot of the Medical CDU was planned to commence within the week following the inspection, this will be a seven day service (day time hours only). Standard Operating Procedures have been agreed and are ready to be implemented.

Inspectors determined that although significant work had been carried out in the area of improving triage decisions there remain some issues to be resolved before the full outcomes of this work can be achieved. This recommendation is considered to be addressed in principle.

Staff support

Support clinics for staff were held in February and March 2014. The clinics were facilitated by the central nursing team, the co-director of unscheduled and acute care, the occupational health department and human resources. A total of 70 staff availed of this service.

The results of the Employee Wellness Tool, an online survey conducted in May 2014, were available and displayed in the staff room and could be accessed on the shared T drive. Staff were encouraged to take time to read the report and provide comments and suggestions to formulate a plan that will make the ED a less stressful environment to work in.

A Zero Tolerance Risk Assessment was completed on the 19 August 2014. This assessment seeks to manage the risks associated with abuse from patients, their relatives and carers towards clinical. An action plan has been developed but no timescales for completion have been set.

Work-related stress absence accounted for 6.5 per cent of all staff absence in ED during 2013/2014, with an average of 39 days for those individuals who were on sick leave. A stress risk assessment was carried out in September 2014 and an action plan with set timescales devised.

Inspectors were informed at the previous inspections that the number of administrative staff known as patient trackers has increased; however, at that time, only two nights were covered. Since then four additional trackers have been appointed.

The clinical coordinator has an open door policy and all staff are welcome to voice concerns.

Inspectors determined that sufficient work has been done to improve this area to judge the recommendation as addressed.

Organisational culture and the 12 hour waiting time standard

Staff reported that there had been a positive shift in culture within the department. Staff felt more supported, their views were being listened to and there had also been a change in approach taken to achieve the 12 hour target in most instances.

The Minister for Health has set all trusts a very clear target: to eliminate all avoidable 12-hour breaches in ED by 27 October 2014. The Medical Director has launched the IMPACT project, empowering seven clinical teams, supported by experienced managers, to design and deliver the necessary changes across the trust. Each team has specific objectives, based on the Berwick Principles, focused on reducing waste, harm and variation. The Belfast Project will be part of a regional project designed to establish better regional co-ordination, better information sharing between trusts and better planning across and between trusts.

In discussions, some staff informed inspectors that they have not been put under any pressure to prioritise the 12 hour breach target over clinical need. However, other staff stated that breach times do continue to be a priority, sometimes over clinical need. One example of this was noted during the inspection. On the third day of the inspection, the deputy ED sister informed one of the inspectors that ED staff had been asked by patient flow to move a patient to the discharge lounge to avoid the 12 hour breach time. This was verified by the medical consultant and the nurse caring for the patient and recorded in the patient notes. ED staff had refused to do this as it was totally unsuitable to support the needs of the patient. An IR1 form was completed by the ED deputy sister. At the trust feedback session on the 16 December 2014, senior staff present at the feedback agreed to review this issue

The admission of patients by clinical priority is reinforced within the department at daily safety briefings. Inspectors were informed that after core working hours, patient flow can be contacted for advice and support in decision making. Senior Manager or Co-Director on call can also be contacted to provide support and guidance for staff.

Inspectors determined that although significant work has been carried out in the area of improving the culture, there remains some pressure to prioritise the 12 hour breach target over clinical need. Therefore, the full outcomes of this work have yet to be fully realised so this recommendation is considered to be addressed in principle.

RQIA's initial inspection made 13 recommendations relating to staffing issues. Inspectors found that 11 these have been addressed. Two recommendations, numbers 10 and 13 are addressed in principle. Eight new recommendations were made in relation to this inspection.

Ongoing Recommendations

It is recommended that specialty triage decisions are taken as early as possible to reduce pressure and prompt patient flow.

It is also recommended that the organisational culture is reviewed, in relation to breaching the 12 hour waiting time standard, to ensure that there are not inappropriate behaviours in the drive to achieve this target.

New Recommendations

1. It is recommended that the trust reviews the barriers to a timely recruitment process and implements changes to avoid delays.

2. It is recommended that the trust continues to work to promote nurse leadership within the department.

3. It is recommended that to ensure adequate staffing levels, the sickness management process and the use of bank and agency staff is reviewed within the ED.

4. It is recommended that security provision within the ED is improved.

5. It is recommended that the zero tolerance policy is followed consistently by all staff.

6. It is recommended that the rota arrangements for the patient trackers are reviewed in consultation with them.

7. It is recommended that a review of staffing levels in reception is undertaken to ensure that there are adequate levels of staff to undertake all functions of the role.

8. The trust need to appoint sufficient middle grade doctors to ensure that there is a balance of the skill mix on shifts and a reduction in the need for locum staff.

4.2 Safety

Internal ED escalation plan

The Belfast Trust Unscheduled Care Escalation and Enhanced Capacity plan was finalised in December 2014, following a second table top exercise. A copy of the final approved plan was submitted to the HSCB.

The ED internal escalation plan devised by one of the consultants has been reviewed since the first inspection. The criteria of this internal escalation plan may mean that the ED is assessed within the red category frequently. The plan stipulates that if the ED is in the red category, actions should be at the level of Internal Major Incident. This level of actions may at times be assessed as an over-reaction since the department may be in the red category frequently, and the escalation status of the department may change quickly. The policy should be amended.

On the evening of the 9 December 2014, at approximately 20.00 hours the ED was assessed as in the red category. The inspector was advised that all the actions outlined in the escalation plan had not been initiated, as the status within the department can change quickly. The tracker also stated that they had not been asked by the sister at that time to send an email to alert senior staff of the department's status which would be the normal protocol. It was noted that the ED returned to amber status within one hour. The inspector's observations of the ED at this time did not reflect the need to instigate actions of a major internal incident.

Inspectors were provided with the site status reports for the week of the inspection. According to the status reports the ED was in red category on six occasions for that week. However this did not include the red status on the evening of Tuesday 9 December.

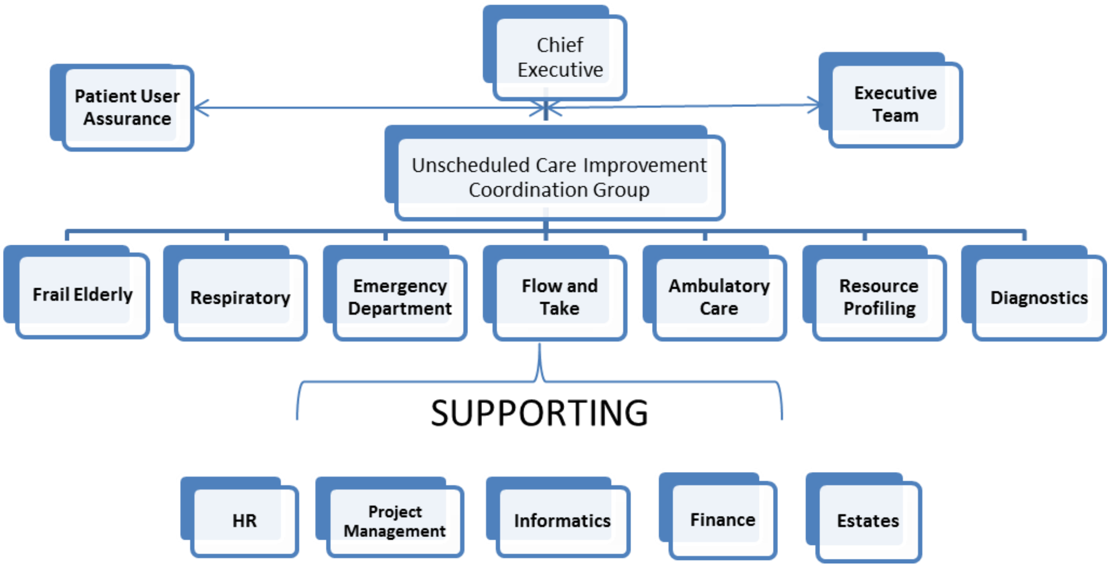
A contingency plan for nursing duties has been developed dependent on assessed ED escalation criteria. This initiative is currently with the trust central nursing team, awaiting approval. The contingency plan outlines that at times of an increased escalation; the focus for nursing duties should be two hourly observations; documentation; safety card actions; nutritional and hydration needs; pressure area care; personal care needs; and communication. It is proposed that the responsibility for the administration of Intravenous (IV) medications and other such interventions will lie with the ED medical staff.

Inspectors determined that although significant work has been achieved in developing a new trust wide escalation plan there remain issues with the ED internal escalation plan. As the full outcomes of this work have yet to be fully realised, this recommendation is considered to be addressed in principle.

Action to improve flows out of ED, to reduce pressures and overcrowding

There has been a substantive trust wide effort focusing on the improvement of unscheduled care pathways which should improve the flows through the ED.

Work, concentrating on the improvement of unscheduled care, is being developed through seven individual work streams. A senior consultant, with senior nursing and management support, will chair each stream, as shown below, and will be guided by very clear aims and objectives.



The key aims and objectives, spanning all seven work streams, are:

- To achieve the four hour standard in all hospitals, 70 per cent by 31 October 2014, 75 per cent by December 2014, 80 per cent by 31 March 2015, 85 per cent by July 2015, 90 per cent by January 2016 and 95 per cent by July 2016.
- To halve the number of patients deemed medically fit for discharge, but who remain in hospital, by 31 December 2014.
- To enable prompt admission of patients, ensure that 50 per cent of patients, deemed fit for discharge, occurs by 1pm.
- To reduce duplication of investigations by 20 per cent by 31 December 2014.
- To ensure that no patient in ED waits longer than 10 hours for admission or discharge by 31 October 2014, reducing to 8 hours by 31 December 2014 and to 6 hours by 31 March 2015.
- To ensure no inter-hospital transfers occur, unless clinically indicated, after 11pm by 31 October 2014, further reducing to 10pm by 31 January 2015.

- To reduce the number of internal patient transfers by 30 per cent, that occur without a clear clinical need, by December 2014.
- To reduce the number of patients being cared for outwith their speciality ward by December 2014.

In addition to this, the ED work stream will seek to achieve:

- An incremental increase in the number of patients clinically assessed within 60 minutes of presentation.
- An incremental increase in decision to admit (DTA) made within two hours of the patient attending.
- An incremental increase of patients discharged by the nurse at triage.
- An increase in numbers of patients seen by ENPs or other clinical staff.
- A decrease in the number of ED admissions.

A new triage system called ATTEND (Advanced Triage and Treatment by Emergency Nurse and Doctor) has been piloted in April and August 2014. The team is comprised of a consultant; two triage nurses; two ED doctors; one HCA; Hospital Ambulance Liaison Officer (HALO) and clerical support.

The principles of ATTEND are:

- patient focused teamwork
- triage and assessment
- early senior review
- early intervention
- early DTA
- early liaison with specialties
- appropriate patient placement
- improved Northern Ireland Ambulance Service (NIAS) handover
- early release of ambulances
- flexible team

The pilot in August 2014 went well despite continued pressures within the unit, and may be adopted as a new way of working in the new department. The challenging workload experienced by staff was rewarded by a faster patient journey with more timely interventions and treatments.

The medical director informed the team at the preliminary feedback that in addition to the IMPACT project there had been some provisional discussions regarding adding a further work stream.

This is:

- In partnership with a company called ALAMAC an operational system has commenced which is designed to improve patient experience by enhancing flow and avoiding delays. The ALAMAC kitbag was introduced at the end of September 2014. This is a data-capturing tool, gathering factual data on unscheduled care performance to expedite flow through the ED. This process involves all wards completing a daily return online before 08:15, with a daily bed meeting scheduled for 09:15.

The co-ordination group for IMPACT will report progress to the executive team and Chief Executive on a fortnightly basis via an update from the group chair.

