Follow-up Inspection Report

3 November 2023 – 31 January 2024

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 Claire Wilmont	**Position:** Lead Nurse
Brief description of the accommodation/how the service operates: The Emergency Department at the Royal Victoria Hospital in Belfast, provides 24-hour emergency care for people presenting with acute illness or injury. The Royal Victoria Hospital is also designated as the Major Trauma Centre for Northern Ireland; and as such, receives some of the most severely injured patients who will avail of optimal multi-specialty and multi-disciplinary care. Major Trauma patients access such services primarily via the Emergency Department.	

2.0 Context / Inspection Journey

The Royal Victoria Hospital (RVH) Emergency Department (ED) was subject to an RQIA inspection that commenced on 3 November 2023 and concluded on 31 January 2024, when feedback was provided to the management and staff of the Emergency Department. The purpose of this inspection was to follow-up on the nine Areas of Improvement (AFI) which had been identified during the previous inspection. The previous inspection commenced on 8 November 2022 and concluded on 3 February 2023; and will be referred to throughout this report as 'the 22/23 inspection'.

Following the 22/23 inspection and in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, RQIA formally informed the Department of Health (DoH) of the findings, in relation to the care, treatment and services provided for patients within the RVH ED. The correspondence was copied to the Permanent Secretary [and HSC Chief Executive]; the Chief Nursing Officer; the Chief Social Work Officer; and the Deputy Secretaries of Healthcare Policy, Social Services Policy, and the Strategic Planning and Performance Group (SPPG) of the DoH. The correspondence reported that it was acknowledged that system-wide pressures were likely contributing to the issues of over-crowding within the ED; and that those pressures were not unique to the RVH and contribute to overcrowding in all EDs across the region.

During the 22/23 inspection, RQIA recognised that achievement of the standards set out in *The Department of Health, Social Services and Public Safety: The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, (March 2006)* (hereafter known as The Quality Standards) was constrained as a result of the sustained pressures which were causing the ED to operate outside its core capacity and purpose. The AFIs were therefore devised in line with what the Trust could be reasonably expected to achieve within that context.

Following the 22/23 inspection of the RVH ED, RQIA carried out a system-level inspection of the Southern Health and Social Care Trust (SHSCT). The purpose of this inspection was to assess a range of contributing factors to overcrowding of EDs. The report was titled: *"Working Collaboratively to Reduce Harm" RQIA System Inspection of a Local Health and Social Care System - Southern Health and Social Care Trust Area* and can be located on the RQIA website here. The RVH follow-up report should be read in conjunction with the SHSCT system-level report as, even though the system-level inspection focussed upon the Southern Trust area, many of the recommendations arising from that report are applicable to all Health and Social Care (HSC) Trusts, Services registered with RQIA to provide Nursing, Residential and Domiciliary Care and stakeholders.

This follow-up inspection to the RVH ED was undertaken to assess progress against the nine AFIs detailed in the Quality Improvement Plan (QIP) within the 22/23 inspection report, which was published in July 2023; and may be viewed here.

The follow-up inspection has provided further evidence that overcrowding within EDs continues to impact patient safety and staff working conditions, staff and patient safety and is an indicative consequence of system-wide pressures that continue to be experienced across HSC.

In keeping with our inspection process, the Trust has had an opportunity to respond to the areas for improvement listed in section 6 and to address any factual inaccuracies within this report prior to it being shared with the DoH in advance of publication.

3.0 How we Inspect/Methodology

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

This inspection was underpinned by the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003* and The Quality Standards.

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

The inspection team comprised of RQIA's Medical Lead and Responsible Officer, Assistant Director for The Hospitals, Independent Healthcare, Reviews and Audit Team, Senior Inspectors, Hospital Team Inspectors, Pharmacy Inspectors and administrative support staff.

This inspection was conducted using a blended approach which included a series of meetings with the Trust's ED, the Senior Management Team (SMT), ED staff engagement sessions; an onsite visit to the ED; and the review of submitted evidence supporting the actions taken by the Trust against each AFI.

Feedback was sought from all staffing groups in relation to the Trusts progress with the nine AFI's made during the 22/23 inspection. Feedback sessions were held on the following dates 29 November, 14 December and 21 December 2023.

