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To drive improvement

Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Royal Infirmary of Edinburgh
NHS Lothian

20 – 22 February 2023

Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer by emailing his.contactpublicinvolvement@nhs.scot

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www.healthcareimprovementscotland.org

About our inspection

Background

All of Healthcare Improvement Scotland's inspection programmes have been adapted since the start of the COVID-19 pandemic.

Taking account of the changing risk considerations and service pressures, in November 2021 the Cabinet Secretary for Health and Social Care approved adaptations to our inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. To minimise the impact of our inspections on staff delivering care to patients, our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records. Further information about the methodology for acute hospital safe delivery of care inspections can be found on our website.

New infection prevention and control standards were published in May 2022. These are applicable to adult health and social care settings and replaced the healthcare associated infection standards (2015). These standards have been used to inform infection prevention and control related requirements within this report.

Our focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- Observe the delivery of care within the clinical areas in line with current standards and best practice.
- Attend hospital safety huddles.
- Engage with staff where possible, being mindful not to impact on the delivery of care.
- Engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards.
- Report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

The Royal Infirmary of Edinburgh is a major acute teaching hospital located on the Edinburgh BioQuarter. With a 24-hour accident and emergency department, it provides a full range of acute medical, surgical and specialist services for patients from across Lothian.

About this inspection

We carried out an unannounced inspection to the Royal Infirmary of Edinburgh, NHS Lothian on Monday 20 to Wednesday 22 February 2023 using our safe delivery of care inspection methodology. We inspected the following areas:

- emergency department
- intensive care unit
- medical assessment unit
- ward 102
- ward 103
- ward 105
- ward 106
- ward 108
- ward 201
- ward 202
- ward 204
- ward 206
- ward 207
- ward 208
- ward 210, and
- ward 230.

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff (where appropriate), and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Lothian to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Tuesday 14 March 2023, we carried out an unannounced follow-up visit to the Royal Infirmary of Edinburgh to establish if concerns we raised during our initial visit had been addressed.

On Thursday 16 March 2023, we held a virtual discussion session with key members of NHS Lothian staff to discuss the evidence provided and the findings of the inspection.

As a result of serious concerns about patient safety within the emergency department identified during this inspection we wrote to NHS Lothian to formal escalate our concerns in accordance with level 1 of our escalation process in the Healthcare Improvement Scotland and Scottish Government: operating framework. A copy of the letter has been published with this report.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Lothian and in particular all staff at the Royal Infirmary of Edinburgh for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice, recommendations and any requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

At the time of inspection, the Royal Infirmary of Edinburgh, like much of NHS Scotland, was experiencing a significant range of pressures including increased hospital admissions, increased pressures in the emergency department and admission units and reduced staff availability. During our onsite inspections the hospital was operating at over 100% capacity.

In ward areas, senior managers were visible, wards were generally calm and well organised and we observed good leadership and care being delivered. Patients and relatives spoken with described a good experience of care and helpful staff.

During the safety huddles we attended, we observed a strong focus on patient care needs across the hospital. However, serious patient safety concerns within the emergency department were identified during this inspection.

Inspectors raised a number of serious patient safety concerns regarding the emergency department during both our onsite inspection and return visit regarding the delivery of fundamental care for patients, patient safety, care and dignity, the current operating environment, leadership and coordination of care in the emergency department, as well as concerns about staff wellbeing.

Other areas for improvement identified during the inspection include the management of intravenous fluids, medicine administration processes, locked doors policies and procedures, and feedback to staff following incident reporting.

NHS Lothian senior managers responded quickly to concerns raised during the initial inspection. However, during our return visit on 14 March 2023, we remained concerned that the immediate actions put in place by NHS Lothian did not lead to significant improvements in the delivery of safe and effective care within the emergency department. This resulted in us writing a formal letter of non-compliance

to NHS Lothian in accordance with level 1 of our escalation process, setting out the serious patient safety concerns that required immediate action.

NHS Lothian promptly responded to this escalation, providing a detailed plan of improvement action to address each of the concerns. We will seek assurance on progress with planned improvement actions in accordance with our published inspection methodology.