A new ED patient handover flow chart has been developed. The flow chart is entitled: Procedure for handover at emergency department (ED) at Royal Victoria Hospital. It gives clear guidance to the Northern Ireland Ambulance Service (NIAS) on the actions to take when they arrive at the ED, taking into consideration the nature of the patient's condition.

Inspectors found that significant work has been undertaken by the trust to improve patient flow in ED, and to help to reduce pressures. It is too early to assess the full impact of these measures to determine if they have resulted in effective outcomes for patients. Therefore this recommendation is addressed in principle.

Infection Prevention and Control

At previous inspections the clinical educator had indicated that it was difficult for staff to assess a place onto infection prevention and control (IPC) mandatory training. Inspectors were informed that the issues identified with this process have been resolved.

The clinical educator has worked closely with the IPC team in preparing staff for the management of a patient with Ebola virus. The clinical educator has carried out cascade training for 120 ED staff; basic IPC training on standard precautions is included in this training. Domestic staff have also received this cascade training.

Since the initial RQIA inspection in January 2014, improvements have been made in hand hygiene, however, in September 2014, an independent hand hygiene audit score within the ED was calculated at 10 per cent. A detailed action plan was devised to improve practice.

Inspectors carried out two independent hand hygiene audits during inspection.

- On the 9 December 2014 a 80 per cent score was achieved
- On the 10 December 2014 a 70 per cent score was achieved

Lapses were mainly due to staff not performing hand hygiene following touching a patient or their environment.

On occasions, inspectors observed that some staff did not comply with the trust dress code and hand hygiene policy, or the appropriate use of personnel protective equipment (PPE).

Examples of non-compliance were:

- Gloves but no aprons were worn when disposing of used laundry, cleaning beds and emptying bedpans.
- PPE was worn when not necessary, when answering the phone or when gathering equipment prior to a procedure.
- Medical staff did not decontaminate hands and don PPE when entering a room with a patient under contact precautions.
- A member of medical staff wore a watch in the clinical environment, another wore a cardigan with sleeves below the elbow.
- Some staff wore stoned/dangling earrings and necklaces.

The trust has facilitated training and support for staff to enable them to comply with infection prevention and control policies and procedures. All staff need to take ownership for their practice and comply with trust policies.

The previous recommendation related to equipping staff to comply with infection prevention and control policies and procedures. Inspectors found that the trust has facilitated training and provided support for staff to enable them to comply with infection prevention and control policies and procedures; therefore this recommendation is addressed. The new recommendation is to ensure that individual staff practice is improved.

Nursing documentation in the ED

The ED flimsy has been reviewed and amended since the last inspection and new documentation (daily living chart) has been introduced for the assessment of patients who remain in ED for two hours after the decision to admit has been taken.

Over the course of the inspection 16 care records, commonly known as a flimsy, were reviewed.

Inspectors identified that the sections of the flimsy on skin assessment, social history, MRSA/CDI and peripheral IV insertion, were not fully completed on 14 out of 16 occasions.

Entries by nurses on night shift in the nursing section of the flimsy were not always present. On a number of occasions, the first entry in the nursing section of the flimsy was by day staff. For example a patient from a nursing home, who attended the ED at 02.44, had no entry on the flimsy until 08.15. On observation this patient required nursing interventions for personal care, pressure care and nutrition; however these were not documented.

Nursing entries on the flimsy were at times illegible, difficult to read and had little detail on nursing interventions and care. Care documented referred mainly to the administration of antibiotics and carrying out clinical observations, rather than reflecting the need, for example, to carry out personal care interventions.

On one occasion all information received from a nursing home was not recorded on the flimsy during triage, and confirmation was not initially sought from the patient's next of kin. The inspector identified this to the deputy sister. The deputy sister investigated and advised that a follow up of the patient was carried out by the doctor; details were rectified on the flimsy.

When the inspector reviewed the flimsy for another patient, there was no recorded evidence to indicate regular consistent monitoring of the patient's blood sugar. This is vital, especially as an infection can alter blood glucose levels. The patient did have IV fluids erected and had been given tea and toast.

Staff were provided with training over the period of a week on pain management. The training was delivered by the acute and chronic pain teams. During this training staff were also introduced to the ABBEY pain scale for use in people with dementia who cannot effectively communicate their level of pain.

Pain is assessed at triage, however inspectors noted that pain is not being routinely assessed as an element of the National Early Warning Score (NEWS) clinical observations, or the effectiveness of analgesia recorded.

Inspectors were informed that if pain is assessed as zero it does not register on the ED flimsy. This is caused by a software problem with the Symphony system. In the interim period inspectors informed staff to write the pain assessment on the flimsy.

Monitoring audits of nursing documentation has been introduced from August 2014; the main findings are detailed below.

ED Documentation audit results (August – November 2014) carried out by ED sisters on a weekly basis. The main issues identified were:

Interventions not being recorded – 88 per cent compliance
On-going interactions not being recorded – 86 per cent compliance
Patient outcome not being recorded – 89 per cent compliance.

Action Plan

- Each Sister to feedback on audit results at sisters meeting with action plan focused on outstanding issues.
- Each team will do their audits for 6 weeks at a time
- Feedback of audit results at ED monthly staff meetings
- Spot checks on hourly walk rounds
- IPCT, pressure area risk assessments to be added in to weekly audits. The audit should also capture if ED daily living documentation is commenced after 2 hours from a decision to admit.

Weekly audits: for the ongoing assessment of Category 2 and 3 patients. The main issues arising from these were:

- Documentation of discussions with medical staff and occasionally observations are not recorded as often as dictated by the NEWS.
- On the whole, the documentation for these patients has been good with patients being triaged appropriately, all patients being placed in appropriate clinical areas when necessary and evidence of discussion with medical staff documented.

Completion of the daily living chart and risk assessments was added to the patient care record documentation audit, following this inspection.

Inspectors found that review of these flimsy's identified little improvement in the documentation of patient care, with little assessment of the activities of daily living and limited documentation on the delivery of care. Pain assessment and score, while part of the initial triage flimsy assessment, was not regularly monitored as part of NEWS.

One of the main challenges for nurses working in ED is maintaining core caring concepts while effecting evidence based emergency interventions. The trust is working with staff to appreciate caring as well as the technical aspects of nursing care and promote person centred care in ED.

Inspectors determined that although some work has been carried out there has not been sufficient progress achieved in the area. Therefore this recommendation is partially addressed.

Patient Risk Assessments

A review of the documentation highlighted that patient risk assessments are not routinely completed by staff within the ED. The trust have made an effort to improve the documentation and staff awareness for the need to complete these risk assessments. However a more concerted effort is required by staff.

Inspectors identified that the daily living chart was not completed by staff after two hours from a decision to admit. On discussion, staff advised that they thought the chart was to be completed after four hours.

Even after four hours this was not evident on the review of documentation, and was only completed by staff following discussion with the inspector.

Risk assessments for infection prevention and control were completed on occasions; no risk assessments for pressure ulcer risk were completed. Accompanying documentation for a patient identified pressure area redness and incontinence lesions. This information was not recorded on the nursing flimsy and a repositioning chart only commenced three hours after attending ED. A daily living chart was commenced when prompted by the inspector.

Inspectors were advised at feedback that checking of patient care would now be commenced on an hourly basis.

Review of fluid balance charts noted that these were not always completed when IV fluids were erected. New fluid balance charts were not always in place from one day to the next, for patients admitted overnight. Visual infusion phlebitis score charts are not in use within ED to monitor the IV infusion site.

Inspectors determined that although some work has been carried out there has not been sufficient progress achieved in the area. Therefore this recommendation is partially addressed.

RQIA made five recommendations relating to safety issues. Inspectors found that one of these have been addressed. Two recommendations, (14 and 15) are addressed in principle and two, (17 and 18) remain as partially addressed. In addition one new recommendation was made.

New Recommendation

9. It is recommendation that all staff take ownership for their infection prevention and control practice and comply with trust policies.

Ongoing Recommendations

It is recommended that the internal ED escalation plan criteria and the trust escalation policy are reviewed.

It is recommended that the Belfast Trust identifies any immediate opportunities to improve flows out of ED, to reduce pressures and overcrowding.

It is recommended that nursing documentation in the ED is reviewed, and recording improved to ensure that all patient needs are identified.

It is recommended that all risk assessments are completed within the set timescales. These should be reviewed and updated on a regular basis or when there are changes in the patient’s condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.

4.3 Environment

An environmental review was undertaken following IPC environmental audits. This found that no further structural building measures can be taken to improve the environment for the existing building. Some minor repairs have been undertaken, and the estates department has refurbished sections of the ED wall panels with new antibacterial wall covering.

Inspectors found some issues that require improvement such as wet floor signs not removed when the floor has dried. One of the toilets was out of order; a second toilet had a stale urine smell. The floor had been repaired with duct tape, but was worn. According to staff, the floor of the toilets had been replaced after the first inspection. The toilets in the unit and in the reception were clean but worn. Mop buckets and dust mops were left unattended outside cubicles for long periods of time. In patient areas, piles of dust and debris were left under dust mops. Mops were left in mop buckets of water all day.

The micro fibre system is being introduced and this will enable the floor to dry faster and there will be less equipment in use.

The physical access to patients in the event of an emergency remains difficult when being cared for in the focused assessment area, as patient trolleys are placed closely together. Inspectors were informed that the new department will not open in January 2015 as planned. Staff were unable to confirm when the opening will take place.

Although the trust is focusing on improving the environment through reducing the potential for crowding, observation of the current environment evidenced no change from the previous inspections. Improvement in the environment has not yet been realised through reducing the potential for crowding. Therefore this recommendation remains partially addressed.

Equipment

The availability of essential patient equipment and supplies has been reviewed as recommended. The ED have introduced some new patient trolleys which had been purchased for use in the new department. Staff felt that there is generally enough equipment to cater for patient needs and a sister has been given designated responsibility for monitoring the stock levels and accessibility of ED equipment.

Inspectors found some issues that require improvement. Supplies of clean linen were available on trolleys located at various points throughout the department. The linen store was cluttered and untidy, one of the shelves was broken, linen and linen bags were on the floor. Staff advised that accessing linen was still a problem, due to limited supplies. Cages of linen were left outside the linen store. The linen service contract states that the person delivering the linen should place linen on the linen store shelves. This does not appear to be happening. Dockets are to be signed off by ED staff and any short fall in stock highlighted.

There was a mix of draw sheets[1] and flat white linen sheets in use throughout the department. The draw sheets were coarse and did not cover the trolley surface. Draw sheets are used on patients brought in on ambulance trollies. When the patient is transferred onto the ED trolley, the draw sheet should be removed and replaced with a sheet, however this is not always the case.

Availability of pillows continues to be an issue although the ED purchases 20 pillows each week. Inspectors were informed that all staff are reminded to ensure that patients are comfortable and that there are adequate pillow supplies.

Observation of patient trolleys indicated that these required more in depth cleaning   Trolleys were observed being moved from cubicles to areas around the central work station, and corridors. There was no trigger system in place to assure that trolleys were cleaned. A variety of staff groups have responsibility for cleaning different sections of the trolleys. This should be reviewed as there is no designated overall responsibility to ensure trolleys are clean.

[1] this is a sheet that is placed in such a way that it can be taken from under a patient without disturbing the bed clothes)

Domestic staff stated that they deep clean all trolleys monthly. Some trolley mattresses were stained, others were damaged.

The purple burn bin in the bloods room was over flowing. Staff informed inspectors that pharmacy staff had disposed of out of date medication in boxes on top of IV infusion sets. Some patient equipment in the resuscitation area was dirty and dusty. The resuscitation trolley in focus assessment was dusty and not sealed. Inspectors were informed that this is no longer required. There was no suction machine on resuscitation, however this is on order. The review of documentation noted inconsistency in recording of resuscitation trolley checks.

Inspectors determined that the initial recommendations have been addressed. During the course of the inspection additional issues were identified therefore three new recommendations were made.

RQIA made four recommendations relating to the environment. Inspectors found that three of these have been addressed. One recommendation, number 19, remains partially addressed. In addition, two new recommendations were made.