Article 34 of the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order (2003)* (the 2003) Order places a statutory "Duty of Quality" on each HSC Trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and social care which it provides to individuals; and the environment in which it provides that care. This means that each organisation, large or small, has a legal responsibility to ensure that the care it provides complies with the standard statements defined in The Quality Standards and which are expected by the public.

Article 35 of the 2003 Order also places a statutory duty on the RQIA to inform the DoH, when it views that an HSC service is providing unacceptably poor quality of health and social care (whether generally or in particular areas); or if there are significant failings in the way the service is being run.

RQIA independently report on the quality and availability of health and social care, in line with our statutory duties; so that opportunities for care provision improvement continue to be highlighted.

4.0 Inspection Findings

4.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The previous inspection to the RVH ED was undertaken on 8 November 2022. During that inspection nine AFI were identified.

Progress against these nine AFI was assessed through evidence provided by the Trust and evidence gathered during the onsite element of the inspection. Views obtained from ED staff was a significant part of the evidence gathered to support this inspection.

It is acknowledged that the Trust have made improvements in relation to the AFI made during the 22/23 inspection, but the sustained system-wide pressures which contribute to ED overcrowding continued to create a challenge for the Trust and the safety and well-being of patients and staff.

<table>
<tr><th colspan="3">Areas for improvement from the 22/23 inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td colspan="3">FIRE SAFETY</td></tr>
<tr><td rowspan="2">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</td><td>The Trust Should ensure that fire evacuation plans are updated to account for the eventualities where there is crowding within the ED.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

It was confirmed that fire evacuation plans had been updated and a bespoke fire training programme remains in place for all staff which includes fire evacuation training.

This AFI has been assessed as met.

Refer to section 4.2 for further information.</td></tr>
<tr><td colspan="3">WORKFORCE</td></tr>
<tr><td rowspan="2">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</td><td>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).</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Whilst the assessment of workforce required across all staff groups to operate a safe ED has commenced, this AFI remains in progress and therefore is partially met, and will be stated for a second time.

Refer to section 4.3 for further information.</td></tr>
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<table>
<tr><th colspan="3">WORKFORCE</th></tr>
<tr><td rowspan="2">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</td><td>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.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The SMT informed RQIA of a number of actions taken to improve the effectiveness of their communication with ED staff.

Staff feedback was also sought in relation to the effectiveness of these communication strategies.

This AFI has been assessed as partially met and will be stated for a second time.

Refer to section 4.3 for further information.</td></tr>
<tr><th colspan="3">WORKFORCE</th></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 5.1 Criteria 5.3.3 (c, d)

Stated: First time

To be completed by:
1 May 2023</td><td>The Trust should ensure all staff meet mandatory training requirements and any additional training needs identified to meet the needs of the changing patient profile. This may include a training needs analysis.

It was confirmed a training needs analysis is carried out annually, to inform commissioning in accordance with service need.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
It was confirmed the Trust have good oversight mechanisms in place to monitor mandatory training and training needs analysis for nursing staff.

This AFI has been assessed as met.

Refer to section 4.3 for further information.</td></tr>
</table>

<table>
<tr><th colspan="3">ENVIRONMENT</th></tr>
<tr><td rowspan="2">Area for improvement 5

Ref: Standard 5.1 Criteria 5.3.1 (f)

Stated: Second time

To be completed by:
1 April 2023</td><td>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.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Oversight systems for environmental cleanliness had improved within the ED however, deficits in environmental cleanliness were still evident. Findings were fed back to the Lead Nurse during the onsite inspection.

This AFI has been assessed as partially met and will be stated for a second time.

Refer to section 4.4 for further information.</td></tr>
<tr><th colspan="3">INFECTION PREVENTION AND CONTROL</th></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: Standard 5.1 Criteria 5.3.1 (f)

Stated: First time

To be completed by:
1 September 2023</td><td>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.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

It was confirmed that work has been completed to define roles and responsibilities for cleaning all areas of the ED.

This AFI has been assessed as met.