What action we expect the NHS board to take after our inspection

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

We expect NHS Lothian to address the requirements. The NHS board must prioritise the requirements to meet national standards. The improvement action plan developed by the NHS board is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org

This inspection resulted in five areas of good practice, three recommendations and 13 requirements.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

Areas of good practice

Domain 2	
1	Patients and relatives we spoke with described kind and compassionate care (see page 16).

Domain 5	
2	Staff and patient interactions observed in ward areas demonstrated a high regard for patient well-being and comfort (see page 22).

Domain 7	
3	Nursing staff described being well supported by senior nursing leadership (see page 26).
4	There was visible nursing leadership in ward areas (see page 26).

Domain 9	
5	An open and transparent quality assurance system is being implemented to assess and improve the quality of person-centred care (see page 28).

Recommendations

Domain 5	
1	NHS Lothian should continue to raise awareness with staff about the Scottish Government's current guidance regarding the use of fluid-resistant face masks or face coverings in non-clinical areas (see page 22).

Domain 7	
2	NHS Lothian should prioritise repeating the emergency department, Emergency Medicine specialty specific staffing and professional judgement tools to understand their workforce requirements (see page 26).

Domain 9	
3	NHS Lothian should consider including the emergency department within the Royal Infirmary of Edinburgh within the quality assurance system framework, to support improvement in fundamental care delivery (see page 29).

Requirements

Domain 1	
1	NHS Lothian must ensure detailed and effective plans are in place to ensure safe fire evacuation of patients and staff within overcrowded areas (see page 12). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).
2	NHS Lothian must ensure learning from incident reporting improves safety and outcomes for patients and staff; and improve feedback to staff on incidents raised through the incident reporting system (see page 12). This will support compliance with: Healthcare Improvement Scotland Quality of Care Framework (2018) Indicator 3.1 and Learning from adverse events through reporting and review: A national framework for Scotland.

Domain 2	
3	NHS Lothian must ensure that patient's privacy and dignity is maintained at all times and all patients have access to a call bell (see page 16). This will support compliance with: Health and Social Care Standards (2017) criteria 4.11, 5.2, 5.3 and 5.4; Healthcare Improvement Scotland Care of Older People in Hospital Standards (2015) Standard 2; Healthcare Improvement Scotland Quality Framework (2018) Indicator and Health and Social Care Standards (2017) Criterion 1.23; and relevant codes of practice of regulated healthcare professions.
4	NHS Lothian must ensure when patients are cared for in mixed sex bays, and where there is reduced access to shower facilities, this is regularly risk assessed and suitable mitigations are put in place to maintain patient dignity and quality of care (see page 16). This will support compliance with Health and Social Care Standards (2017) Criterion 1.20.
5	NHS Lothian must ensure appropriate policies and procedures are in place for instances where it may be appropriate for ward doors to be locked (see page 16). This will support compliance with: Health and Social Care Standards (2017) Criterion 1.3; and relevant codes of practice of regulated healthcare professions.

Domain 5	
6	NHS Lothian must ensure safe intravenous line care practice to prevent the risk of infection and to ensure effective intravenous fluid management (see page 22). This will support compliance with: National Infection Prevention and Control Manual (2023) criteria 2.4 & 4.2; Health and Social Care Standards (2017) Criterion 1.24; and relevant codes of practice of regulated healthcare professions.
7	NHS Lothian must ensure an accurate assessment of patients care needs and make sure fundamental care needs are met. This includes pressure area care, food, fluid and nutrition and assistance with mobility (see page 22). This will support compliance with: Health and Social Care Standards (2017) Criterion 1.24 and relevant codes of practice of regulated healthcare professions.

8	NHS Lothian must ensure the appropriate management and monitoring is in place to ensure the safe administration of medicines (see page 22). This will support compliance with: Professional Guidance on the Administration of Medicines in Healthcare Settings and relevant codes of practice of regulated healthcare professions.
9	NHS Lothian must ensure patients' safety when patients are cared for on trolleys for extended periods of time (see page 22). This will support compliance with: Health and Social Care Standards (2017) Criterion 1.24 and relevant codes of practice of regulated healthcare professions.
10	NHS Lothian must ensure that staff carry out hand hygiene and change PPE in line with current guidance (see page 22). This will support compliance with: National Infection Prevention and Control Manual (2023).
11	NHS Lothian must ensure that patient equipment is clean and ready for use and that the care environment is maintained to support effective cleaning (see page 22). This will support compliance with: National Infection Prevention and Control Manual (2023).