Ongoing Recommendation

It is recommended that in the interim period, pending the opening of a new ED, a review of the existing environment should be undertaken to identify measures that could improve the situation. ED staff should be involved in the planning of the new department.

New Recommendations

10. It is recommended that the issues identified in relation to environmental cleanliness be addressed.

11. It is recommended that the ED staff monitor the service contract for the storage and supply of linen.

12. It is recommended that staff practice in relation to cleaning of patient equipment is improved and recording of resuscitation trolley checks are consistently recorded.

4.4 Patient Experience

Inspectors observed that there was a greater emphasis placed on protecting patient privacy and dignity. However, spatial constraints and continued issues with patient flow in the ED still remain a challenge. Inspectors still observed overcrowding of patients on trolleys beside the central work station. The close proximity of trolleys continues to create problems with the delivery of personal care, toileting and confidentiality during communication.

Observation of staff interactions found that overall staff treated patients and those accompanying them courteously. Staff introduced themselves to patients and general conversation was good. During the inspection the outcomes area was calmer, leading to better communication and positive interaction with patients. In comparison, when very busy in the focused assessment area, communication and interaction with patients was minimal, and staff did not always fully engage with patients.

Conversations with patients could be overheard at times. The details of patient medication was discussed beside another patient, whilst an empty room was available. Verbal communication was not always supported by documentation. Patients in focused assessment and the waiting area need more regular information and explanation on their planned care and on waiting times to be seen. There was no signage in the waiting area to provide information on waiting times. The trust anticipates recruiting volunteers for the waiting area to provide information and answer queries.

Inspectors observed that patient observation monitor alarms were easily heard when the department was quiet. However as patient numbers and noise levels increased this created difficulty in hearing patient monitor alarms and call bells.

Signage for patients and visitors was, on occasions, in the form of handmade posters. These were not always displayed prominently, for example directions from reception to the focused assessment area.

In the outcomes area, inspectors observed good communication with the patients, including discussion on their reason for admission. In the focused assessment area, patients did not always appear to be aware of what was happening to them and wanted to engage with staff. Inspectors observed patients trying to engage with staff to ascertain what was happening with them.

Overall patients looked comfortable. However draw sheets were being used as sheets under the patient. One patient used their own shawl as a blanket. Pillows were not available for all patients.

Observation evidenced maintenance of patients' privacy and dignity when patients were using commodes in the cubicles. However when ED is overcrowded, facilities available for patients were limited.

Inspectors acknowledge that generally the majority of staff did try to maintain the patient's privacy and dignity. However, the ongoing problems with overcrowding and subsequent difficulties with delivering personal care, and toileting needs, means that there is still ongoing work required in this area.

Inspectors determined that although some work has been carried out there has not been sufficient progress achieved in the area. Spatial constraints, overcrowding of patients on trolleys and continued issues with patient flow determined that this recommendation is partially addressed.

Mealtimes

With the exception of the short stay ward, patients were not prepared for their meal, for example toileting, positioning in chair or trolley. There were no wipes available for hand hygiene. Meals served looked appetising, were hot, and appropriate for the needs of the patient. There was three choices of main course to choose from, plus a puree option.

At mealtimes, a heated trolley comes to the department; a catering assistant serves the meals. Staff from the short stay unit came to the trolley and made meal requests. Inspectors were informed that there was a lead nurse identified for the focused assessment and outcomes areas, however during the inspection this lead nurse was not observed directing meal service. It had been agreed that a yellow sticker was to be placed at the entrance to the cubicles to indicate if the patient required a meal. In the outcomes area the patient name board was to be starred to indicate patients who required a meal. None of these indicators were observed. The domestic staff collected and distributed meals.

The lack of bedside tables, congestion and a lack of co-ordination contributes to a poor patient food service experience. Patients continue to balance meals on their knees or sit on a chair and use the trolley as a table. New bespoke trolley tables have been ordered for the new ED.

Drinks were given out with breakfast, but were not part of the plated meal service at lunch time. Drinks were not regularly offered to patients. No signage was in place to indicate 'nil by mouth' for four patients in outcomes. Mouth care was not routinely offered to those who were 'nil by mouth', for example one patient attended the unit and was triaged 'nil by mouth' at 09.58 and the patient left the unit at 20.00. There was no mouth care evident on observation of practice and flimsy documentation.

Inspectors determined that although some work has been carried out there has not been sufficient progress achieved in the area. Therefore this recommendation is partially addressed.

Patient and Carers Experience

Inspectors conducted interviews with patients and carers, or left them a questionnaire to complete. The overall findings show that patients were generally happy with the care provided.

In the questionnaire a range of one to five options were given, five being most satisfied. Overall scores for questionnaires were four and five.

There were a few questions that scored three or less, related to:

- concerns about care
- pain relief
- staff not aware that they were upset or distressed
- staff did not introduce themselves
- staff do not speak in a way which could easily be understood
- not all staff were welcoming, or fully understood the patient's condition
- didn't treat me as an individual
- are staff approachable, "no they walk on by"
- do staff provide you with assistance, are willing to help, listen to your questions or concerns, "only if not busy"
- do staff provide you with enough information in order for you to understand what you are consenting to, " staff tell you one thing then tell you another"

Quotes from patients

"Have been in ED several times, would come here as first preference, I have been here with my family and have been in the short stay ward before going to ward for a few days."

"All round I am happy with the treatment I received."

"Very professional."

"No complaints."

"Waiting time was long, seen by nurses, but not by a doctor for nearly four hours."

10,000 Voices Project

RQIA was advised that the 10,000 Voices project is now finished in relation to ED. The project offered people the opportunity to speak about their experiences as a patient, or as someone who has experienced the health service. The project also allowed patients to highlight the things that were important to them, with the aim to help direct how care is delivered in Northern Ireland.

The ED has undertaken planned 10,000 Voices (listening to patient stories) workshops and these have now been completed. The stories reflected the service in both a positive and negative light with an almost 50/50 split. The stories will now be displayed in the staff room. An improvement action plan has been devised for implementation.

Improving the patient and client experience is an important area for all health social care organisations. This is ongoing work for the Public Health Agency (PHA) in their regional work plan for 2014 to 2016.

Sufficient work has been carried out to ensure this is an area for constant review therefore this recommendation is considered to be addressed.

RQIA made three recommendations relating to patient experience. Inspectors found that one of these has been addressed. Two recommendations, (23 and 24) remain partially addressed.

Ongoing Recommendations

It is recommended that staff should be supported to ensure appropriate care and privacy is given, and that patients are treated with dignity and respect.

It is recommended that there is a system in place to identify patients who require a meal and sufficient staff to ensure patients receive the appropriate assistance with their meals.

5.0 The Acute Medical Unit

The Acute Medical Unit (AMU) was not inspected. However as inspectors were informed of some issues with outliers a short spot check was undertaken.

Inspectors were informed by the ward sister that bay F is planned to be the direct admission bay. This was due to start on 1 December 2014, with patient numbers reduced, and the bay empty, however due to pressure for beds, these beds were reopened.

There have been 22 new band 5 nurses employed, but staff advised that their need for induction, training and mentoring has increased workload and pressure on longer term staff. Staff advised that there has been a lot of change, however this has not been evaluated and continual change is difficult to keep implementing. Long term sickness has gone up, some of this is seasonal.

Nursing staff advised inspectors that outside of the regular ward meetings, communication between nursing and other disciplines assessing or delivering care remains an issue. Nursing staff are not always advised on what interventions or plan of care has been decide for patients. Other disciplines deliver care or review patients but do not always inform nursing staff of this before leaving the ward.

Consultants are available in the mornings to review patients. There is a designated Acute Medical Consultant who reviews patients after 17.00 each evening however they can at times be difficult to access, especially after 17.00. There is an on-call rota for other medical specialties if a Consultant needs to be contacted.

Ward staff advised that there can be approximately 20 outliers per day and discharging patients from the ward remains an issue. Inspectors were advised by an AMU consultant that, the number of patients who were outlying had increased to 40 at the time of the inspection.

BCH Direct[2] is an assessment and direct admission facility for frail older persons in the BCH. BCH Direct can only be accessed by ED before 09.30 each day, with a maximum of two patients able to be accepted and transferred. After 09.30 transfer from ED is only following consultant to consultant discussion. AMU cannot directly access BCH Direct.

[2] BCH Direct is an assessment and direct admission facility for Frail Older persons in the BCH

Observations

On arriving on the ward the inspectors were initially unable to locate a nurse looking after a particular patient. When this was raised with the nurse in charge, the inspectors were advised that the nurse looking after the particular patient was at a meeting. The staffing ratio has been increased however it was acknowledged that there remain some vacancies in the ward at the time of the inspection.

Lunch service was briefly observed. It was noted that lunch was plated and served by domestic/catering staff. There was no co-ordination and input by nursing staff to identify patients' dietary needs or who would require assistance. Soup continues to be served in tea cups with plastic spoons.
A patient in a side room was banging on the bedside table with a cup to call for help. Inspectors spoke to the patient, who wanted some milk, but did not have a call bell; inspectors noted that the call bell was tucked behind the pillows. It was also noted that the patient had two tablets, not taken, in their hand. Inspectors gave the patient the call bell and activated it for assistance. There was no staff response to the call bell after a period of five minutes. Inspectors had difficulty in locating a staff member to assist the patient.

On locating a nurse, inspectors were advised that nursing levels were depleted as one nurse was off the ward attending a meeting. Inspectors identified that the patient required assistance, this was immediately addressed. The issue of medication not correctly administered was also raised with the nurse and the ward manager, before inspectors left the ward.

The trust should continue to address the recommendations made regarding AMU.

6.0 Next Steps

The Belfast Trust has been asked to update its quality improvement plan in light of the findings of this inspection. An additional quality improvement plan will be devised for the new recommendations.

On the 8 April 2014 the Health Minister's statement to the Northern Ireland Assembly outlined that from 2015-16 onwards, RQIA should undertake a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland each year. This programme is in development and it is anticipated that pilot inspections to test the indicators and methodology to deliver this inspection regime will commence in April 2015.

RQIA anticipate that further inspections will therefore be included in this new regime or on ministerial request.

