Inspection Report

8 November 2022 - 3 February 2023

Belfast Health and Social Care Trust

Type of service: Emergency Department
Address: Royal Victoria Hospital, 274 Grosvenor Road, Belfast, BT12 6BA
Telephone number: 028 9024 0503

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Responsible Person: Dr Cathy Jack	**Position:** Chief Executive Officer
Person in charge at the time of inspection: Ms Linsey Sheerin	**Position:** Service Manager
Brief description of the accommodation/how the service operates: The Royal Victoria Hospital, Emergency Department, provides a 24-hour emergency service that assesses and treats people who have acute illnesses and injuries that require urgent attention. The Royal Victoria Hospital is designated as the regional Major Trauma Centre for Northern Ireland and as such is equipped and staffed to provide full multi-disciplinary care for the most severely injured patients who arrive via the Emergency Department.	

2.0 Summary

2.1 Summary of Inspection

The Royal Victoria Hospital (RVH) Emergency Department (ED) was subject to an unannounced RQIA inspection that began on 8 November 2022. Interim feedback was provided to Trust Senior Managers on 12 January 2023; and the inspection concluded on 3 February 2023, at which time feedback was further shared with the ED staff team.

The RQIA inspection team was comprised of care, pharmacy, and estates inspectors, together with an administrative support team.

The inspection was carried out in response to the increasing level of intelligence received by RQIA highlighting concerns about the impact of significant pressure in the ED. The intelligence received included Early Alerts to the Department of Health; complaints; and correspondence from the Royal College of Nursing (RCN).

The inspection took place during a period of heightened winter demand, ED department crowding, and long waiting times. Notwithstanding that this report specifically relates to the ED at the RVH; it is also noted that similar issues and challenges are likely to be experienced in other EDs across Northern Ireland.

The inspection focused on the model of ED care; patient flow; staffing (including skill mix, knowledge and practice); environmental factors; ED leadership, management and governance.

The inspection identified a number of areas of concern that were impacting upon the provision of safe and effective patient care.

The specific areas of concern related to: staffing; crowding; Infection Prevention Control/environmental issues; patient care; medicines management; and governance.

As part of the inspection process, the RQIA team engaged with the *Strategic Planning and Performance Group* (SPPG) of the Department of Health (DoH) and senior managers in the Belfast Trust, in order to contextualise findings attributable to increasing service demand, service capacity, and regional service pressures.

During the course of the inspection, the RQIA team also engaged with a wide range of staff groups, including managers, nursing and medical staff, the pharmacist team, support services, community navigators and administrative staff. Through these engagements, we heard from clinical staff who expressed concerns about their ability to provide safe care, which they believed to be as a direct result of the enduring ED pressures.

RQIA inspectors also spoke to patients within the ED during the times that Inspectors where physically in the ED which included week days, night time and weekends.

A total of nine areas for improvement (AFIs) have been made following the conclusion of the inspection.

2.2 Summary of Inspection Findings

The findings of the inspection include:

'Crowding' (The service operating beyond its capacity and core purpose)

- Significant 'crowding' in ED on a sustained basis
- Fire risks due to 'crowding', potentially compromising effective evacuation if required
- Material delays to Ambulances 'off-loading' patients to the ED
- Significant efforts of staff to correctly prioritise presenting patients based on clinical need

Workforce

- Patients recognise staff as being compassionate
- High levels of workforce vacancies
- Staff burnout, well-being issues and low morale – staff express strong concerns
- Extensive use of agency and locum staffing and concern about insufficient time for induction and orientation
- Low uptake of mandatory training due to a lack of time to avail of it and with scheduling of shifts

Infection Prevention and Control

- Extended areas to accommodate increased patient numbers not equipped for purpose
- Cleaning schedules not in place for all areas of ED (compounded by lack of space to conduct cleaning due to 'crowding')
- High levels of hand hygiene and PPE compliance by staff

Safety/ Incidents

- Concerns about medicine management errors and potential under reporting
- Increased reported incidents affecting patient safety, including pressure sores, falls, and medication.

Patient Experience

- Lack of dignity, privacy and confidentiality for patients
- Insufficient support for patients who need help with nutrition and fluid intake
- Some patients anxious about risks

Communications and Leadership

- Staff lack visibility of what plans and actions are being taken to address the pressures, both local to the service and regionally
- No assurance that regional escalation processes due to hospital pressures is consistently applied

(see Section 5.0 for full details)

Inspectors found the service did not comply with the quality standards, set out by the Department of Health for health and social care services in Northern Ireland. It was clear that the ED was operating beyond its core purpose and capacity. This was the result of increased numbers of patients in the department; and patients staying in the ED, beyond their need for emergency acute care, and requiring ongoing care. This was because the pathways out of the ED, whether to admission to hospital wards or for social care needs in the community, were not available. This is often referred to as 'crowding' but it is important to recognise that it is a result of the ED operating well beyond its capacity and beyond its core purpose.

The Inspection identified that, as a result of these issues, the RVH ED service is operating below the *HSSPS Quality Standards for Health and Social Care Services (2006)*. At times inspections of services identify areas that fall below these standards, and work is then required by the provider to take steps to rectify these. In this case, RQIA have a concern that it will be very difficult for the quality standards to be achieved and sustained if the service continues to operate outside of its capacity and core purpose, due to wider system pressures.