Domain 7

12	NHS Lothian must ensure that they consistently report and record staffing risks, as well as robustly recording mitigations and recurring risks in line with good governance processes (see page 26). This will support compliance with: Health and Care (Staffing) (Scotland) Act (2019).

Domain 9

13	NHS Lothian must ensure effective senior management oversight and support, to reduce the risks for staff and patients receiving care at times of extreme pressure within the emergency department (see page 29). This will support compliance with: Health and Social Care Standards (2017) Criterion 4.23; Healthcare Improvement Scotland Quality Framework (2018) indicators 6.2 and 6.3, and relevant codes of practice of regulated healthcare professions.

What we found during this inspection

Domain 1 – Key organisational outcomes

- Quality indicator 1.2 – Fulfilment of statutory duties and adherence to national guidelines

NHS Lothian was experiencing significant pressure across the Royal Infirmary of Edinburgh including increased hospital capacity, delayed discharges and increased waiting times in the emergency department, with 315 patients waiting over 12 hours during the week of the first onsite inspection.

Serious patient safety concerns within the emergency department, including fire safety, have been escalated to NHS Lothian in a formal letter of non-compliance.

At the time of this inspection, NHS Lothian was experiencing significant pressures across the Royal Infirmary of Edinburgh including hospital capacity, staff shortages, delayed discharges and increased waiting times in the emergency department. During both inspection visits the hospital's capacity was greater than 100%. The impact of this will be discussed in more detail later in the report.

The national target for accident and emergency waiting times means that 95% of patients should wait no longer than four hours from arrival at the emergency department or other admission units before admission, discharge or transfer for other emergency treatment.

Across NHS Scotland, for the week ending 26 February 2023, 64.5% of patients were seen within the 4-hour target with 1,275 patients waiting over 12 hours. In the Royal Infirmary of Edinburgh 41.4% patients met the 4-hour target with 315 patients waiting over 12 hours. Further information can be found in the NHS Performs weekly update of emergency department activity and waiting time statistics.

During our inspection we observed some of the impact of the increased capacity within the emergency department. The emergency department within the Royal Infirmary Edinburgh was extremely busy and over capacity, with many patients waiting for extended periods of time to be seen or admitted to ward areas. This was compounded by general practitioner referred patients also being received within the department. Inspectors were told that the hospital does not utilise additional or contingency beds in ward areas to meet the increased demands in the emergency department. Senior managers explained that the decision had been taken to continue to care for patients who required admission to the hospital within the emergency department until a bed was made available within the appropriate care area.

On the first day of inspection there was 89 patients in the emergency department at the start of the day. There are only 35 cubicle spaces and four resuscitation bays available for patients in the department, which meant that patients were being cared for on trolleys in corridor areas or at the side of the nursing stations. Throughout the day patient numbers within the department increased to 110, with 35 patients waiting up to 8 hours and 20 minutes for their first assessment. Evidence provided by NHS Lothian demonstrated that within the week prior to the first onsite inspection, the department was at times operating at over 300% capacity.

On the return visit in March, 55 patients awaiting admission to an appropriate care area within the hospital were being cared for in the emergency department, with the longest wait time being 25 hours and 3 minutes. Across the hospital, delayed discharges totalled between 107 and 133, putting further pressure on the full hospital system.

We asked NHS Lothian for evidence of the staff shift report from the emergency department for the week leading up to the initial onsite inspection date. We could see that on several occasions staff had reported the department as overcapacity and unsafe and stating the department was a fire safety risk.

Inspectors observed that the emergency department was overcrowded, at times with no space for staff to move in any direction due to the number of patients being cared for in corridors and around the nursing stations.