7.0 New Recommendations

1. **It is recommended that the trust reviews the barriers to a timely recruitment process and implements changes to avoid delays.**

2. **It is recommended that the trust continues to work to promote nurse leadership within the department.**

3. **It is recommended that to ensure adequate staffing levels, the sickness management process and the use of bank and agency staff is reviewed within the ED.**

4. **It is recommended that security provision within the ED is improved.**

5. **It is recommended that the zero tolerance policy is followed consistently by all staff.**

6. **It is recommended that the rota arrangements for the patient trackers are reviewed in consultation with them.**

7. **It is recommended that a review of staffing levels in reception is undertaken to ensure that there are adequate levels of staff to undertake all functions of the role.**

8. **The trust need to appoint sufficient middle grade doctors to ensure that there is a balance of the skill mix on shifts and a reduction in the need for locum staff.**

9. **It is recommendation that all staff take ownership for their infection prevention and control practice and comply with trust polices.**

10. **It is recommended that the issues identified in relation to environmental cleanliness be addressed.**

11. **It is recommended that the ED staff monitor the service contract for the storage and supply of linen.**

12. **It is recommended that staff practice in relation to cleaning of patient equipment is improved and recording of resuscitation trolley checks are consistently recorded.**

8.0 Quality Improvement Plan – New Recommendations

RQIA Follow-Up Inspection re Unscheduled Care in BHSCT 9-11 December 2014
New Recommendations (Jan 2015 Report)
Quality Improvement Plan

Reference number	Recommendations	Designated department	Action required	Date for completion/time scale
1	It is recommended that the trust reviews the barriers to a timely recruitment process and implements changes to avoid delays.	ED	The Trust is committed to timely recruitment of staff within the Emergency department and is currently reviewing all stages of the recruitment process.	31 Mar 2015
2	It is recommended that the trust continues to work to promote nurse leadership within the department.	ED	The Trust recognises the need for strong leadership and is promoting nurse leadership within all wards and departments. This is evident in the appointment of a Clinical co-ordination for ED and further development opportunities for the ED Sisters.	1 Mar 2015
3	It is recommended that to ensure adequate staffing levels, the sickness management process and the use of bank and agency staff is reviewed within the ED.	ED	The Department is fully engaged with the implementation of the Attendance Management process. The Trust continues to recruit staff and bank and agency are used to supplement vacancies and absences.	Ongoing
4	It is recommended that security provision within the ED is improved.	ED	The security requirements for the ED have been reviewed with department staff and PCSS. The number of access points to the department remains an issue which the Trust is addressing.	31 Mar 2015
5	It is recommended that the zero tolerance policy is followed consistently by all staff.	ED	Staff are continuously encouraged to report all incidents of violence and aggression and a consistent approach promoted.	Ongoing

Reference number	Recommendations	Designated department	Action required	Date for completion/time scale
6	It is recommended that the rota arrangements for the patient trackers are reviewed in consultation with them.	ED	Belfast Trust is currently reviewing the rota arrangements for the ED patient trackers across both the RVH & Mater sites. This consultation period will comply with "Organization Change Management" Policies within the Trust and will be a full and transparent discussion.	31 Mar 2015
7	It is recommended that a review of staffing levels in reception is undertaken to ensure that there are adequate levels of staff to undertake all functions of the role.	ED	A review of staffing levels in ED reception will be undertaken.	Mar 2015
8	The trust need to appoint sufficient middle grade doctors to ensure that there is a balance of the skill mix on shifts and a reduction in the need for locum staff.	ED	The Trust is currently embarking on a marketing and advertising campaign to recruit Consultants, middle grade doctors and qualified ANPs. The Trust is also exploring the development of a General Practitioner Clinical Fellow post which will provide additional support to the department.	Ongoing
9	It is recommendation that all staff take ownership for their infection prevention and control practice and comply with trust polices.	ED	The Trust supports this recommendation and all staff are reminded of their responsibilities to comply with Trust Policy in this regard. This will be monitored by the Nurse in Charge and issues addressed accordingly.	Ongoing
10	It is recommended that the issues identified in relation to environmental cleanliness be addressed.	ED	The team in ED will continue to work closely with PCSS colleagues to ensure the department's level of cleanliness is maintained at times of overcrowding.	Ongoing

Reference number	Recommendations	Designated department	Action required	Date for completion/time scale
11	It is recommended that the ED staff monitor the service contract for the storage and supply of linen.	ED	The supply of linen contract is managed by PCSS. Senior nursing staff will work closely with PCSS to ensure the provision of linen supplies at times of pressure.	Ongoing
12	It is recommended that staff practice in relation to cleaning of patient equipment is improved and recording of resuscitation trolley checks are consistently recorded.	ED	On a shift to shift basis, equipment is cleaned according to the cleaning schedule for each area. This will be monitored by the Nurse in Charge and issues addressed accordingly.	Ongoing

9.0 Quality Improvement Plans

RQIA Review of Unscheduled Care QIP
Quality Improvement Plans

Summary: Emergency Department

Ref No	Recommendations	Action	Status
Staffing			
1.	It is recommended that the posts of ED senior sister should have a job evaluation to review if the staffing grade is appropriate for the duties of the posts.	Completed.	
2.	It is recommended that a further review of nurse staffing levels is undertaken for ED at RVH to ensure that there are adequate levels of staff to provide all the functions of the department.	Completed.	
3.	It is recommended that nurse staffing in the resuscitation area is reviewed to enable provision at a level of one nurse to one patient.	Completed subject to on-going review.	
4.	It is recommended that nurse staffing in the focused assessment area is reviewed.	Completed subject to on-going review.	
5.	It is recommended that there a review should be undertaken of the provision of support services to ED.	On-going following RQIA inspection in December. Estate Services have being contacted regarding door to restrict access to the Department. Security management and PSNI Crime Prevention met with Sister in charge and performed a walk about. ED staff were offered and availed of visits to the CCTV Control Room to view the coverage within ED. Additional security patrols are in place since new rotas were introduced. A portfolio providing an overview of security within ED was produced for the benefit of ED staff detailing all the CCTV installations, door access locations and panic alarm points/activation procedure. A photographic still of each camera was also made available. A protocol was also made available regarding seeking security and/or PSNI assistance. Posters are in place regarding Zero tolerance and	

Ref No	Recommendations	Action	Status
		are currently being reviewed.	
6.	It is recommended that a learning needs analysis is undertaken to facilitate career development for all of the nursing team in ED. Nurse education should also focus on learning from incidents and the principles of safety.	Completed and on-going.	
7.	It is recommended that processes are reviewed to improve the retention of staff, and to ensure that staff have appraisal and supervision sessions in line with the Belfast Trust policy.	Team leader for staff will be responsible for conducting Exit interviews. Annual reviews and CNO Supervision standards are assigned to the Ward Sisters / Charge nurses. Development of Staff Newsletter, re-establishment of Team Meetings and development of a Communication Framework to improve employee engagement, cascade of key messages and improve opportunities for employee-manager listening.	
8.	It is recommended that systems are put in place to ensure that where staff report on incident which indicate safety issues, feedback should take place such as an e-mail. Staff should also be provided with an analysis of trends in incidents, relating to their area of work, on a regular basis.	Completed and on-going.	
9.	It is recommended that there is an immediate review of emergency medicine consultant numbers for the ED at RVH	A review of ED Consultant numbers has been undertaken. Funding has been secured and appointed to 15 of the 16 consultant positions. Recruitment to Middle Grade positions is on-going. Recruiting to 3 ENP positions for the Trust which will assist with absences in middle grade rota. 2 trainee ACPs are in post and will train further applicants in line with the Regional ANP programme.	
10.	It is recommended that specialty triage decisions are taken as early as possible to reduce pressure and prompt patient flow.	RVH ED is currently piloting Advanced Triage Treatment by emergency nurse or doctor "ATTEND" to enable early triage decisions. AMU Consultants are undertaking speciality triage of patients within the Emergency Department, with early senior review to facilitate timely specialty triage of patients. It is further proposed to undertake this function within a Clinical Decision Unit (CDU) co-located with AMU.	
11.	It is recommended that regular staff meetings are held for staff working in the ED department.	On-going. Staff meetings are held monthly.	

Ref No	Recommendations	Action	Status
12.	It is recommended that additional systems are put in place to support staff working in ED and help them deliver person centred and compassionate care.	On-going. Nurse Contingency plan has been submitted.	
13.	It is also recommended that the organisational culture is reviewed, in relation to breaching the 12 hour waiting time standard, to ensure that there are not inappropriate behaviours in the drive to achieve this target.	On-going. As issues arise, they are escalated to the Co-Director on call.	
Safety			
14.	It is recommended that the internal ED escalation plan criteria and the trust escalation policy are reviewed.	Review of Trust's Escalation plan include ED Escalation plan has taken place following exercise on 2nd December, 2014. Additional information is being obtained for submission to RQIA following inspection in December, 2014.	
15.	It is recommended that the Belfast Trust identifies any immediate opportunities to improve flows out of ED, to reduce pressures and overcrowding.	The IMPACT project is on-going.	
16.	It is recommended that systems are reviewed to ensure that staff in ED are equipped to adhere to the Belfast Trust's infection prevention and control polices.	On-going. HCAI meeting has taken place. HCAI recovery plan.	
17.	It is recommended that nursing documentation in the ED is reviewed, and recording improved to ensure that all patient needs are identified.	Nurse in Charge Action card. Nursing documentation audit form has been updated to include Risk Assessment. Assurance framework is being developed through the Sisters' meetings.	
18.	It is recommended that all risk assessments are completed within the set timescales, these should be reviewed and updated on a regular basis or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.	This is monitored on a shift to shift basis by the Nurse in Charge and is on-going.	
Environ ment			
19.	It is recommended that In the interim period, pending the opening of a new ED, a review of the existing environment should be undertaken to identify measures that could improve the situation. ED staff should be involved in the planning of the new department.	Work is carried out in the existing Department to maintain an acceptable working environment and is subject to on-going monitoring.	

Ref No	Recommendations	Action	Status
20.	A review of resources should be undertaken to ensure that items of stock/non stock equipment are available, for example pillows and blankets.	Immediate actions following December RQIA inspection – Mattresses checked. All faulty trolleys reported to Estates and repaired.	
21.	The availability of essential patient equipment is reviewed, such as Baxter IV pumps, cardiac and observation monitors.	Completed.	
22.	A review of equipment that is old or needs to be replaced should be undertaken, including patient trolleys.	Completed.	
Patient Experience			
23.	It is recommended that staff should be supported to ensure appropriate care and privacy is given, and that patients are treated with dignity and respect.	Staff are committed to maintaining patient privacy and dignity at all times. This is assessed on an on-going basis and staff are supported to mitigate risk and ensure dignity and privacy is maintained at times of overcrowding. Staff shadow the patient's experience as part of their induction programme & on-going development. Feedback from this will be collated and shared with the team.	
24.	It is recommended that there is a system in place to identify patients who require a meal and sufficient staff to ensure patients receive the appropriate assistance with their meals.	Since RQIA inspection, a member of staff has been requested to source tables for patients, new system for identifying patients who need fed. A new fridge to provide chilled foods for patients has now being installed.	
25.	It is recommended that the Belfast Trust should monitor and action patient, relative, and carer comments to improve the patient experience.	10,000 voices. Patients being invited to staff meetings. Fundamental of Care.	

Area: Emergency Department

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
Staffing				
1.	It is recommended that the posts of ED senior sister should have a job evaluation to review if the staffing grade is appropriate for the duties of the posts.	ED	ED Senior Sister/Charge job description has been reviewed by HR. The matching panel sat on 21st October and the outcome of this job matching process was that the grade of the post remains unchanged, i.e. Band 7.	
2.	It is recommended that a further review of nurse staffing levels is undertaken for ED at RVH to ensure that there are adequate levels of staff to provide all the functions of the department.	Central Nursing / ED Nursing team	This recommendation was reviewed. The Trust recruited an additional number of staff all of whom have been appointed, have completed induction and are in post. The Emergency Department nursing levels have been reconsidered by the clinical team, supported by central nursing, using BEST methodology. In October 2013 the department was staffed as follows **Band 7**: 8.2 **Band 6**: 8.0 **Band 5**: 51.19 **Band 3**: 13.78 **CE**: 1.00 **Total**: **82.17** **ENP's**: 5.8 A review of nurse staffing at this time indicated an increase in nurse staffing to 87.48 WTE which would enable an increased number per shift within the department. Recruitment was commenced at this time. In addition to this increase, the preliminary RQIA report made some further staffing recommendations, and this was increased to 100 WTE. Recruitment process for all these new posts is completed. However, due to natural attrition, there has been some difficulty in maintaining the 100WTE as a consistent number. All vacant posts, as they arise are submitted to the scrutiny panel and approved by return. The lead in time can	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			result in delays between staff leaving and appointments being made. There is a band 6/7 on duty 24/7 who oversees the clinical practices of the nursing team, providing support, supervision advice and guidance. There has been a change to Band 6/7 rota to enable 2 Sisters/ Charge Nurses to be on duty until 2am. The skill mix is 87% registered staff to 13% non-registered nursing support staff. The review of nurse staffing was completed in February 2014 and recruitment completed in May 2014. A further BEST review was carried out in June 2014. There has been a further objective validation carried out by NIPEC as part of a Regional review. Staffing levels will be kept under close scrutiny by the Associate Director of Nursing and the Clinical coordinator.	
3.	It is recommended that nurse staffing in the resuscitation area is reviewed to enable provision at a level of one nurse to one patient.	Central Nursing / ED	The Funded staffing level allows for 3 staff to be allocated for 1-1 care for patients in Resus. When there are vacancies and or staff absence, a request is made to Bank to fill the deficit. The nurse in Charge will move resource as required to match the requirement of the patient dependency on a shift by shift basis. During the month of December, there was a peak of short term sickness. This is currently being reviewed and managed under the Attendance Management Policy. The contingency approach was that no other staff were facilitated with annual leave requests to maximise staff resource for the Christmas period. The Clinical co-ordinator and Nurse in Charge are responsible for ensuring that staff are rostered and allocated	Ongoing