Refer to section 4.4 for further information.</td></tr>
<tr><td>Area for improvement 7

Ref: Standard 5.1 Criteria 5.3.1(f)</td><td>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.</td><td></td></tr>
</table>

Stated: First time **To be completed by:** 1 September 2023	**Action taken as confirmed during the inspection**: There was evidence the Trust Infection Prevention Control Team (IPCT) had completed a large infection prevention control (IPC) audit. However, further work is required to strengthen the associated action plan and any future action plans. This AFI has been assessed as **partially met** and will be stated for a second time. **Refer to section 4.4 for further information.**	**Partially met**
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.	**Partially Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as **partially met**. The area for improvement is not stated for the second time as workforce review inclusive of pharmacy resource remains on-going (Refer to section 4.3). **Refer to Section 4.5 for further information.**	
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 Hospital Early Warning Score (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.	**Partially Met**
	Action taken as confirmed during the inspection: It was confirmed the Trust had updated and reviewed its escalation plan. However, staff raised concerns the escalation was not 'fit for purpose', and didn't effectively alleviate the sustained pressures. This AFI has been assessed as **partially met** but has been subsumed into a new AFI. **Additional information is provided in section 4.6.**	

4.2 Fire Safety

AFI 1

The Trust Should ensure that fire evacuation plans are updated to account for the eventualities where there is crowding within the ED.

It was confirmed that fire evacuation plans had been updated and a bespoke fire training programme remains in place for all staff which includes fire evacuation training.

While the fire evacuation plan has been updated, Trust staff continued to express concerns in relation to the practicalities of evacuating an overcrowded department when it is continuing to operate above its capacity.

The ED is supported by Northern Ireland Fire and Rescue Service, and it was confirmed there is ongoing engagement between ED staff and the Trust Fire Officer to address staff concerns.

This AFI has been assessed as met.

4.3 Workforce

AFI 2

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).

Monthly workforce meetings have been established with representation from all staff groups, and base line data for all staff groups is being collated to determine funding against current staffing and any gaps.

There is ongoing review/redesign of senior medical cover, and weekly collective leadership meetings with the Medical Workforce Administration Team, Clinical Leads and Senior management.

It was confirmed that all nursing posts (band 5) are currently filled within the ED however, staff reported skill mix was a significant challenge with a high percentage of staff less than one-year post-qualification. Staff described significant deficits within the band 6 nursing staff workforce which creates challenges in relation to maintaining adequate triage cover, and in mentoring and supporting new staff members. In an effort to address this, senior nursing staff complete clinical shifts to temporarily support this skill mix deficit.

Whilst agency nursing staff help support staffing deficits, substantive staff reported their level of skill is not considered at the time of appointment and agency staff cannot be utilised to train substantive staff members.

Workforce was discussed during the staff engagement sessions. It was reported that nursing staff turnover remains high and newly qualified staff will typically come to the ED for a six-month period and then move to other posts due to the significant pressure experienced in the ED. Staff felt this this was attributable to concerns about ED safety, and therefore representing a less attractive working environment.

Staff raised concerns regarding the severe lack of senior medical cover within the ED. Medical staff reported the current ED is not conducive to staff training, and that 'staff train in chaos'. The environment was described as 'toxic', stress levels were reported as high resulting in ED staff resigning from their posts due to the enduring pressure. It was reported that previously staff had favoured working in the RVH ED, but now 'won't stay once their training has completed'. It was further purported that introducing any additional medical staff may have a limited effect, as there is no surplus clinical space to treat patients. In this way, waiting times may not be improved by increasing medical staffing and therefore would do little to reduce the reportedly high number of patients leaving without waiting for an assessment.

Staff also expressed concern relating to the limited availability of administrative staff.

Nevertheless, Medical Student Technicians were reported as making a positive impact within the department providing valued assistance specifically during weekend periods.

It was noted that not all staff were aware of the commencement of an ED workforce review (to incorporate all staff groups) and some felt that it wasn't relevant in the absence of additional funding.

This AFI has been assessed as partially met and will be stated for a second time.

AFI 3

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.

The SMT informed RQIA that the following actions were taken to improve the effectiveness of their communication with ED staff which included but was not limited to;

- The visit of the newly appointed Chair to ED on 27 July 2023
- Stakeholder Summits (October & December 2023)
- An opportunity for Urgent Care staff to chat with the Chief Executive on 3 August 2023 regarding bespoke care
- Extraordinary Trust Broad meetings to discuss the Unscheduled Care (USC) Winter Plan on 11 January 2022 and 29 November 2023
- January 2023: Revised Regional USC Escalation Guidance shared with ED team
- 22 March 2023: Senior Leadership Group - all senior managers across entire Trust, discussion on RVH ED reconfiguration
- Monthly business meetings with representation from all operational teams, used as a forum for disseminating and discussing communication from the Executive team
- Introduction of the Regional Coordination Centre (RCC) refer to section 4.6 for further detail
- Implementation of a 'phone first' model which aims to ensure patients can get direct access to the most appropriate care which may avoid the need to attend ED
- Regional quality improvement focus placed upon alternative patient pathways
- The launch of an unscheduled care staff engagement project called 'TEAm' time, which serves as a platform for face-to-face staff networking and shared learning
- The launch of an unscheduled care newsletter for staff

Within the minutes of the monthly business meetings there was evidence of discussions regarding a number of quality improvement projects such as improving patient pathways in an effort to prevent re-attendance to the ED.