This inspection has taken this context into account in identifying areas for improvement within RVH ED, requiring the Trust to take actions to improve safety for patients and for staff, that the Trust can reasonably be expected to address. RQIA acknowledge that achieving compliance with the standards will require service reform across the whole system. Until these wider system issues are resolved, RVH ED will continue to face the severe difficulty of not being in a position to operate within its designed purpose and so not in a position to achieve the quality standards required of it.

2.3 Summary of RQIA Actions

- RQIA will continue to use the evidence identified from this inspection to seek assurance from the Belfast Trust that progress has been made against those areas for improvement that lie within their control, and are set out in the Quality Improvement Plan, and this may be coupled with or result in further actions by RQIA where necessary to encourage improvement.

- RQIA recognise that many of the pressures observed during the inspection are occurring at Emergency Departments across Northern Ireland. We have shared our findings with the Department of Health (DoH), and we will liaise with the Healthcare Policy Group to inform the Service Transformation Programme.

- We will also liaise with the Strategic Planning and Performance Group (SPPG) of the DoH, to inform a regional response to the findings of this inspection report.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how these services were performing at the time of our inspection, highlighting both good practice and areas for improvement. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during the inspection.

This inspection was underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

- In advance of this inspection, a range of relevant information was reviewed, including:

- Previous inspection reports;
- Review of the previous returned Quality Improvement Plans (QIPs);
- Information on Concerns;
- Information on Complaints;
- Other relevant intelligence received by RQIA; and
- Point of care patient feedback reviewed via Care Opinion's website.

Preparations for the inspection also extended to the review of previous *areas for improvement* relating to the inspection of RVH ED that was undertaken as part of a wider RVH inspection on 14 -16 December 2015; and the RQIA unannounced IPC inspection carried out on 2 August 2019.

It is noteworthy to recognise that RQIA also conducted an *Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations, July 2014*.

This inspection included discussions with patients, relatives and staff; observation of practice; and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; management and governance reports; minutes of meetings; duty rotas; IPC (Infection Prevention and Control) audits and training records.

4.0 What people told us about the service

Posters were displayed within the ED informing patients, staff and visitors about the inspection. Staff and patients were invited to complete a questionnaire during the inspection and the results of the returned questionnaires are described within this report. The inspection team also engaged with fifteen patients across ED to gather their views and experiences of the care within the department.

Patient Feedback

Feedback from patients was complimentary of nursing and other staff, including Northern Ireland Ambulance Service (NIAS) staff, with patients recognising and highlighting the efforts made by staff to provide the best possible care despite the significantly challenging context. Patient views are further outlined in Section 5.2.9.

Staff Engagement

A large number of staff across all disciplines provided views. These were gathered individually, in focus groups and via an electronic questionnaire which staff had an opportunity to complete anonymously. Staff described that they were concerned about their ability to provide safe care at all times but were positive about the support they provided to each other and described good team working within the context of the challenging circumstances.

Overall, staff described feeling well supported by their direct line management but did express that senior/executive leadership were not able to address all the concerns related to crowding and growing service pressures.

Approximately 85% of staff reported low morale linked to being unable to always provide the expected standards of care. Staff described protracted crisis management due to crowding of the ED. Staff reported that the current staffing levels associated with vacancies, combined with crowding impacted their ability to maintain patient safety. A high percentage of respondents (95.65%) from the staff questionnaire felt service users were not always safe or adequately protected from harm.

5.0 Inspection Findings

5.1 Patient Flow

Patient flow was reviewed to enable inspectors to understand the movement of patients through the ED.

Staff demonstrated efforts to maintain patient flow despite severe crowding, staff shortages and the inability to transfer to specialist wards. There was good collaboration with the patient flow team and site co-ordinator through multiple meetings which took place throughout the day to help direct patients to appropriate ward areas. A senior nurse navigator receives patients from NIAS which helps to release ambulances so that they may respond to other calls.

At one point during the inspection thirteen ambulances were waiting to offload patients which hampered the attainment of the fifteen-minute patient offload key performance indicator (KPI).

Guidance was available for staff, that during periods of escalation a consultant should be available at triage to facilitate senior clinical decision making. A Standard Operating Procedure (SOP) is available for staff navigating and overseeing this ED access point.

The second access point is for ambulatory patients via the Urgent Care Centre (UCC). This is open 24/7 with dedicated GP presence between 8am – 12midnight and access to this unit is via referrals from GPs in the greater Belfast area and also patients who attend without any referral.

Within the UCC a patient is referred, seen, treated and discharged; or referred into another pathway, for example Ear, Nose and Throat (ENT) service, surgical assessment, or same day emergency care (SDEC) (Zone B). An SOP is available for the SDEC which includes a chaired area and a ten-bedded short stay ward.

Staff described that more patients were arriving to UCC significantly unwell and requiring urgent triage and transfer directly to Majors or Resus, or on occasion bypassing triage to be moved directly to the ED, due to their presenting need. At night, two registered nurses (RNs) and one Healthcare Support Worker (HCSW) staff this area; should a patient require transfer to Majors or Resus one of the three staff members are required to accompany the patient, thus reducing UCC staff presence until such times as they return.