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			in accordance with service need. Overall staffing levels are reviewed on a monthly basis.	
4.	It is recommended that nurse staffing in the focused assessment area is reviewed.	Central Nursing / ED	Nurse staffing for the focused assessment areas has been reviewed. 100 WTE allows for an increase of nurses in the focussed assessment area which now gives us the ability to flex staffing levels depending on patient acuity. The Clinical co-ordinator and Nurse in Charge are responsible for ensuring that staff are rostered and allocated accordingly. This was considered as part of the review of nurse staffing completed in February 2014 and recruitment completed in May 2014. We continue to recruit to vacant posts as they arise. If it is anticipated that additional staff are required to care for patients waiting for admission to the wards the senior sister requests bank staff to care for these patients. Overall staffing levels are reviewed on a monthly basis.	
5.	It is recommended that there a review should be undertaken of the provision of support services to ED.	Patient Client Support Services/ED	A review in respect of support services has been undertaken in consultation with the clinical team by the PCSS senior team and is now complete. There is a dedicated portering team based in the Emergency Department 24/7. This was put in place in January 2014. There were some initial problems post implementation which have since been resolved through Trade Unions. There are also enhanced cleaning services in place with dedicated cleaning staff for the emergency department until 10 pm with further services then available from the night	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			cleaning team until 7am. Additional catering provision is in now place which is overseen by the catering manager / supervisor regularly to ensure adequate food and beverage provision is available. Supplies of water, bread tea and coffee are available in the department at all times and emergency stores are readily available for times of surge. Estate Services have being contacted regarding door to restrict access to the Department. Currently waiting for a response from Estates Security is readily available 24hrs a day with hourly walk through and more frequent visits to ED by Security officers. A proposal for a 24 hour presence is being considered. Security management and PSNI Crime Prevention met with Sister in Charge and performed a walk about. ED staff were offered and availed of visits to the CCTV Control Room to view the coverage within ED. Additional security patrols are in place since new rotas were introduced. A portfolio providing an overview of security within ED was produced for the benefit of ED staff detailing all the CCTV installations, door access locations and panic alarm points/activation procedure. A photographic still of each camera was also made available. A protocol was also made available regarding seeking security and/or PSNI assistance. Posters are in place regarding Zero tolerance and are currently being reviewed.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
6.	It is recommended that a learning needs analysis is undertaken to facilitate career development for all of the nursing team in ED. Nurse education should also focus on learning from incidents and the principles of safety.	The ED and Directorate team supported by Central Nursing	A learning needs analysis is undertaken annually to facilitate career development of all the nursing teams. The educational requirements will be commissioned as identified by the clinical education facilitator and department Sisters. Staff have a two-week taught induction to support mandatory educational requirements facilitated by the clinical education centre. They then have a six week supernumerary period in the department which is facilitated by the Clinical Education Facilitator. We have contributing to the Regional NIPEC document on ED Nursing Career Framework. The nursing staff undertake Manchester Triage training within their first three months of appointment. Staff will be allocated to work in Ambulance triage with other experienced staff in the first instance when they are deemed to be competent to do so. This enables them to develop their knowledge and skills with the support of experienced colleagues. After one year and once deemed competent in triage by the senior nurse or their mentor, staff will then be allocated to work in the main triage area, where they will take decisions to place patients as dictated by their clinical need and in accordance with the Manchester Triage categorisation. All newly qualified staff undergo preceptorship for a period of six months which will be regularly reviewed and tailored to the needs of the individual nurse. They are also required to complete a portfolio of evidence of their learning within one year and this is overseen by their preceptor and the clinical educator. All new staff appointed to ED have periods of supervised practice in all clinical areas within the department and additional support offered as required.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			All nursing staff have their individual needs both professional and personally identified through their KSF/PDP and supervision. Annual review figures = 72% Clinical supervision 1^{st} = 98% Clinical supervision 2^{nd} = 80% All nursing staff complete the supervision sessions as required by the CNO standards. Ward sisters review on a monthly basis. Staff Meeting TOR/ Sample minutes Communication strategy Senior Nurse contribution to NIPEC Professional Framework for Emergency Care Nursing continues. Next phase of project to include full consultation with staff.	
7.	It is recommended that processes are reviewed to improve the retention of staff, and to ensure that staff have appraisal and supervision sessions in line with the Belfast Trust policy.	The ED and Directorate team supported by Central Nursing	A Learning & Development / Support programme is in place for all new nursing staff and managers. The development programme focuses on role modelling behaviours, coaching, leadership and team development. This is considered key to retention. Exit Interview questionnaires are sent by the Senior Nursing Sister to all nursing staff on receipt of their resignation. To date we have received a nil return. One to one exit interviews will now be offered to staff that plan to leave. Team leaders will be responsible for conducting Exit Interviews. All current Work Life Balance applications and Secondments requests are considered and approved where feasible. CNO Supervision standards, figures at end of January r for	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			ED are: Clinical supervision 1st = 98% Clinical supervision 2nd = 80% Annual reviews and CNO Supervision standards are assigned to the Ward Sisters / Charge nurses. Development of Staff Newsletter, re-establishment of Team Meetings and development of a Communication Framework to improve employee engagement, cascade of key messages and improve opportunities for employee-manager listening.	
8.	It is recommended that systems are put in place to ensure that where staff report on incident which indicate safety issues, feedback should take place such as an e-mail. Staff should also be provided with an analysis of trends in incidents, relating to their area of work, on a regular basis.		Staff meeting takes place every 4 weeks and are coordinated by the senior sisters. Safety issues are a standard item on the agenda and are presented at each meeting. Senior Nursing staff meetings take place monthly. Senior Nursing staff in ED provide twice daily safety briefings which is noted on the Department's white board. This is complimented by hourly walkarounds by the Consultant and Nurse in Charge. There is also Board Rounds three times per day by the Clinical team supported by a Senior Nurse. Staff have being appraised of how to raise and escalate concerns in relation to safety All IR1 forms are reviewed by the Senior Sister and the Clinical Coordinator, and where deemed necessary, individual feedback is given to the member of staff. Monthly governance meetings take place with the Governance Lead. At these meetings the SAIs are reviewed and learning identified and shared across the EDs and sometimes regionally. Morbidity and Mortality (MMs) take place monthly. The Trust ED teams meet every six weeks regarding	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			operational business of which safety is a standing item. From 1st November 2014, the Bands 6s and 7s report their audit activity and associated action plans to the Senior Sister and Clinical Co-ordinator. Currently developing and implementing a new standardised ward based performance scorecard which will present trended measures in a range of performance areas including reported incidents. A PSNI Site Risk Assessment was carried out on the 11th November, 2014.	
9	It is recommended that there is an immediate review of emergency medicine consultant numbers for the ED at RVH.	ED	A review of ED Consultant numbers has been undertaken. Funding has been secured and appointed to 15 of the 16 consultant positions. Recruitment to Middle Grade positions is on-going. Recruiting to 3 ENP positions for the Trust which will assist with absences in middle grade rota. 2 trainee ACPs are in post and will train further applicants in line with the Regional ANP programme.	
10	It is recommended that specialty triage decisions are taken as early as possible to reduce pressure and prompt patient flow.	ED	RVH ED is currently piloting Advanced Triage Treatment by emergency nurse or doctor "ATTEND" to enable early triage decisions AMU Consultants are undertaking speciality triage of patients within the Emergency Department, with early senior review to facilitate timely specialty triage of patients. It is further proposed to undertake this function within a Clinical Decision Unit (CDU) co-located with AMU.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
11.	It is recommended that regular staff meetings are held for staff working in the ED department.	ED	This recommendation has been reviewed through staff support clinics and the following actions agreed, effective immediately: • Team brief takes place 2-3 times per day at set times to accommodate shift patterns. Brief will be led initially by manager/sister in charge. • A monthly team meeting takes place. Agenda items include feedback to staff from SAI's, IR1's, complaints, patient compliments and staffing developments. A quarterly staff newsletter has been designed and issued.	
12.	It is recommended that additional systems are put in place to support staff working in ED and help them deliver person centred and compassionate care.	Unscheduled Care /Human Resources / Occupational Health / Central Nursing / /Risk & Governance	This recommendation has been reviewed through provision of staff support clinics and the following actions agreed and communicated to staff, effective immediately; • To ensure our communication, terminology and language is person-centred. • Improved communication structures including regular ward / team briefings • Further investment in nurse to patient ratio to improve quality of care and to help provide a safer environment • Learning & Development interventions to support all staff and new employees • A review and improvements to resources and ways of working, both clinical and operational	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			• Draft Nursing Contingency plan has being submitted for consultation. This will be included as part of the local Escalation plan to ensure that nursing staff focus on safeguarding and maintaining positive patient experience. • A Clinical Co-ordinator • A Clinical Director has been appointed from the current group of RVH ED Consultants • A Governance Safety lead. • An Associate Director of Nursing for Unscheduled Care The ED has recruited four additional ED Trackers. ED Occupational Health and Health and Safety completed a stress survey in April 2014, the results of which were shared with staff. Findings have been shared with ED. Stress Risk assessment has been completed and initial consultation with Trade Unions taken place. Review of Zero Tolerance Policy, display of posters, enforcement of rules regarding abusive patients and relatives (including liaison with Security staff) and review of Security staff base. The nursing component of the local Escalation plan has being developed to focus on safeguarding and Maintaining positive patient experience. A poster campaign post stress survey is planned which will focus on the health and well-being of all staff which will identify resources for staff to avail of and encourage staff	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			participation. A Nurse in Charge Action Card is being piloted. Band 7 Development Day with RCN planned for January 2015.	
13.	It is also recommended that the organisational culture is reviewed, in relation to breaching the 12 hour waiting time standard, to ensure that there are not inappropriate behaviours in the drive to achieve this target.	Human Resources / Occupational Health / Central Nursing / Unscheduled care	The Chief Executive has made it clear that it is and was the Trust's expectation that patients are admitted to beds on the basis of clinical priority and thereafter by waiting time. The Trust has commenced a new process of on-going improvement with the aim of improving patient safety, experience and outcomes by empowering medical and other clinical staff to design and implement the changes necessary including patient waiting times in the ED (IMPACT). The underpinning culture is one that is medically led, clinically collaborative and managerially supported in terms of the focus on unscheduled care as a move to improve overall performance and not just the 12 hour target.	
Safety				
14.	It is recommended that the internal ED escalation plan criteria and the trust escalation policy are reviewed.		At the time of inspection, the Trust had a revised trust escalation policy in draft based on speciality agreed triggers and actions to maintain patient flow within each speciality. Revised escalation and capacity plan in place and a table top exercise to test the plan has taken place on 21st October 14 and learning points to be actioned and Escalation Plan document reviewed. There is a further pilot of the Escalation plan scheduled for 2nd December, 2014. Additional information is being obtained for submission to the RQIA following inspection on 16th December, 2014. As a consequence of this review, it became apparent the process for this is not presently consistent. It is planned to discuss this with the senior team.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
15.	It is recommended that the Belfast Trust identifies any immediate opportunities to improve flows out of ED, to reduce pressures and overcrowding.	Exec Team	The Trust has commenced a new process of on-going improvement with the aim of improving patient safety, experience and outcomes by empowering medical and other clinical staff to design and implement the changes necessary for sustained improvement. There are 7 medically led work streams, the chairs of which sit on a co-ordinating group with service Directors and the Medical Director (chair). Each of the work streams below has a specific set of objectives; • Frail Elderly • Respiratory • Emergency Department • Flow and Take • Ambulatory care • Resource • Diagnostics The Co-ordination group will report progress to the Executive team and Chief Executive on a fortnightly basis via an update from the group chair. - In partnership with ALAMAC we have commenced an operational system designed to improve patient experience by enhancing flow and avoiding delays. -An Assessment and Direct admission facility for Frail Older persons in the BCH was established in October, 2014 – BCH	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			Direct. Bed profiling exercise is now complete which better aligns the number of speciality beds to meet demand. This is particularly relevant in respiratory medicine Rapid Access Neurology Clinics (RANC) have been established to improve patient access to specialist neurology opinion, reducing the number of patients requiring admission. We are progressing to implement a neurologist of the week.	
16.	It is recommended that systems are reviewed to ensure that staff in ED are equipped to adhere to the Belfast Trust's infection prevention and control polices.	ED / Central Nursing	The management of effective Infection Prevention and Control measures particularly in relation to procedures on hand washing remains an on-going imperative for the ED. Appropriate Infection Prevention and Control policies are part of mandatory training and updates. The Infection Prevention and Control Team works closely with the Emergency Department to support effective infection prevention and control on an on-going basis across all disciplines. Infection Prevention Control (IPC) refresher training is on the Trust mandatory training programme. IPC work closely with the relevant Nursing Development Lead (NDL) who delivers ANTT training. Four nurses and staff from ED have attended this training each month since January. Records indicate that 12 staff require training in Antiseptic Non Touch Technique. Regular peer hand hygiene audits take place weekly. Independent hand hygiene audits also occur as part of the regular audit cycle if observed within the area. The results of these audits are available and shared with all disciplines within the department. The results are recorded on the balanced scorecard and variances discussed at the Co-Director governance meeting.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			Action plans are submitted for non-compliance. In August 2014 the hand hygiene audit compliance was 100%. External IPC team review demonstrated a significant disparity against peer audits with a very poor result in September of 10%. This is not acceptable and a further internal action plan was instigated to engage multidisciplinary review, evaluation of data and set improvement standards. Nursing Development Lead and Assistant Service Managers undertaking spot audits. This is monitored via the Directorate governance teams to the HCAI Improvement Team. Current independent audit scores for November = 100%. As part of the RQIA inspection, they carried out hand hygiene independent audits, the results of which were 70% and 80%. Issues highlighted use of PPE and uniform compliance and both of which have been highlighted to members of the clinical team. HCAI meeting was held with the Directorate Senior team to discuss current position. A HCAI recovery plan has been developed.	
17.	It is recommended that nursing documentation in the ED is reviewed, and recording improved to ensure that all patient needs are identified.	Central Nursing / ED	A review of nursing documentation has taken place. New Nursing documentation has been introduced and an audit of compliance with the new documentation has been completed. Guidance for nursing has been developed on the use of this documentation. The Trust is also working with the regional records group to devise a regional ED record. During the RQIA inspection, some deficits in nursing documentation were identified and immediate actions have	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			been implemented to address this. Nursing documentation audit form has been updated to include risk assessments. Each responsible Nurse in Charge will provide individual feedback at the six-weekly senior nurse meeting. Any necessary immediate actions will be discussed and implemented.	
18.	It is recommended that all risk assessments are completed within the set timescales, these should be reviewed and updated on a regular basis or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.	Central Nursing / ED	Nursing documentation has been revised and now encompasses the relevant risk assessments for example falls, pressure area and risk of absconding The risk assessments required to be undertaken are identified as part of the nursing admission documentation with the relevant assessment templates included in this documentation. Nursing staff in the ED and new Medical Assessment Area will be reminded of the need to ensure all relevant risk assessments are undertaken and this will be monitored by Nurse in Charge. Audit of same will be undertaken and formal feedback given at each Sister/ Charge nurse meeting with dissemination through the staff teams at the staff meetings. Monthly audits are carried out of EWS charts and actions identified as required**.**	
Environment				
19.	It is recommended that In the interim period, pending the opening of a new ED, a review of the existing environment should be undertaken to identify measures that could improve the situation. ED staff should be involved in the planning of the new department.	ED	***Existing Department*** An environmental review has previously been completed and no further building measures can be taken to improve the situation for the existing building. Hence there is a focus on improving the environment through reducing the potential for crowding. Estates Dept has refurbished RVH ED with new antibacterial wall covering and bumper rails.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			New Department The Trust would like it noted that Senior Medical and Nursing staff have led on both the original design and subsequent redesign of the ED and have attended site visits to the new department. Move to new facilities is planned for Jan 2015 There is a dedicated ED commissioning nurse and there is an appointed clinical lead. Patient pathways and new ways of working are piloted in the current ED in preparation for the move to the new ED. • ED commissioning sister attends and updates all senior staff and business meetings. • ED multidisciplinary representation at commissioning subgroup and Standard Operating Procedures group. • Senior Nursing and Medical staff represented on new ED procurement groups where appropriate. • Work is on-going with the Commissioners regarding IPT.	
20.	A review of resources should be undertaken to ensure that items of stock/non stock equipment are available, for example pillows and blankets.	ED / Patient Client Support Services	A review of resources has been undertaken and any appropriate procurement action taken. This is subject to on-going review and close monitoring. Additional stocks of laundry to be held by PCSS for times of increased requirement. Contractual arrangements with external provider are under review. Persisting issues have necessitated escalation. Immediate actions following the December RQIA inspection which included a mattress survey and any identified as being unsuitable were removed.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			All faulty trolleys were reported to the Estate Department and were subsequently repaired.	
21.	The availability of essential patient equipment is reviewed, such as Baxter IV pumps, cardiac and observation monitors.	ED	A review of essential patient equipment requirements has been undertaken and any appropriate procurement action taken. Capital bids have been submitted and approved to allow the purchase of monitoring and resuscitation equipment and now at the procurement stage. The sister/charge nurse is responsible for this on an on-going basis and will be reminded of this.	
22.	A review of equipment that is old or needs to be replaced should be undertaken, including patient trolleys.	ED	A review of equipment has taken place and any needs identified have been addressed. A number of new patient trolleys have been purchased and are in use in ED. Continuing responsibility for this action is part of the Service Manager / delegated to Clinical co-ordinator as appropriate. Immediate actions following the December RQIA inspection which included a mattress survey and any identified as being unsuitable were removed. All faulty trolleys were reported to the Estate Department and were subsequently repaired.	
Patient Experience				
23.	It is recommended that staff should be supported to ensure appropriate care and privacy is given, and that patients are treated with dignity and respect.	Unscheduled Care /Human Resources / Occupational Health / Central Nursing	Staff are committed to maintain patient privacy and dignity at all times. This is assessed on an on-going basis and staff are supported to mitigate risk and ensure dignity and privacy is maintained at times of overcrowding. Staff shadow the patient's experience as part of their induction programme. Feedback from this will be collated and shared with the team.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
			10,000 voices project continues and the ED have established a working group which focuses on extracting the themes from the patient stories which are then shared with staff.	
24.	It is recommended that there is a system in place to identify patients who require a meal and sufficient staff to ensure patients receive the appropriate assistance with their meals.	ED / Patient Client Support Services	Arrangements are now in place to ensure that tea, coffee and water are available at all times for patients and relatives. It is the responsibility of the nursing staff to identify patients' requirements at meals times and to ensure they are provided with adequate support and assistance. Team Leaders of each clinical space are allocated to oversee that patient's nutritional needs are met. Food provision and requirements for the ED are assessed for each meal time and a variety of suitable snacks and hot meals are made available every day. The December RQIA inspection identified on-going issue to meal time experience in relation to "balancing meals whilst on a trolley". A solution to this is being sought. Discussion has taken place between Central Nursing Team and Senior PCSS staff in relation to how the meal time experience can be improved. Members of the catering team attended the ED staff meeting in January, 2015 and discussed possible improvements in current service provision. A new fridge to provide chilled foods for patients has now been installed. Acknowledgement has been given to the limitations of the current system in use for patients requiring meals in ED and an alternative system is being considered and this will include support from the Central Nursing team.	