It was confirmed that staff engagement has taken place across the unscheduled care directorate, and next steps were identified to include the introduction of a staff forum, regular staff surveys and a newsletter. It is anticipated this will strengthen communication across staffing groups.

Staff understanding of the action SMT have taken to address issues of over-crowding

ED staff confirmed, whilst they may be aware of proposed plans to reduce overcrowding within the department, they will only be informed of their implementation at a late stage and operational staff are not included in planning discussions. Senior medical staff reported receiving power point presentations without supporting explanation; or that they receive lengthy emails which are not widely disseminated and lack clarity.

ED staff described the term 'winter pressures' as meaningless, as the winter pressures are now ever-present and that actual harm to patients was under-reported, with prolonged stays and delayed pathways starting in the ED environment. Concerns were additionally raised that a high percentage of the longest waiting patients within the ED were often over seventy-five years of age and, as a demographic, are known to have higher mortality rates when care pathways are delayed.

These conditions were reported as doing little to prevent the prevalence of moral injury affecting ED staff, where there is a sense of failure when patients come to harm but they feel powerless to do anything about it.

We are aware that the ED consultant body have exchanged written communications with the office of the Chief Executive regarding ongoing safety concerns; and questioning the steps that the Trust have taken to deal with them.

The Trust reported that they had been able to secure additional community places at a risk to their financial stability and that 'Hospital at Home' has increased their capacity. Nevertheless, they reported that, given the concerns raised by some senior medical staff, the Trust had paused the shift of elective cardiology and neurology to the Belfast City Hospital (BCH) site. The Trust also informed stakeholders that other services earmarked for relocation by [unspecified] senior Medical Chairs have been thoroughly explored but assessed as not feasible.

RQIA were invited to attend the BHSCT Stakeholder Summits in October and December 2023. The stakeholder events were attended by senior representatives from across HSC, including SPPG, Public Health Agency (PHA), Patient Client Council (PCC), Northern Ireland Medical & Dental Training Agency (NIMDTA) and Northern Ireland Ambulance Service (NIAS). At both these events members of the Trust's senior leadership delivered a series of presentations outlining the intended steps to decompress the RVH site and the inherent complexities and difficulties in any moves to do so. The summits also included specific commentary surrounding the potential relocation of specialities to the BCH site; and the projected conditions and timeframes required to facilitate this.

The Trust recognised that their staff remain seriously concerned about the overcrowding in RVH ED and in other EDs; and consequently the Trust have asked both the Health & Safety Executive Northern Ireland (HSENI) and the Commissioner for Older people (COPNI) to visit the EDs to witness the impact of pressures first hand.

Despite the action detailed above, ED staff still feel that there has been little evidence of improvement; with some staff reporting that conditions had actually worsened. Even though ED staff acknowledged that system-wide pressures were impacting on the ED, including the problems associated with primary care assessment and community placements; they felt that there had been a distinct lack of action locally to implement apparent solutions from within the Trust.

Staff also reported that the introduction of the new Acute Frailty Unit on the RVH site has provided an alternative patient pathway for eligible patients however, this has reportedly not made a significant difference to ED overcrowding and frail patients are now 'spilling into corridors' from this ward.

There is an apparent disconnect in understanding between ED staff and SMT in relation to the progress and feasibility of site decompression strategies. There was a consensus amongst ED staff that information sharing and communication on the actions taken to reduce overcrowding were ineffectively disseminated to staff groups within the ED.

This AFI in relation to the effectiveness of communication has been assessed as partially met and will be stated for a second time.

Importantly however, there was consensus between ED staff and SMT that the overarching solution to site decompression sits outside of the Trust's control; and requires an ongoing co-ordinated regional approach.

AFI 4

The Trust should ensure all staff meet mandatory training requirements and any additional training needs identified to meet the needs of the changing patient profile. This may include a training needs analysis.