A Hospital Ambulance Liaison Officer (HALO) is employed by NIAS to assist in the timely handover and offloading of patients in ED and this facility was reported to provide beneficial support. However, this service is not available at night time. The availability of a HALO can vary and rotas are not communicated to the ED team.

Within ED staff use the Manchester Triage criteria to prioritise patients in order of clinical priority thus increasing patient safety. Staff confirmed that the triage criteria is included in staff induction and staff are required to undertake a number of competencies during their first year in the department, before being competent to apply the triage system. A number of staff are trained as Manchester Triage Assessors to support this stage of assessment.

Difficulties in discharging patients into the community from the hospital wards was highlighted as the key factor impacting patient flow within the ED. Additional factors included delays in the repatriation of patients to hospitals in their resident Trust. The RVH must repatriate patients from its wards in order to create capacity to accept referrals from the other Trusts due to their regional specialities status. Staff reported they were unaware of any existing repatriation protocols outside of cardiology patients following primary percutaneous coronary intervention (pPCI). RQIA is aware there is a set of repatriation agreements in place for major trauma, however this is not in place for all specialities.

During the inspection an alarm was activated in response to discovery of a fire. Whilst possible evacuation was discussed staff remained calm and required only the evacuation of relatives. As a result of crowding, timely and effective evacuation would have been a significant challenge should that have been deemed necessary. The Trust were advised that any fire plan should support effective processes and take note of the potential for crowding in ED. The Estates Department and Trust management shared actions they had taken to mitigate risk of fires caused by smoking, this includes signage, installation of CCTV, increased cleaning and review of bin types.

One AFI has been made in relation to the fire plan reflecting effective evacuation processes when ED is overcrowded.

5.2 Staffing Model/ Workforce Impact

The Telford Model is a tool widely recognised to assist in determining safe nurse staffing levels for any service. The model is not prescriptive but supports local decision based on the number of patients and their needs, this includes consideration the acuity of patients and the type of care they may need. At the time of the inspection front line staff confirmed that the staffing model for ED had not been reviewed for three years and as a result the current staffing model had not taken account of the changed profile of the ED.

This was discussed with Senior Managers during a further meeting, post inspection. The Senior Managers provided evidence of ongoing reviews of the nurse staffing within the ED and confirmed that staffing levels had been increasing since 2016, this review process incorporated the Telford and Delivering Care models.

There was acknowledgment during this meeting with Senior Managers, that the ED service manager is not the budget holder for other disciplines which are critical to the operation of the ED, such as tracker staff, Allied Health Professional (AHP) and pharmacy staff. Staff to patient ratio in line with best practice guidance was not being met and any review of the model should take into account the entire MDT team which is critical to the delivery of the ED services.

There are staff vacancies across all levels with the highest vacancy rate within the Band 5 Nursing group (44.7%). The Trust utilised agency staff where possible and supported flexible working incentives for staff. Staff absence has increased over the past year, with work related stress a significant contributor. It was positive to note that processes are in place to support staff health and wellbeing with the support of Occupational Health.

The medical rota was covered with support by locum doctors. Staffing provision particularly for OOH is not commensurate with OOH's demand. Most of the gaps in the rota occurred at night. Consultants reported they often remain on shift beyond their normal rostered time. Burn out of staff was reported to be a significant issue.

Staff expressed concerns about the high number of newly qualified staff and the significant responsibility given to them as a consequence of crowding. Staff also reported difficulty finding protected time for the essential work of upskilling and inducting new and agency staff and orientating them to the ED.

Medical and nursing staff were concerned about arrangements for medical cover in UCC and level 2 escalation ward (see section 5.2.3 for further explanation), advising that gaps in the rota are usually filled by locums, with a high reliance on specialist registrars and middle staff grade.

Mandatory training uptake was low in a number of areas especially moving and handling, IPC, adult safeguarding and child protection. Some staff indicated that they would benefit from training on the management of patients with mental health and learning disability needs, substance misuse and de-escalation of challenging behaviours.

A newly introduced share point loop was in place which will enable staff to complete training remotely, at home, and in return receive their time-off-in-lieu. A Clinical Education Facilitator assisted with mentoring and induction of new staff as well as updating the training records in addition to other duties such as supporting engagement with relatives and access to chaplains. A range of specialist commissioned courses to support and upskill staff were also available and discussed at staff performance reviews and appraisals.

Some staff reported training on awareness of ligature risk was being rolled out. Breakaway skills and disengagement training was also available. Staff wellbeing was also an area of focus with mindfulness and resilience training offered for the Band 5 group of nurses. Band 6 nursing staff had attended a recent leadership day which covered these aspects as well as role clarification and strategic demands on the service.

Staff views were sought during the inspection through one to one engagement, focus groups and through responses to an on line questionnaire. Themes emerging from staff engagement included low morale, consistent pressure due to crowding, staff shortages, impact on staff health and wellbeing, impacts on quality of care, and moral injury.

Some experienced violence and aggression feeling unsafe at times. It was noted that advice issued by professional regulators and letters issued by the Chief Medical Officers and Chief Nursing Officers on 11 November 2022 sought to reassure staff that the working context would be fully considered in evaluation of any professional matters raised. Some staff reported limited opportunity for professional reflection and some described experience of a 'blame culture'.