We asked NHS Lothian for the most recent fire safety risk assessment and fire evacuation action plan for the emergency department. Senior managers told us the most recent fire safety risk assessment, undertaken on October 2022 had been carried out due to concerns about the overcrowding in the department. A number of recommendations had been made within the assessment. For example, it was recommended that the location and number of patients within the department must be reviewed to ensure the corridors are kept free. The detail within the fire evacuation plan describes twice yearly fire evacuations should be undertaken. However, senior managers confirmed to inspectors these had not taken place due to the department being so busy.

The fire evacuation plan in place at the time of inspection did not reflect the significant impact of overcrowding in the department, or consider the current staffing pressures. We are not assured of fire safety within the emergency department. This has been escalated to NHS Lothian along with other concerns that will be described later in this report and we have informed the Scottish Fire Service of our concerns. A requirement has been given to support improvement in this area.

We asked NHS Lothian to provide evidence of any incidents reported by staff from the emergency department through their incident reporting system for three months prior to the inspection. Senior managers were open and transparent with this information and a significant number of these formal incident reports were supplied.

From this information we observed the significant patient safety concerns that inspectors identified during our inspection reflect concerns raised by staff in clinical incident reports. Staff had reported incidents affecting both patient and staff safety. These included reports of violence and aggression towards staff; medication errors including patients receiving the wrong medication, experiencing delays in receiving their medication or not having regular medication prescribed; and delays in care and diagnosis. There were also several incidents where patients had fallen, some of these from the trolley where they were being cared for.

In several incidents staff had reported fundamental patient care needs were not met and had raised concern about the impact of overcrowding on patient dignity. These will be discussed more fully in domains 2 and 5.

We discussed the incident reports with NHS Lothian to understand any wider learning from these reports across the department and ascertain the feedback that is given to staff who report incidents or raise concerns. Senior managers explained that NHS Lothian encourages staff to report incidents. The purpose of collecting such data is to identify learning and implement improvement. However, they acknowledged that feedback to individual staff following the submission of an incident report required improvement. Senior managers confirmed there had been a significant rise in patient safety incidents and were able to share internal governance processes for reviewing these. Concerns about patient safety and care will be discussed later in the report. We are not assured that learning from incident reports within the emergency department has been effective in improving the safety of patients and staff, or that systems and processes in place are sufficient to provide feedback to staff once an incident has been reported. A requirement has been given to support improvement in this area.

Within evidence provided, we observed that NHS Lothian have recorded a risk within the boards corporate risk register detailing the increased pressures and the impact of this on the board's ability to meet the 4-hour waiting time target. This risk has been rated very high. However, the mitigating actions have not been effective in minimising the impact of the extreme overcrowding within the emergency department.

Requirements

Domain 1	
1	NHS Lothian must ensure detailed and effective plans are in place to ensure safe fire evacuation of patients and staff within overcrowded areas.
2	NHS Lothian must ensure learning from incident reporting improves safety and outcomes for patients and staff; and improve feedback to staff on incidents raised through the incident reporting system.

Domain 2 – Impact on people experiencing care, carers and families

- Quality indicator 2.1 – People's experience of care and the involvement of carers and families

Patients and relatives we spoke with described kind and compassionate care. Inspectors observed good examples of person-centred care. However, within the emergency department patients did not have access to call bells and there were no emergency buzzers in place. Concerns related to patient dignity and care have been escalated to NHS Lothian in a formal letter of non-compliance.

Patients and relatives we spoke with described kind and compassionate care. In the majority of areas inspectors observed respectful and caring interactions between staff and patients, including instances when medical and nursing staff had taken time to provide detailed information to patients about their care.

For example, within the intensive care unit staff were observed explaining treatment interventions comprehensively and allowing time for the patient or their relatives to ask questions. Another patient in a ward area explained they had been in the ward for a long period of time with their room looking out on a quiet courtyard. Staff had taken the opportunity to move the patient to another room overlooking the front of the hospital to give them more of a view. The patient felt staff were taking care of their mental health as well as their physical needs.

The Meaningful Activity Centre is a pilot service being delivered by the hospital's enhanced care team. We were told the service is currently available for Medicine for the Elderly and Orthopaedics and for patients living with dementia, or patients with other cognitive impairment who may be experiencing stress or distress. It aims to provide a safe therapeutic environment where patients can participate in activities, socialise and engage in one to one or group conversation. We observed examples of individual planning to find meaningful activities designed around the patient. We were told that a business case has been submitted which would allow this service to move to dedicated premises on the ground floor, improving access to outdoor space.