It was confirmed a training needs analysis is carried out annually, to inform commissioning in accordance with service need.

For clarification this AFI was made in relation to staff training for nurses and the response by the Trust on actions to address this was in line with this understanding. This AFI was therefore assessed on this basis.

Mandatory training figures for nursing staff are captured monthly and the Nurse Development Lead highlights any needs to the Lead Nurse & Clinical Educator. Any issues regarding limited or unavailable training places are escalated to the Central Nursing Team who escalate these concerns directly with education providers or the Trust Nurse Development Lead.

A training needs analysis for nursing staff training is undertaken annually to indicate service need and commissioning requirements.

It was confirmed that the Trust have good oversight mechanisms in place to monitor training needs and record mandatory training.

The Trust should ensure similar mechanisms for the oversight of training for all staff groups within the ED.

This AFI has been assessed as met.

4.4 Environment & IPC

AFI 5

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.

Oversight systems for environmental cleanliness had improved within the ED, with shared responsibility between ED staff, the IPCT, Patient Client Service Staff (PCSS), and Estates staff.

While systems of oversight have improved, supported by the implementation of cleaning schedules and the general environment was less cluttered, deficits in environmental cleanliness are still evident. There was evidence of high and low level dust in a number of areas and on equipment across all areas. Non-compliance in relation to IPC sharps box procedures was observed. Mattress auditing had been recently introduced however, mattresses viewed by inspectors were found to be visibly stained.

Staff reported that IPC is difficult to control and challenging due to over-crowding. Examples of this included the ability to access hand washing facilities when patients are being cared for in corridors, and the ability to physically access overcrowded areas to fully complete environmental cleaning. Housekeeping staff were reported as committed and continually clean any free spaces, but this was reported as virtually impossible to maintain due to overcrowding.

This AFI has been deemed as partially met and will be stated for a second time.

Refer to AFI 7 for further information.

AFI 7

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.

There was evidence that the Trust had completed a large IPC audit of the ED during October 2023. An action plan is in place to address the issues identified within the audit however, further work is required to strengthen this action plan and any future action plans in line with SMART principles (specific; measurable; achievable; realistic and time bound).

The Trust should review the findings of the above audit to determine the required frequency of further routine IPC auditing within the ED. Additionally, the above audit should inform the review and revision of cleaning schedules.

Inspectors welcomed that the ED continues to complete personal protective equipment (PPE) and hand hygiene (HH) audits, and that the frequency of auditing is determined by compliance figures.

The IPCT conduct planned visits to the ED, and are available to ED staff for additional support and advice as required.

It is the Trust's responsibility to provide assurance that adequate IPC auditing arrangements are in place.

This AFI has been deemed partially met and will be stated for a second time.

4.5 Medicines Management

AFI 8

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.***

Staff reported that critical medicine posters were displayed in prominent areas.

Staff advised that, due to the high number of attendees, variable length of patient stay in ED, and current level of pharmacy resource medicine reconciliation may not always occur in a timely manner. Pharmacy staff advised that tasks were prioritised according to importance and the level of pharmacist cover provided on any given day. In order to reduce the likelihood of a critical medicine being omitted/delayed, staff stated the nurse induction process covers conditions where these medicines may be prescribed. Staff described additional measures to ensure critical medicines were not omitted/delayed including; a sticker system which denotes which patients are prescribed these medicines and also that pharmacy technicians highlight when a patient is prescribed critical medicines and take measures to obtain.

Members of the pharmacy management team advised the level of pharmacy resource remains unchanged since the previous inspection. Pharmacy staffing was described as severely under resourced, staff retention was described as poor, and staff feel they are firefighting and prioritise what they feel is the most important task at the time, at the expense of other tasks. Discussion with pharmacy staff indicated that further progress and service improvement cannot be achieved until a workforce review is undertaken and adequate pharmacy resource is allocated. Management advised that staffing numbers are indicated in The Royal College of Emergency Medicine (RCEM) position statement, and will be used to determine the pharmacy resource required. The workforce review to include all professional groups is detailed under AFI 2 (section 4.3).

Staff advised that high risk medicine incidents are reported using the incident reporting system and the learning is shared across directorates. Incidents are discussed at the weekly governance meetings and shared at directorate level.