Others reported an openness to report concerns and incidents. Some desired more evidence of follow-up and remedial actions taking place after reporting.

Operational staff reported supporting each other and good team working. They were well supported by their direct line management and sometimes sought increased visibility of Senior Managers and more progress, in addressing systemic challenges and action which would reduce the crowding. Senior Managers give examples of communication with staff and described a range of plans as part of winter pressure responses, which it hoped would reduce pressures in the ED and improve flow through the hospital. Senior managers acknowledged the challenges staff had experienced and that despite actions taken and plans in place, crowding persisted. Senior Managers also outlined their commitment to support staff with continued engagement.

Three AFIs have been made in relation to Workforce.

5.3 Environment and IPC

The environment of the RVH ED was reviewed to assess whether it met the needs of the service.

The unscheduled care village consists of UCC, Zone B (also known as the Clinical Assessment Unit (CAU), Emergency Nurse Practitioner (ENP) space within the Musculo-Skeletal Clinic, Ambulatory Emergency Department (AED) and main ED which consists of Amber Resus, Red Resus and Respiratory Assessment and Treatment Unit (RATU).

There are also two escalation wards on Level 2 and Level 8 of the hospital used in times of acute pressure. Patients are transferred to these wards from ED once a decision to admit has been made. They do not fall under the management of ED; however, level 2 patients do remain on the ED electronic patient management system.

Navigation around these areas was often difficult for both patients, visitors and staff. Directional signage was poor and during the inspection it was noted that patients, visitors and relatives were seeking directions to access the different areas.

During the inspection there was significant crowding in Majors and Amber and Red Resus which had created difficulty in performing adequate cleaning and ability to move and access to patients.

Some work surfaces and mattresses were not sufficiently clean or in good state of repair. On observation some sharps boxes were not sufficiently clean or secure.

Several storage and utility areas were cluttered. Oxygen cylinders were not stored appropriately. Waste bins in several areas were broken. Patient beds were blocking main thoroughfares and there was limited access to hand washing sinks in Amber Resus. Processes for disposal of dirty linen were not always adhered to.

Cleaning schedules were not in place for all areas of ED. Environmental audits carried out by the Patient and Client Support Services (PCSS) team, were completed on a spot check basis with low percentages of questions scored.

Records in relation to auditing of PPE and hand hygiene were reviewed during the inspection, with a high level of compliance noted.

In Level 2 Escalation Ward there were concerns regarding the storage of commodes and management of waste. There was also insufficient storage at the patient's bedside with items being stored on the floor further impacting IPC compliance and appropriate cleaning.

Staff described good collaborative working relationships between ED staff and the IPC team and told us they were responsive when required and that IPC team have increased their presence within ED. At the outset of COVID-19 the demand on the IPC team dramatically increased. This was further challenged by vacancies and unexpected absences. While a business case for additional IPC nurse resource was submitted pre COVID-19, the outcome of this is still outstanding.

While there is no specific IPC nurse dedicated for ED, IPC support and advice is provided by the IPC team. There was evidence of IPC team visits to the ED, and whilst findings of these visits were shared with the nurse in charge it was not clear who had responsibility for implementing and monitoring any identified actions. The IPC team were reviewing their visits to ED in relation to frequency, focus of observations and reporting process in order to support ED colleagues. The IPC team conduct independent observation of PPE and hand hygiene periodically. Environmental auditing is overseen by the Patient Client Support Services (PCSS) team. During any visit by the IPC team, observations/concerns regarding the environment are highlighted to the nurse in charge or PCSS if appropriate. If a particular concern arises the IPC team would also consider formal environmental auditing.

Two AFI's have been made in relation to IPC and one has been made in relation to the Environment

5.4 Medicines Management

An assessment of how critical medicines are managed in the ED formed part of this inspection. A critical medicine is one were the timeliness of administration is crucial to minimise harm for patients. Every effort should be made to avoid omitted and delayed doses of critical medicines. A critical medicines poster should be displayed in prominent areas as a reminder for staff.

Upon arrival a medical history is taken from the patient/carer which includes their prescribed medicines. The Northern Ireland Electronic Care Record (NIECR) is not reviewed as part of the triage. Therefore, if the patient/carer does not, or cannot share information on prescribed critical medicines they may be missed until the medical assessment is undertaken and the NIECR is reviewed by a medic. The medical assessment may however take place several hours after arrival. There is the potential for critical medicines to be delayed/omitted which could lead to harm. The Trust should consider how these risks can be addressed and managed.

Nursing staff described the pharmacy team as an invaluable but understaffed resource. The pharmacists support nurses and doctors in a number of areas including medicines reconciliation, preparation of antidotes, IV fluids and obtaining supplies of medicines.

A pharmacist is available from 8am to 5pm seven days a week, however there is no dedicated cover outside of these times.

The pharmacist team advised that the biggest opportunity for improvement in safety would come from having sufficient resources to complete medicines reconciliation during triage, manage admissions and discharges. Considering the improved patient safety that pharmacists bring to the ED, consideration should be given to expanding the pharmacist team's resources and availability.