Reference number	Recommendations	Designated department	Action required / completed	Date for completion/ timescale
25.	It is recommended that the Belfast Trust should monitor and action patient, relative, and carer comments to improve the patient experience.	The ED and Directorate team supported by Central Nursing	The Trust continues to monitor the patient and client experience through a number of tools including 10,000 voices and the patient and client experience standards. An ED working group was established to extract the themes from the 10,000 Voices with plans now to develop an action plan to implement improvements as appropriate. A presentation of 10,000 voices and patient experience was presented to the public trust board on March 13th 2014. A further ED patient satisfaction was carried out in May 2014. The second phase of 10,000 voices will be rolled out early 2015. As part of the induction process for newly appointed nursing staff, they will shadow a patient's journey through ED to identify areas for improvement through 'Fresh Eyes'. Patient and relative engagement – two patients have been identified in the process to formalise this. Senior nurses from ED have been involved in the regional Fundamentals of Care Audit tool.	

Summary: AMU

Ref No	Recommendations	Action	Status
Staffing			
1.	It is recommended that there is clarity of the functions of AMU and specialist units in relation to take-in. Review timing of key meetings to ensure that specialty triage decisions are taken as early as possible.	Clarity of functions of AMU was undertaken, Acute Physicians undertake specialty triage at 8am, allocating patients to other specialty teams. The AMU team meeting has been moved to later in the morning to facilitate consultants' review of patients under their care. A 4.00pm meeting between Patient Flow Co-ordinator and AMU with Medical Senior decision maker has being implemented A proposal in relation reconfiguration of the AMU has gone to Modernisation team within HR. This will be discussed with Trade Union colleagues.	
2.	It is recommended that a review of nurse staffing levels is undertaken for the AMU to ensure that there are adequate levels of staff to provide all the functions of the unit.	Completed and on-going.	
3.	It is recommended that that the AMU ward sister has protected time for management duties and that staff have appraisal and supervision sessions in line the trust policy.	Completed.	
4.	It is recommended that a learning needs analysis is undertaken to facilitate career development for all of the nursing team in AMU.	Completed. HR colleagues will delivery bespoke training Jan/Feb 2015 with AMU staff.	
5.	It is recommended that processes are reviewed to improve the recruitment of staff.	Exit surveys have been sent to staff who have left.	
6.	It is recommended that any immediate opportunities to improve patient flow to and from AMU, to reduce pressures are identified.	AMU Consultants are undertaking speciality triage of patients within the Emergency Department, with early senior review to facilitate timely specialty triage of patients. It is further proposed to undertake this function within a Clinical Decision Unit (CDU) co-located with AMU.	
7.	It is recommended that there is an immediate review of medical staffing levels in AMU at both senior and junior levels.	Completed and on-going.	
8.	It is recommended that F1 grade doctors in AMU are provided with a bleep.	Completed	

Ref No	Recommendations	Action	Status
9.	A review of resources should be undertaken to ensure that items of stock/non stock equipment are available.	Completed and stock items are ordered as required.	
10.	The essential patient equipment is available.	Essential equipment has being ordered as required.	
11.	There should be a review of administrative support.	There is a Ward Clerk available to AMU nursing staff 24/7.	
12.	It is recommended that ways to improve the tracking of patients and to implement an electronic system as rapidly as possible are identified.	An electronic take list portal system has been developed and introduced which allows acute medical patients to be closely monitored from admission through to onward transfer and/or discharge.	
13.	It is recommended that there is a formal mechanism in place for a formal medical handover at weekends.	Completed	
14.	It is recommended that processes are reviewed to improve the recruitment and retention of medical staff.	Completed	
15.	It is recommended that additional systems are put in place to support staff working in AMU and help them deliver person centred and compassionate care.	Delivery of person centred and compassionate care is monitored by the Nurse in Charge on a shift by shift basis and is on-going.	
16.	It is also recommended that the organisational culture is reviewed, in relation to breaching the 12 hour waiting time standard, to ensure that there are not inappropriate behaviours in the drive to achieve this target.	On-going. As issues arise, they are escalated to the Co-Director on call.	
17.	It is recommended that the current configuration of the ward size and layout are reviewed to provide a more conductive environment for staff and patients.	60 bedded AMU is being re-profiled to 2 wards of 26 beds with two distinct clinical nursing teams. A 6-bedded Clinical Decision Unit (CDU) will be located in one of the 26 bedded ward. The nurse staffing profile is being reviewed in conjunction with the AMU team, Trade Union colleagues and HR to meet the needs of the reconfigured ward.	
18.	It is recommended that staff should prompt and encourage patients to drink.	Patient experience survey is in place to review patient satisfaction.	
19.	It is recommended that there is an effective system in place to identify patients who require a meal and sufficient staff to ensure that patients receive the appropriate assistance with their meals.	A process is in place within AMU to ensure patients receive assistance with meals when required. A meal supervisor is identified on a shift by shift basis by the Nurse in Charge.	
20.	It is recommended that domestic staff should have sufficient time to complete patient bedside discharge cleans.	Completed.	
21.	It is recommended that the Belfast Trust should monitor and action patient, relative, carer comments to improve the patient experience.	There is a programme on-going within the Unit to obtain user feedback while patients remain within AMU.	