The Level 2 Escalation ward located outside the main ED was not in use and no medicines, including controlled drugs, were stored there. During the on-site inspection, the medicine storage rooms in Majors B area and Zone B were controlled access rooms, authorised staff gained entry via a swipe card system. The rooms were clean and tidy, work surfaces were free from clutter therefore facilitating effective cleaning of the area. Whilst improvements in the storage arrangements for medicines were observed, staff advised that further improvements are necessary.

This AFI has been assessed as partially met. The AFI is not stated for a second time as a workforce review, which incorporates pharmacy, resource remains on-going. Refer to section 6.0.

4.6 Escalation

AFI 9

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 Hospital Early Warning Score (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.***

During the inspection SMT representatives informed RQIA that the Trust has reviewed and updated its internal escalation plan and subsequently shared the updated plan with the inspection team. The updated plan acknowledged a number of supporting documents should be read in conjunction with it namely; the *HSC Regional Unscheduled Care Escalation Guidance, January 2023* and the *2023/24 Belfast Trust Winter Plan*.

It is noteworthy that the updated regional unscheduled escalation guidance no longer adopts HEWS as a means for regional comparison; and remains un-calibrated for this purpose. This task now falls to the Regional Coordination Centre (RCC).

On December 4, 2023 the RCC was launched and the Trust advised that their internal escalation plan would remain under ongoing review and subject to change based upon the effects of RCC implementation.

All HSC Trust Chief Executives agreed to delegate authority to the RCC Director to take operational decisions on behalf of the provider system of unscheduled care in order to manage and balance system-level risks across the region.

Although the internal escalation plan does not specifically refer to the designation of the RVH as the regional Major Trauma Centre; BHSCT has confirmed that since the introduction of the RCC they continue to highlight the importance of the ED being the access point for the reception of regional major trauma admissions.

Despite the updating of the internal escalation plan, staff described it is 'unfit for purpose', as the service is continually operating at the ceiling of its plan and it is felt that they are never in a position where any further steps can be taken. Staff felt there were further options that could be employed to reduce pressure, such as more effective use of the hospital's discharge lounge earlier in the day, and use of alternative accommodation outside of the RVH site. Furthermore, there was an expressed wish for a Department-led process which involves inter-Trust cooperation for region-wide repatriation, and therefore would augment existing site decompression strategies.

Additionally, whilst there was evidence of email communication detailing the required action following internal SIT-REP meetings, the required threshold measures were perceived as meaningless in a constantly highly pressured environment. This has reportedly led to an inconsistent application of such measures and a sense of isolation from other internal Trust stakeholders who could potentially assist with site decompression. This was purported as reflective of an enduring culture which does not promote the understanding of unscheduled care needs and collective responsibility.

This AFI has been assessed as partially met and has been subsumed into a new AFI. Refer to section 6.0.

5.0 Feedback Session

Following every inspection, feedback is provided to the Trust in advance of the report being issued. In an effort to support the Trust in its communication with all staff, RQIA asked the Trust to ensure representatives from all groups of ED staff and members of the senior management team attend the feedback session.

There were representatives from a variety of staff groups which included members of the Trust's SMT, senior clinicians, nursing, administrative and pharmacy staff.

The feedback session solely focused on providing feedback on the Trust's progress with the nine AFIs identified during the 22/23 inspection. The attendees were provided with an outline of the format of the feedback session, advising the order below:

- Rationale;
- Methodology;
- Areas for Improvements;
- Staff Feedback;
- Summary; and
- Next Steps.

An opportunity was provided for attendees to ask questions at the end of the feedback session.

It was acknowledged that, whilst some staff feedback was provided during this meeting, further staff feedback would be included within this report which is shared with the Trust and the DoH.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	5*

*The total number of areas for improvement includes four that have been stated for a second time, and one new AFI has been made.