The pharmacists described the difficulties in discharging patients who require follow up from community pharmacy and general practitioners. They outlined the significant time taken in attempts to contact these services via telephone to discuss patients' medicines which is leading to delayed discharges. The Trust should consider how they can work in partnership with the Department of Health and the SPPG to identify opportunities for improved communication between healthcare professionals.

There is no routine audit process for medicines management within the ED. If identified, medicine incidents relating to critical medicines or which cause harm to the patient are reported. Staff advised that there are likely to be unseen errors which are not reported. Urgent improvement in audit and governance is required to ensure that all medicine incidents are identified and reported so that learning from incidents and action plans to prevent recurrence can be implemented and shared to improve patient safety.

Medicines management was also reviewed in Level 2 Escalation Ward which is discussed in Section 5.2.5.

One AFI has been made in relation to Medicines Management

5.5 Level 2 Escalation Ward

This escalation ward is located outside of the main ED and had previously closed and moved to Level 8 in April 2022 due to relocation, de-escalation, and essential works being carried out. However, due to pressures it became operational again in October 2022. It is located at the end of a waiting area for the x-ray department which causes some issues of privacy and dignity for patients.

There was not a dedicated core staff team for this area, staff were unable to clearly describe oversight and escalation arrangements for this area, and specific Standard Operating Procedures (SOP) for the area were not available.

Staff confirmed that medical cover is provided by speciality on an 'as and when' required basis. There is no dedicated multi-disciplinary team (MDT) and staff described difficulty in securing MDT input to assess and review patients located in Level 2.

Level 2 is not staffed or equipped to manage medicines safely. There is no medicine trolley and the medicine cupboards were unlocked, overstocked and disorganised during the inspection. A review of medicine Kardexes showed that patients were missing doses (up to three days) of prescribed medicines due to not having the medicines in stock. These included medicines to manage blood pressure, asthma, prostate cancer, depression and vitamin deficiencies. The process for managing and administering controlled drugs is unsafe and does not follow the SOP for the management of controlled drugs.

Urgent review of medicines management on Level 2 is thus required to ensure that safe processes are in place and patients are administered their medicines as prescribed.

These matters were brought to the immediate attention of the Trust and assurances were provided that a SOP was in place and most recently updated on 18 January 2023 following a previously updated SOP in October 2022 when the area was reopened.

The Trust told us that they have since restructured and reorganised the governance and oversight and identified a Lead Nurse for the escalation areas. The Band 7 Ward Sister in Level 8 Escalation ward will oversee the local management of Level 2 as well as Level 8.

The medical specialities team will cover this area, and the shadow nurse rota has been reviewed with medical ward nursing staff providing cover to support consistency. The Trust recognise the need for a stable workforce as Level 2 is being utilised more frequently than anticipated due to patient flow issues. Senior Managers advised that the Trust is moving to recruit, at risk, for a substantive staff team. Some estates work has since taken place to improve the environment such as curtains put in place for patients instead of portable screens to offer improved privacy.

One AFI has been made in relation Medicine Management in Level 2 Escalation

5.6 Patient Safety and Human Rights

Incident management

Incident reporting and monitoring is a key aspect of identifying safety risks to patients. Through the review of documents and discussions with staff the incident reporting processes were assessed. Over a one-month period we noted high levels of reporting of incidents on the Trusts Datix system, the internal incident reporting system.

Crowding and medication incidents were reported in high numbers. Management in ED informed us that the crowding related incidents are reviewed by the Executive Management Team and reported to the Trusts Chief Executive. Presentations had recently been delivered to Non-Executive Board Members and the Director of Nursing to highlight the significant impact of crowding has on numbers of incidents such as pressure sores, violence and aggression, medicine errors and staff resignations.

Medication errors were reported to the pharmacy lead. As a result of increased medication errors there is now a section on the MYEMERGENCY DEPARTMENT APP dedicated to learning from medicine errors. This has a topic of the month and is shared via a video message for staff, the example of Insulin as one monthly topic area was noted during inspection.

Falls and deep tissue injury (DTI) were among the most prominent incidents in the Datix reporting system. In response to an increase in falls incidents, ED is planning to explore a number of initiatives in an effort to help mitigate against the growing number of falls.

Senior Managers in ED have engaged with the Tissue Viability Nurse (TVN) and we were advised some bespoke training has been carried out in response to pressure area care to reduce incidents of pressure sores. Airflow mattresses have also been ordered for trolley beds to enhance patient comfort and reduce pressure impact.

Some staff told us that they did not receive direct feedback on the analysis of the reported incidents. Oversight of the Datix system for reporting incidents is undertaken by the Lead Nurse who advised they communicate identified trends and patterns to the ward and deputy ward sisters who are required to share the learning with staff.

Overall the systems in place to report and analyse incidents were robust and data was being used effectively to identify areas of particular risk and actions that could practically be taken to mitigate these.

Privacy and Dignity

It was evident the crowding in ED was impacting significantly on dignity, privacy and confidentiality. Doctors were observed speaking with patients during their assessment were others could overhear conversations.

Elderly and frail patients who required help with their nutrition and fluid intake did not always have sufficient support. Staff reported concerns regarding their ability to provide assistance with personal hygiene and pressure care for patients and dignified palliative care. Patients were cared for in close proximity to one another and crowding did not always allow for sufficient space between male/female patients for dignified care to be provided. The Occupational Therapist had presented findings to the Non-Executive Director and Senior Managers to evidence the impact of protracted stays in the ED environment on deterioration in the levels of dependence of this vulnerable group.