Ref No	Recommendations	Action	Status
22.	It is recommended that staff should be supported to ensure appropriate care and privacy is given, and that patients are treated with dignity and respect.	It is the responsibility of all staff to ensure patient privacy and dignity is maintained. Staff is advised to raise concerns. A Buddying system approach is in place.	
23.	It is recommended that there is a review of patient discharges to minimise delays and ensure patients have the appropriate care package in place.	A complex discharge team is in place. This team includes social work staff and is actively working to eliminate delay in complex discharges. A Steering Group is in place to look at improving practice of simple discharge with a focus on medicine and cardiology on the RVH at the initial phase. A Project Team from AMU are tasked to look at the Discharge letter process within the Unit.	
24.	It is recommended that the assessment of patients' nursing needs should be patient focused and identify individual needs and interventions required. This should be reviewed and updated in response to the changing needs of patients.	The holistic needs of every patient are assessed by nursing staff. This is subject to on-going audits – the results of which are shared with nursing staff with a view to improving care delivered.	
25.	It is recommended that all risk assessments should be completed within the set timescales. These should be reviewed and updated on a regular basis, or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.	Appropriate risk assessments are carried out for every patient in AMU. These are subject to audit and are on-going.	
26.	It is recommended that care plans should be devised for all identified patient needs. These should be reviewed and updated within the set timescale, or in in response to changing needs of patients.	The nurses responsible for the patient care review the care plan on a shift by shift basis and make any updates as required depending on the patient's needs. This is subject to audits which are on-going.	
27.	It is recommended that nnurse record keeping should adhere to NMC and NIPEC guidelines.	Currently, two of the Deputy Ward Sisters are carrying out monthly audits of the documentation and results of which are fed back to staff.	

Area: Acute Medical Unit Area

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
Staffing				
1.	It is recommended that there is clarity of the functions of AMU and specialist units in relation to take-in. Review timing of key meetings to ensure that specialty triage decisions are taken as early as possible.	AMU	Clarity of functions of AMU was undertaken, Acute Physicians undertake specialty triage at 8am, allocating patients to other specialty teams. The AMU team meeting has been moved to later in the morning to facilitate consultants' review of patients under their care. A 4.00pm meeting between Patient Flow Co-ordinator and AMU with Medical Senior decision maker has being implemented. AMU Consultants are undertaking speciality triage of patients within the Emergency Department, with early senior review to facilitate timely specialty triage of patients. It is further proposed to undertake this function within a Clinical Decision Unit (CDU) co-located with AMU. A draft workforce paper is now completed and the draft operational procedure is now developed. A proposal in relation reconfiguration of the AMU has gone to Modernisation team within HR. This will be discussed with Trade Union colleagues.	
2.	It is recommended that a review of nurse staffing levels is undertaken for the AMU to ensure that there are adequate levels of staff to provide all the functions of the unit.	The AMU and Directorate team supported by Central Nursing	The AMU nursing levels have been reconsidered by the clinical nursing team, supported by central nursing, using Telford and Association of UK University Hospitals methodology. In October 2013 the department was staffed at a nurse to bed ratio of 1:1.3. On benchmarking with other similar units the range for nurse to bed staffing is from 1.4-2.17.	

<table>
<tr><th>Ref number</th><th>Recommendations</th><th>Designated department</th><th>Action required</th><th>Date for completion/ Timescale</th></tr>
<tr><td></td><td></td><td></td><td>The following recommendation was made to consider the acuity of patients within the unit at that time, recognising the flow and profile of the patients.

<table>
<tr><th>Beds</th><th>NTBR</th><th>Staffing</th></tr>
<tr><td>10 beds</td><td>1.3</td><td>13</td></tr>
<tr><td>20</td><td>1.4</td><td>28</td></tr>
<tr><td>30 beds</td><td>1.55</td><td>46.5</td></tr>
<tr><td></td><td>Overall NBTR – 1.45</td><td>Required Staffing 87.5</td></tr>
</table>

Further to this increase the preliminary RQIA report made some recommendations, in relation to the role of the ward sister and handover of patients. As a result, funded staffing establishment was increased to 104 WTE, the new staffing model is now 1.71 nurse to bed ratio. Ward Sister/Charge Nurse role was supported to be supervisory.

All new staff in post have undertaking an induction and where required Preceptorship.</td><td></td></tr>
<tr><td>3.</td><td>It is recommended that that the AMU ward sister has protected time for management duties and that staff have appraisal and supervision sessions in line the trust policy.</td><td>The AMU and Directorate team supported by Central Nursing</td><td>A recruitment process on-going for additional Band 6s to maintain the Ward Sister’s supervisory status. The current staffing budget and daily allocation permits protected time for the ward sisters to be supervisory.

Band 6s and 7s met in September 2014 to define and agree roles and responsibilities within the Unit. Following this meeting, 5 Band 6 teams were formed. Each team has responsibility for a number of nurses and will review on a monthly basis their annual reviews, supervision sessions and mandatory training with the assistance of NDLs. Mandatory training is reviewed monthly.
Annual Reviews</td><td></td></tr>
</table>