Areas for improvement and details of the Quality Improvement Plan were discussed with ED staff and representatives from the senior management team, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006).	
WORKFORCE	
Area for improvement 1 **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:** Second time **To be completed by:** June 2024	The Trust's Management Team [SMT] 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).
	Response by registered person detailing the actions taken: A monthly workforce review group was conveened in early 2023, this group is responsible for reviewing all staff groups that support emergency care aiming to implement were feasible best practice and opportunities for improvement. Reviewing medical workforce is challenging as there is often a perceived conflict between what is seen as a full complement of one tier medical staff i.e. the GIRFT report and what actually represents safe staffing levels i.e. RCEM workforce census. Our reliance on locum medical cover for our middle grade and junior rotas is significant, we are being innovative in how we recruit and retain medical staff into substantive roles, inclusive of international medical recruitment. We are reviewing all aspects of emergency care services to try and provide services based on the staff that we have available to us, until we can recruit to substantive positions. Retention of all staff groups is affected by the working environment, to improve the working environment the service requires the Trust to reduce congestion in the RVH ED by an executive led engagement with other services to develop meaningful escalation and a multispecialty SDEC service. Work is underway chaired by the Deputy Chief Executive, Medical Director and Executive Director of Nursing to support the implementation of same day emergency care services across specialties.
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:** Second time	The Trust should improve the effectiveness of its communication with clinical staff to enhance the visibility of actions being taken by SMT 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.

To be completed by: June 2024	**Response by registered person detailing the actions taken**: Operational team: Adult ED service have 2 formal meetings: ED business meeting which occurs monthly, ED medical workforce meeting which occurs weekly. We are currently updating our terms of reference for both these meetings and have encouraged wider representation from all teams delivering direct patient care. Hot debriefs continue on a Monday morning. Divisional: daily safety huddle using a Charles Vincent Model of Safety, to escalate issues and concerns and seek timely resolution or support from wider services. Executive team: daily safety huddle using a Charles Vincent Model of safety with a specific focus on USC pressures and how other directors can support timely and efficient flow. Organisational level: The Chairman and Non executive Directors have met with representatives of all staff groups on 2 occasions, these provided an opportunity to escalate concerns and seek assurances on plans to find resolutions. The outcome of these has led to a series of workshops with specific themes focused on flow, as well as the ability to increase our unfunded escalation beds to a maximum of 3 per ward.
ENVIRONMENT	
Area for improvement 3 **Ref: Standard** 5.1 Criteria 5.3.1 (f) **Stated:** Second time **To be completed by:** June 2024	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.
	Response by registered person detailing the actions taken: There has been significant engagement with our IPCN colleagues and an unannounced RQIA type inspection has been completed. The teams are currently working through their action plans in this regard.

INFECTION PREVENTION CONTROL	
Area for improvement 4 **Ref:** Standard 5.1 Criteria 5.3.1(f) **Stated:** Second time **To be completed by:** June 2024	The Trust should 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.
	Response by registered person detailing the actions taken: An RQIA type audit was completed by the IPCN team, whilst there has been improvement there are still areas within an overall action that continue to be developed. Ongoing weekly monitoring and audits remain in place along with a focus on 'stop and challenge'.
ESCALATION PLAN	
Area for improvement 5 **Ref:** Standard 4, 7 Criteria 4.3 (b, h); 7.3 (g) **Stated:** First time **To be completed by:** June 2024	Notwithstanding that the Trust has strategically planned to address the enduring site pressures; it is incumbent that the internal escalation plan has thresholds and associated actions which are adjusted in line with current pressures; and that any level of action to be taken is readily communicated to all relevant stakeholders across the Trust. The Trust should ensure that appropriate governance is in place to monitor the effectiveness of any escalation measure employed to reduce pressure. In this way, all relevant stakeholders are aware of their roles and responsibilities at each level of internal escalation; and that any subsequent access to regional escalation will evidence that all internal Trust measures have been exhausted.
	Response by registered person detailing the actions taken: The Regional Coordinating Coordination Centre (RCC) was established in early December 2023, and its focus initially has been on the delivery of daily oversight of performance at regional and individual Trust level, and the taking forward of a service improvement programme through an affiliate model which aligns RCC leads to individual Trusts. The Chief Executives have commissioned an objective demand and capacity exercise regarding the unscheduled pressures to be completed in the coming weeks, across the five Trusts (not NIAS) and identify potential solutions for long term, sustainable improvement. At the last meeting between the BFT ED Staff and some of the Non Executive Directors (24th January 2024), it was agreed that all wards within the RVH & Mater hospital sites would expand boarding up to a maximum of three patients per ward, as a short term strategy to alleviate ED

	overcrowding, fully recognising this was an action of last resort, all wards and departments have updated their risk assessment in this regard. We have continued with 70 to 80 patients boarding between both sites on a daily basis, as pressure at the front door has been ongoing. A presentation to Trust Board Assurance Committee based on our risk assessment in relation to delays within the ED has been completed.

Please ensure this document is completed in full and returned via the Web Portal

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