Issues impacting on the provision of safe and effective care are significant and the causes are complex. Some causes relate to workforce availability and others the system wide pressures which are impeding the effective flow of patients through the hospital system. These issues require to be addressed at a local level by managers within the Trust, at a Regional Level across all Trusts and at a Departmental of Health Level and require effective integrated working across our health system.

5.7 Mental Health and Learning Disability/Violence and Aggression

It was reported there was an increase in patients presenting with Mental Health (MH) crisis. Violent and aggressive incidents were reported to have increased with lengthy waiting times and crowding exacerbating this at times.

Patients presenting with MH crisis during the inspection were often cared for in chairs, sometimes for long periods. It was noted the environment was not ligature free and staff were aware of risks associated with this. Inspectors were advised patients abscond frequently and the security team and Community Navigators assist ED staff with searches and returning patients to ED.

PSNI attend ED if an assault has occurred and staff often rely on the Trusts security team to assist them. Training for MHLD, substance misuse and de-escalation training were noted as areas that would be beneficial to staff but were not yet offered.

It was established that an Acute Liaison nurse for Learning Disability has been appointed in the hospital but has not been visible to date in ED. Senior Managers also told us that while the alcohol recovery centre was stood down during the COVID-19 pandemic they are at the beginning phases of revisiting this beneficial service.

In response to the need for additional support, Community Navigators have been employed by the Trust following a Quality Improvement Project.

This is a team of staff who support patients by providing additional support for those patients presenting with mental health crisis, which includes chaperoning, observing, and helping in searches for absconded patients.

This has been a positive approach and we observed good working relationships which have developed between these navigators and ED staff.

5.8 Escalation, Leadership and Governance

Inspectors sought to understand the short and medium term plans to address the current crowding crisis both locally and regionally.

At a local level using its internal Hospital Early Warning Scoring System (HEWS), the Trust has been operating at the black (highest/critical) level of escalation, frequently for several months. The inspection team were unable to confirm that the Trust had implemented all the required actions within Code Black during these times, or steps available for further escalation. Furthermore, the Trust's escalation policy was not sufficiently specific to the designation of the RVH as the regional Major Trauma Centre. At times of significant crowding it was not clear how the actions taken would ensure the ED would protect adequate capacity to respond to a major incident.

SIT-REP calls facilitated by the Site Coordinator occur three hourly throughout the day – 8am, 11am, 2pm, 4:30pm, a final call with on call Co Director at 8pm, and a final SITREP report is circulated at 10pm. RQIA were advised by Senior Managers that patient acuity and workforce capacity within ED are reviewed, and decisions taken when necessary to redirect staff from other areas of the hospital to support ED pressures.

RQIA engaged with Commissioners from the SPPG following the inspection to understand the regional oversight of the escalation procedures across all the EDs and to understand decision-making relating to the 'smoothing' and redirection of ambulances between the Trusts. They found no current mechanism to provide assurance that the regional escalation processes were consistently applied across all HSC Trusts to support regional co-ordination.

The decisions on smoothing and redirection of ambulances between Trusts rests currently with NIAS based on live information from each of the EDs. Challenges were described in respect of ensuring all Trusts work together effectively to ensure best possible flow of patients through the ED system. This was highlighted as a regional area for improvement and will be communicated to the Department of Health by RQIA.

One AFI has been stated in relation to Escalation

5.9 Patient Experience

Inspectors engaged with fifteen patients across Majors, AED and Level 2 and as discussed in Section 4 they were supportive of all staff and the efforts made to provide them with the best care.

Some patients had accepted that attendance at ED would result in long waiting times in an overcrowded setting. Some noted that the department was noisy, overcrowded and lacked the opportunity for maintenance of privacy and dignity.

Patients felt staff were unable to always respond in a timely manner to requests, including responding to buzzers and assistance requested for basic needs such as patients reporting feeling cold.

Patients sometimes felt anxious regarding the risks to themselves, staff and the environment associated with patients displaying violence and aggression.

Overall the patients reported feeling informed about their care and treatment. They observed that nurses were overworked and visibly short staffed however, stated staff were compassionate.

This extended to the NIAS staff who reassured them and provided explanations. Patients spoken with during the inspection felt the wait times for ambulances and transfer from ambulance to ED were appropriate and not excessive.

The Trust provided reports from its live patient feedback system which, tracks a number of specific experience indicators and provided evidence that many patients in the ED reported positively on their experience.

5.10 Good practice/initiatives

A small number of improvement initiatives were noted during the inspection. Staff reported local initiatives to help boost morale including “TOAST Awards”, in which staff are nominated by a senior staff member for achievement of what has been done well, and “Fairy Gift Bags” which staff leave anonymously for each other in recognition of that extra mile or how they stood out for that day.

Pharmacists had provided additional training for nursing staff however it can be difficult for those staff to be released to attend training. The lead nurse advised of a monthly two-minute video which is uploaded onto the staff app which they can access at any time. The most recent training video related to the management of warfarin and a refresher on critical medicines is planned for the coming month. The governance pharmacist was also undertaking a QI project to review the management of medicines within ED.