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			Reviews data for period April 2014 –December 2014 Annual Reviews = 99% Ward Sisters review this figures on a monthly basis. Supervision Session 1 = 95% Supervision Session 2 = 67% Ward Sisters assist Band 6 teams to review these figures on a monthly basis and report to Clinical Coordinator and Associate Director of Nursing who will update the Executive Director of Nursing monthly.	
4.	It is recommended that a learning needs analysis is undertaken to facilitate career development for all of the nursing team in AMU.	The AMU and Directorate team supported by Central Nursing	A learning needs analysis is undertaken annually to facilitate career development of all the nursing teams. The educational requirements will be commissioned as identified by the Ward Sisters supported by the Nursing Development Lead. Staff training needs have being identified which will inform the annual commissioning cycle. All new staff have a two-week taught induction to support mandatory educational requirements facilitated by the Clinical Education Centre. They have a two week supernumerary period in the department which is facilitated by the ward sisters and their deputies. All newly qualified staff undergo preceptorship for a period of six months which will be regularly reviewed and tailored to the needs of the individual nurse. All staff are supported to attend mandatory training both corporate and clinically required, eg NIV training Band 5 staff were supported to attend Away Days which took place from September through to October. They are being given the opportunity to share their concerns and	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			ideas of ways to improve the unit. On conclusion of the away day events, action plans will be completed, implemented and reviewed. Action plans are now agreed**.** HR will be delivering bespoke training Jan/Feb 2015 within AMU.	
5.	It is recommended that processes are reviewed to improve the recruitment of staff.	Clinical Coordinator supported by HR & Central Nursing	A review of recruitment processes with HR and Nurse Workforce Lead has taken place. Exit survey has being sent to staff. A number of responses have been received from staff indicating the reasons for leaving as career progression opportunities.	
6.	It is recommended that any immediate opportunities to improve patient flow to and from AMU, to reduce pressures are identified.	The AMU and Directorate team supported by Performance & Planning / Central Nursing	AMU Consultants are undertaking speciality triage of patients within the Emergency Department, with early senior review to facilitate timely specialty triage of patients. It is further proposed to undertake this function within a Clinical Decision Unit (CDU) co-located with AMU. ALAMAC project commenced in the Trust on 1 September, 2014 which uses patient numbers objectively which will prevent crisis and predict the future capacity and demand. AMU contributes to these meetings along with other Trust colleagues. A simple Discharge Steering Group was set up in October, 2014 to look at improving practice of discharge with a focus on medicine and cardiology on the RVH at the initial phase. A presentation to the Flow & Take IMPACT group and Executive Team has taken place. An Expeditor role within AMU was trialled in October, 2014. Outcome from this was that clinical staff were freed to delivery more direct patient care, however, the role did not significantly contribute to reduce length of staff or more timely diagnostic within AMU.	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
7.	It is recommended that there is an immediate review of medical staffing levels in AMU at both senior and junior levels.	AMU	Medical staff levels have been addressed and found to be adequate (6.5 senior medical staff and 3 staff grades, plus a team of trainees). Northern Ireland Medical and Dental Training Agency (NIMDTA) have allocated 6 Foundation Year 1s to AMU with effect from Aug 14.	
8.	It is recommended that F1 grade doctors in AMU are provided with a bleep.	AMU	All FY1s in AMU have been provided with bleeps.	
9.	A review of resources should be undertaken to ensure that items of stock/non stock equipment are available.	AMU	A review of resources has been undertaken and any appropriate action taken. The sister/charge nurse is responsible for this on an on-going basis. The Housekeeper role is currently in the recruitment process.	
10.	The essential patient equipment is available.	AMU	A review of essential patient equipment requirements has been undertaken and any appropriate action taken. Continuing responsibility for this action is part of the Ward Sister/Charge Nurse and Clinical Co-ordinator role.	
11.	There should be a review of administrative support.	Planning & Performance	Additional administrative support is in place to ensure 24/7 clerical support in AMU.	
12.	It is recommended that ways to improve the tracking of patients and to implement an electronic system as rapidly as possible are identified.	Planning & Performance	From February 2014 as an immediate response to this recommendation, additional clerical staff were assigned to the wards across the 24 hour period to improve patient tracking. An electronic take list portal system has been developed and introduced which allows acute medical patients to be closely monitored from admission through to onward transfer and/or discharge. The focus was primarily to address the patient	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			tracking issues for those patients who were admitted via Emergency Department to Acute Medicine. This was the group of patients that gave rise to most of the patient tracking problems. This has been tested by clinicians in AMU and has gone live in AMU. This has been viewed as a positive development for the Acute Medical team in the tracking of patients. Patient Tracking project team are now focussing on other areas to improve the process further.	
13.	It is recommended that there is a formal mechanism in place for a formal medical handover at weekends.	Unscheduled Care	This recommendation has been addressed. A formal mechanism of medical handover for AMU is being put in place at week-ends Introduced a 4pm meeting between Patient Flow Co-ordinator and AMU with Medical Senior decision maker.	
14.	It is recommended that processes are reviewed to improve the recruitment and retention of medical staff.		It is recommended that processes are reviewed to improve the recruitment and retention of medical staff.	
15.	It is recommended that additional systems are put in place to support staff working in AMU and help them deliver person centred and compassionate care.	Human Resources / Occupational Health / Central Nursing / Unscheduled care / Risk & Governance	Feedback from workshops - (verbal – Leadership Centre - It is anticipated that a written report has been received from the Leadership Centre- November) suggested new ways of working within the Unit. A pilot of “buddying system is in place to ensure support of the continuity of care by staff to their allocated patients, e.g. each Band 5 is buddied with another Band 5 to ensure support and cross floor clinical activity. The “Buddying System” will be reviewed end of December, 2014 and feedback from staff was positive. Questionnaire response have being completed. On every shift there is a Nurse in Charge who is responsible	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			for the overseeing that patient centred dignified care with compassion is being delivered by the team. A monthly team meeting takes place. Agenda items include feedback to staff from SAI's, IR1's, complaints and patient compliments. In addition the following staff have been appointed; • A Clinical Co-ordinator • A Clinical Director has been appointed from the current group of RVH ED Consultants • An Associate Director of Nursing for Unscheduled Care Occupational Health and Health and Safety Departments completed a stress survey in April 2014, the results of which were shared with staff. Findings have been shared with AMU management, training was undertaken with staff in September and a stress risk assessment is currently underway. There has being pilot of Patient/Family Experience Survey of AMU. Most recent audit is 100% positive experience. There are a number of comments which were not covered in the audit that patients requested which are now being looked at. A further 14 patients have completed the Patient Experience survey. An action plan completed.	
16.	It is also recommended that the organisational culture is reviewed, in relation to breaching the 12 hour waiting time standard, to ensure that there are not inappropriate behaviours in the drive to achieve this target.	Human Resources / Occupational Health / Central Nursing /	The Trust has commenced a new process of on-going improvement with the aim of improving patient safety, experience and outcomes by empowering medical and other clinical staff to design and implement the changes necessary including patient waiting times in the ED.	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
		Unscheduled care	The Chief Executive has made it clear that it is and was the Trust's expectation that patients are admitted to beds on the basis of clinical priority and thereafter by waiting time.	
Environment				
17.	It is recommended that the current configuration of the ward size and layout are reviewed to provide a more conductive environment for staff and patients.	AMU	60 bedded AMU is being reprofiled to 2 wards of 26 beds with two distinct clinical nursing teams. A 6 bedded Clinical Decision Unit (CDU) will be located in one of the 26 bedded ward. The remaining beds are to be allocated to Gastroenterology & Frailty unit or General medicine. Nursing staff are being reallocated to three ward teams. Discussions are ongoing with nursing staff in conjunction with HR and Trade Union colleagues.	
18.	It is recommended that staff should prompt and encourage patients to drink.	The AMU and Directorate team supported by Central Nursing	It is the responsibility of the nursing staff to identify patient's requirements at meals times and to ensure they are provided with adequate support and assistance. This is overseen by the nurse in charge. A meal time supervisor is nominated on every shift to oversee patient meals being delivered. Discussions have taken place with Central Nursing and Catering to review breakfast arrangements. Relevant policies are available and will be highlighted to staff to ensure compliance with policy. A patient/family experience survey of their experience of care in AMU. Initial feedback was 100% positive. As part of the documentation audit, a review of the Fluid Balance chart will also be included. A further 14 patients have completed the Patient Experience survey. 100% of those who completed were satisfied with the drinks service.	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
19.	It is recommended that there is an effective system in place to identify patients who require a meal and sufficient staff to ensure that patients receive the appropriate assistance with their meals.	The AMU and Directorate team supported by Patient Client Support Services	There is a system in place to ensure that all patients who require assistance are identified and this has been reviewed. A meal time supervisor is nominated on every shift to oversee patient meals being delivered. It is the responsibility of the nursing staff to identify patient's requirements at meals times and to ensure they are provided with adequate support and assistance. This is overseen by the shift coordinator. On-going feedback will be gathered from the patient/family experience survey and action plans written implemented and evaluated when required. A further 14 patients have completed the Patient Experience survey. 100% of those who completed were satisfied with the meal service provided. Ward Sisters are carrying regular observations of meal times to ensure that the systems in place are working well. On conclusion of the workshops, action plans will be completed, implemented and reviewed in conjunction with the Catering Department. Ward sister met with catering staff 21/11/14 A meal time Patient Experience working group is now established.	
20.	It is recommended that domestic staff should have sufficient time to complete patient bedside discharge cleans.	The AMU and Directorate team supported by Patient Client Support Services	The nursing team will identify areas which require cleaning in a timely manner to the cleaning team in hours and to the supervisor out of hours. Enhanced cleaning service in place for AMU. Working in partnership with estates and domestic cleaning, the senior nurses in AMU have carried out mock environmental cleanliness audits. A positive outcome was achieved with actions identified and resolved.	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
Patient Experience				
21.	It is recommended that the Belfast Trust should monitor and action patient, relative, carer comments to improve the patient experience.	Directorate team supported by Central Nursing/ Unscheduled Care	The Trust continues to monitor the patient and client experience through a number of tools including 10,000 voices and the patient and client experience standards. Local areas then agree all action plans within their directorate. This is monitored through directorate governance processes, to patient and client working group and the Assurance structure to the trust board. A presentation of 10,000 voices and patient experience was presented to the public trust board on March 13th 2014. On-going feedback will be gathered from the patient/family experience survey and action plans written implemented and evaluated when required.	
22.	It is recommended that staff should be supported to ensure appropriate care and privacy is given, and that patients are treated with dignity and respect.	Unscheduled Care/ Human Resources / Occupational Health / Central Nursing	Work is underway through Support clinics with staff to identify and address any barriers to providing the appropriate level of privacy, respect and dignity to patients. It is the responsibility of all staff to maintain patient privacy and dignity at all times. Staff are advised to raise any concerns with their inability to do this on a shift by shift basis to the Nurse in Charge. Band 5 staff were supported to attend workshops which took place from September through to October. They are being given the opportunity to share their concerns and ideas of ways to improve the unit. As Per feedback from initial workshops, new ways of working within the unit are being trialled week beginning 20th October, eg each Nurse has been allocated to a Band 6 Team Leader. Discussions have taken place with HR colleagues to progress this work. Staff have been split into 5 teams under the Band 6s. The	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			allocation of staff on the floor has also been reviewed to allow a' Buddying system' ,to ensure support of more junior staff and those in areas where patients are more dependant. Staff will be asked for their feedback on the new ways of working and results will be reviewed by the Ward Sisters to assess effectiveness at the end of December, 2014. Questionnaire has being completed with positive feedback. Following RQIA feedback in December regarding call bell, patient tailored experience was promoted with staff and discussed at Ward Meeting on the 3 December, 2014.	
23.	It is recommended that there is a review of patient discharges to minimise delays and ensure patients have the appropriate care package in place.	Older people's services	A complex discharge team is in place. This team includes social work staff and is actively working to eliminate delay in complex discharges. Implement access to care management, community and rehabilitation services 7 days a week/rehabilitation, increased care packages, rapid response teams at weekends. In partnership with ALAMAC we have commenced an operational system designed to improve patient experience by enhancing flow and avoiding delays. A Steering Group in place to look at improving practice of simple discharge with a focus on medicine and cardiology on the RVH at the initial phase. A Project Team from AMU are tasked to look at the Discharge letter process within the Unit. The project team is awaiting on laptops to process this further.	
2 4.	It is recommended that the assessment of patients' nursing needs should be patient focused and identify individual needs and interventions required.	AMU sisters supported by clinical	This is outlined in trust policy / nursing documentation and NMC standards.	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
	This should be reviewed and updated in response to the changing needs of patients.	coordinator and Central Nursing	Audit to be undertaken. Clinical Co-ordinator will be responsible for ensuring policy and standards are adhered to. A Deputy Ward Sister has been identified in AMU to carry out regular audits on nursing documentation; feedback has been given personally, via the communication boards and staff meetings**.** Further audits by designated Deputy Ward Sister have taken place on documentation and ward sisters have been monitoring on ward rounds and giving feedback to staff. Audit in August in AMU discussed with NDL and further teaching sessions to be provided for all staff on importance of documentation .This is to include nurse care planning /updating and completion of risk assessments. Staff have been trained in how to use the NIPEC Audit Tool. The quarterly audit data are currently being populated for January. Plan to give Designated deputy Ward Sister time to complete teaching sessions on the ward with the support of the NDL to enable Band 5 Nursing staff to engage fully in the work based learning opportunities. Deputy Ward Sister learning needs completed in the use of the NIPEC Recording Care documentation. Newly appointed Band 6 are undertaking a local Induction Programme The introduction of the Patient Experience Survey will evaluate if patients are happy with the care they received. A patient/family experience survey of their experience of	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			care in AMU. Initial feedback was 100% positive. Specific staff's learning needs have being identified and the NDL is providing teaching sessions to the staff concerned.	
25.	It is recommended that all risk assessments should be completed within the set timescales. These should be reviewed and updated on a regular basis, or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.	AMU sisters supported by clinical coordinator and Central Nursing	The risk assessments required to be undertaken are identified as part of the nursing admission documentation with the relevant assessment templates included in this documentation. Nursing staff AMU will be reminded of the need to ensure all relevant risk assessments are undertaken and this will be monitored by Nurse in Charge. A Deputy Ward Sister has been identified in AMU to carry out regular audits on nursing documentation; feedback has been given personally, via the communication boards and staff meetings. Further audits by designated Deputy ward sister have taken place on documentation and ward sisters have been monitoring on ward rounds and giving feedback to staff. Audit in August in AMU discussed with NDL and further teaching sessions to be provided for all staff on importance of documentation. This is to include nurse care planning /updating and completion of risk assessments. Most recent Audit has shown an increase in compliance October, 2014. Plan to give Designated deputy Ward Sister time to complete teaching sessions on the ward with the support of the NDLs and target specific staff. Deputy Ward Sisters training needs to be discussed with NDL then action plan written and implemented. A patient/family experience survey of their experience of care in AMU. Initial feedback was 100% positive. A further	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
			14 patients have completed the Patient Experience survey. 100% of those who completed were satisfied with the drinks service.	
26.	It is recommended that care plans should be devised for all identified patient needs. These should be reviewed and updated within the set timescale, or in in response to changing needs of patients.	AMU sisters supported by clinical coordinator and Central Nursing	Outcome focused management plan and Nursing Care Plan are put in place for all patients. Staff will be reminded to complete, update and amend as appropriate to reflect the changing care needs of patients as per trust policy and NMC and GMC Record Keeping Guidance. A Deputy Ward Sister has been identified in AMU to carry out regular audits on nursing documentation; feedback has been given personally, via the communication boards and staff meetings. Further audits by designated Deputy ward sister have taken place on documentation and ward sisters have been monitoring on ward rounds and giving feedback to staff. Audit in August In Amu discussed with NDL and further teaching sessions to be provided for all staff on importance of documentation .This is to include nurse care planning /updating and completion of risk assessments. Most recent Audit has shown an increase in compliance October, 2014. Plan to give Designated deputy Ward Sister time to complete teaching sessions on the ward with the support of the NDLs and target specific staff. Deputy Ward Sisters training needs to be discussed with NDL then action plan written and implemented. A patient/family experience survey of their experience of care in AMU. Initial feedback was 100% positive. A further 14 patients have completed the Patient Experience survey. 100% of those who completed were satisfied with the drinks service.	

Ref number	Recommendations	Designated department	Action required	Date for completion/ Timescale
27.	It is recommended that nurse record keeping should adhere to NMC and NIPEC guidelines.	AMU sisters supported by clinical coordinator and Central Nursing	A Deputy Ward Sister has been identified in AMU to carry out regular audits on nursing documentation; feedback has been given personally, via the communication boards and staff meetings. Further audits by designated Deputy ward sister have taken place on documentation and ward sisters have been monitoring on ward rounds and giving feedback to staff. Audit in August In AMU discussed with NDL and further teaching sessions to be provided for all staff on importance of documentation .This is to include nurse care planning /updating and completion of risk assessments. Most recent Audit has shown an increase in compliance October, 2014. Increased compliance demonstrated improvements in record keeping. Plan to give Designated deputy Ward Sister time to complete teaching sessions on the ward with the support of the NDLs and target specific staff. Deputy Ward Sisters training needs to be discussed with NDL then action plan written and implemented. The Nurse in Charge uses the Ward Round checklist on a daily basis to ensure processes in place are having an impact in conjunction with the audits on documentation.	

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