The Trust was using a system of gaining feedback on a real time basis from patients within the ED. This was collated and was reviewed on a daily basis by the Senior Managers and was commended.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with *DHSSPSNI Quality Standards for Health and Social Care (March 2006)***.**

	Standards
Total number of Areas for Improvement	9

Areas for improvement and details of the Quality Improvement Plan were discussed with the Senior Managers during feedback on 12 January 2023, as part of the inspection process. The timescales for completion commence from the date of inspection.

This inspection has taken into account system-level context in identifying areas for improvement within ED, requiring the Trust, through the QIP, to take actions to improve safety for patients and for staff, that the Trust can reasonably be expected to address.

The Quality Improvement Plan now follows.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

FIRE SAFETY

Area for improvement 1 **Ref:** Standard 4, 5, 7 Criteria 4.3(l); 5.3.1(a, f) 7.3 (g) **Stated:** First time **To be completed by:** 31 March 2023	The Trust Should ensure that fire evacuation fire plans are updated to account for the eventualities where there is crowding within the ED. Ref:5.2.1
	Response by registered person detailing the actions taken: Fire evacuation procedures have been reviewed in consultation with the Trust Fire Officer. The Trust Fire Officer has initiated a monthly training programme for staff to include evacuation training. 3 April 2023: Fire risk assessment for RVH ED was reviewed and de-escalated. 9 May 2023: NI Fire & Rescue Services Fire Safety Inspector visited RVH ED and stated that at the time of the visit the premises were found to be broadly compliant.

WORKFORCE

Area for improvement 2 **Ref:** Standard 5,6, 7, 8 Criteria:5.3.3 (c, d, l) 6.3(c) 7.3 (a, g)8.3 (e, f) **Stated:** First time **To be completed by:** 1 August 2023	The Trust's Management Team should ensure its assessment of workforce needed to operate a safe ED, is updated to reflect the profile of needs within the department and to support the provision of safe, effective and compassionate care. This must include all professional groups and administrative and support staff. This may require cooperation across directorates and budget holders (Pharmacy; admin; trackers; PCSS). Ref 5.2.2
	Response by registered person detailing the actions taken: 20 November 2022: 10 x Band 2 nursing assistants were appointed at financial risk to the Trust to ensure patients in the RVH ED have timely fundamental care needs met. December 2022: Bespoke International Nurse recruitment commenced. February 2023: Project group established to review reconfiguration of Urgent and Emergency care services on the

	RVH site, this has included a workforce review of all professional groups. 11 May 2023: allocation letter from SPPG detailing investment to be used to maintain and enhance the Belfast Trust Urgent Care Centre service based on the RVH site, investment included funding allocation across all staff groups. 8 June 2023: Reconfiguration of Urgent and Emergency Care Services on RVH site. July 2023: establishment of Multidisciplinary workforce review group**.**
Area for improvement 3 **Ref:** Standard 5,6, 7, 8 Criteria:5.3.3 (c, d, l) 6.3(c) 7.3 (a, g)8.3 (e, f) **Stated:** First time **To be completed by:** 1 August 2023	The Trust should improve the effectiveness of its communication with clinical staff to enhance the visibility of actions being taken by EMT and senior managers and by operational ED workforce, and actions being taken locally and regionally to reduce crowding. The Trust should consider ways to measure the improvement in this area. Ref 5.2.2
	Response by registered person detailing the actions taken: 29 November 2022: Extraordinary Trust Broad meeting to discuss Unscheduled Care winter plan. 11 January 2023: Further meeting with Chairman and Non-Executive Directors. January 2023: Revised Regional USC Escalation Guidance shared with ED team. Ongoing monthly business meetings to be used as a forum for disseminating and discussing communication from Executive team. 9 February 2023: Engagement with Trust Board, Executive Team. 22 March 2023: Senior Leadership Group - all senior managers across entire Trust, discussion on RVH ED reconfiguration. 5 April 2023: Senior Leadership Group detailed project plan in preparation for ED reset. June 2023: Regional QI focus on Phone First, Discharge Pathways, Mental Health Pathways.
Area for improvement 4	The Trust should ensure all staff meet mandatory training requirements and any additional training needs identified to

Ref: Standard 5.1 Criteria 5.3.3 (c, d) **Stated:** First time	meet the needs of the changing patient profile. This may include a training needs analysis. Ref 5.2.2
To be completed by: 1 May 2023	**Response by registered person detailing the actions taken:** There is a monthly trust induction for all new appointees. There is a further bespoke ED induction, this includes practical simulation sessions facilitated by the Clinical Educator. Training needs analysis is carried out annually, to inform commissioning in accordance with service need. Gaps in training at the time of the inspection were in relation to: • manual handling practical, this was due to training places being reduced during the pandemic which has resulted in a back log of trained staff. Places have now returned to pre-pandemic levels and there is an action plan to ensure that all staff are trained. • safeguarding adults and safeguarding children; there are a limited number of available training dates to meet the demand. There is ongoing work within the trust to develop training which will equate to statutory/mandatory levels to address training requirements. • caring for vulnerable patient groups including mental health, addictions and learning disability identified as priority area for training and development. Ongoing commissioning of post-graduate courses including substance misuse, procurement of ASLG “acute psychiatric emergencies” course (first course due to take place November 2023). 30 November 2022: Away day for staff – programme included managing challenging behaviours, substance misuse, ligature training, adult safeguarding and self-care.
ENVIRONMENT	
Area for improvement 5 **Ref: Standard** 5.1 Criteria 5.3.1 (f) **Stated:** Second time	The Trust should improve its system for oversight of standards of environmental cleanliness within the ED to ensure appropriate standards of cleanliness are adhered to. Ref: 5.2.3
To be completed by: **1 April 2023**	**Response by registered person detailing the actions taken:** Monthly cleanliness audits are in place, however there is further work to be undertaken to ensure coordination with PCSS and estates colleagues, with input from IPCN team

	where required. During IPC visits the team's observations and/or concerns regarding environment are highlighted to the nurse in charge or PCSS if appropriate. Nursing Development Leads (NDL) undertaken Infection Prevention Control inspections based on RQIA core indicators / standards annually, this has not occurred due to staffing challenges, these will recommence for all areas. Inspection outcome results will be shared with Lead Nurses, Service Manager, PCSS, estates and IPC if required to agree actions and implementation timeframe.
INFECTION PREVENTION AND CONTROL	
Area for improvement 6 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 1 September 2023	Review and define the roles; responsibilities and schedules of nursing and support staff in light of the changing demands in ED and crowding. This may involve a dedicated support team assigned to the ED. Ref: 5.2.3
	Response by registered person detailing the actions taken: 20 November 2022: 10 x Band 2 care companions were appointed at financial risk to the Trust to ensure patients in the RVH ED have timely fundamental care needs met. Cleaning schedules are in place for all areas/zones in ED. Frequency of cleaning reviewed in conjunction with PCSS staff. July 2023 - 3.0 WTE housekeepers appointed.
Area for improvement 7 **Ref:** Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 1 September 2023	Ensure IPC audits include all areas and ensure items that require follow up are assigned, actioned and recorded to provide evidence of monitoring and oversight. Ref: 5.2.3
	Response by registered person detailing the actions taken: Quarterly independent hand hygiene (HH), Personal Protection Equipment (PPE) audits are completed by the NDL team. Any incidents of non-compliance are addressed with staff involved, at the time of the audit. Results are shared with the Lead Nurse and any required action agreed. The service area complete monthly HH and PPE audits which include all areas in the ED. Trends in scores are monitored and further input is requested from IPC if required. Independent observation of clinical practices, e.g. HH and PPE usage, are undertaken by the IPCNs during visits to ED

	as the opportunity arises. Observations are reported to the nurse in charge at the time.
MEDICINES MANAGEMENT	
Area for improvement 8 **Ref:** Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 1 September 2023	The Trust should strengthen its system to monitor the safe practice in the prescribing, administration, storage and governance of medicines across the Unscheduled Care Village. To Include: • Ensuring a critical medicines poster is displayed in prominent areas. • Ensure medicine reconciliation occurs in a timely manner so that critical medicines are not delayed/omitted • Conduct a review of the pharmacist team to consider feasibility of expanding their resources and availability. • Ensure all medicine incidents are identified investigated and reported to support a culture of shared learning and improved patient safety. • Improve the management of medicines on Level 2, Escalation Ward to ensure safe processes are in place for the management and administration of medicines including controlled drugs. Ref: 5.2.4 & 5.2.5
	Response by registered person detailing the actions taken: Critical medicines posters are displayed in the Majors area, main corridor of ED and drug rooms. There is also a label on the front of BNFs listing critical medicines. Pharmacists aim to prioritise high-risk patients for medicines reconciliation that attend the ED, high numbers of attendances and length of time in the department, make this challenging to achieve for all patients. Pharmacy team currently provide a service between 8am-5pm 7 days a week. Enhanced pharmacy involvement would require additional resource; this will be scoped as part of the wider workforce review group. Medication incidents: Pharmacists have input in reporting and identifying learning from medication incidents. incidents are discussed at the weekly governance meeting and learning is disseminated. Level 2 escalation area closed in February 2023.

ESCALATION	
Area for improvement 9 **Ref:** Standard 4, 7 Criteria 4.3 (b, h); 7.3(g) **Stated:** First time **To be completed by:** 1 September 2023	The Trust should review and update its internal escalation process and procedure. The review should: • Take account of RVH status as the designated regional Major Trauma Centre. • Include a review of the consistent application of HEWS thresholds in response to the changing needs of the ED service and communicate this with relevant stakeholders. • Ensure that following SIT-REP meetings clear communication is issued identifying any required action linked to relevant trigger points within the Escalation Policy. Ref 5.2.8
	Response by registered person detailing the actions taken: Internal escalation plan in place, will be updated with new triggers following reset of RVH ED, once tested and agreed this will be widely circulated and supported by site coordinators. January 2023: Revised Regional USC Escalation Guidance shared with Trust Senior Leadership team. SIT-REP actions discussed and documented in the control room at each of the 3hrly calls, all services represented at the calls. SIT-REP report circulated via email after each call. Visible presence of the designated site coordinator in ED with regular update and communication with Consultant and Nurse in Charge.

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