In the ward areas inspected, patients appeared well cared for. Fundamental care needs were being met and patients had access to call bells. However, within the Medical Assessment Unit (MAU) we observed some broken call bells. We were told these were being repaired. Patients in this area did describe being able to ask for help from staff when required. However, one bay, located in the centre of the unit in sight of the staff and nursing station, had no call bells for patients. Other patients in this bay area were located in side rooms and would not be easily visible to staff if the patient required assistance. A requirement has been given to support improvement in this area (see domain 5).

We observed there were no call bells or emergency buzzers in place in the emergency department. Senior managers explained this was because call bells were considered a ligature risk and therefore unsafe in this clinical area. The impact of the lack of call bells within this department will be discussed later in this domain.

The MAU is a 66 bed unit and receives patients who are admitted to the hospital from the emergency department. We were told due to bed pressures, patients are often now cared for in this area for a number of days rather than the short period of time the unit was designed for. There are only eight showers in this unit, and staff described having to stagger times for people to access the shower facilities. Due to the open plan style of the unit both male and female patients are cared for in mixed sex bays. However, inspectors did observe curtains drawn appropriately to maintain privacy. This high number of patients being cared for in this area for extended periods of time may impact on patient dignity and experience of care. A requirement has been given to support improvement in this area.

During our first inspection of MAU we highlighted to staff that patient name boards above the beds were not filled in, leading to staff referring to patients as bed numbers rather than their preferred name. During our return inspection visit this had been addressed and patient name boards were completed.

Within the emergency department, the extent of the overcrowding had a significant impact on the ability to maintain dignity for the patients being cared for in corridor areas and around the nursing station.

We observed confidential discussions about patient care and treatment plans being discussed in corridors and with hearing distance of other patients and relatives.

During both inspection visits we observed patients being cared for on trolleys placed near the nursing stations. During the first inspection visit many patients on these trolleys did not have blankets to cover them. On our return visit we observed the majority of patients did have blankets to cover them. However, concerns about patient dignity and experience of care remained.

Examples of this include a patient observed in a corridor area on urine soaked sheets, with another patient on a blood stained pillow for several hours before this was changed. Another example was a very visibly distressed patient who had removed their outer clothes leaving only their underwear in place whilst being cared for on a trolley beside the nursing station. Other patients witnessing this also appeared distressed. When we highlighted the situation to nursing staff they explained they were already aware of the patient and that the patient had received pain relief. However, no further action was taken to support patient dignity.

Within the three month period of incident reports provided relating to the emergency department, we observed staff have also raised concerns about patient care and dignity. These included patients arriving from the emergency department to other care areas in the hospital found to be soaked in urine, and staff highlighting

patients' fundamental care needs were not being met due to the pressures in the emergency department. This will be discussed further in domain 5.

During both inspection visits patients repeatedly sought assistance from inspectors for help to access toilet facilities and pain relief. The lack of call bells within the emergency department, and the general volume of noise from patients and staff within the confined spaces, contributed to patients struggling to get the attention of staff when they required assistance. The layout of the emergency department and placement of patients, including when curtains are drawn within cubicles, resulted in patients not being easily visible to staff. During both inspection visits inspectors were required to request assistance from staff to prevent patients falling out of trolleys. In the return inspection, an incident occurred where an inspector was required to intervene and get assistance for a patient at risk of falling off a trolley as they tried to push themselves over the trolley side rails to get to the toilet. During this incident the inspector had to shout loudly twice to get the attention of staff who then came to help. Senior managers have told us a variety of nurse call systems are being considered. However, we have not been provided with a timescale for completion.

Patients also have limited access to toilet facilities in the emergency department, with only a small number of toilets available in this area. The toilets are small and would not accommodate patients who required assistance using them. Staff explained that if a patient was being cared for on a trolley in the corridor areas around the nursing station and required to use a commode or bed pan, they would try to move the patient temporarily to an empty cubicle space to provide privacy to use the toilet facilities and for personal care.

The concerns relating to the emergency department have been escalated to NHS Lothian and requirements have been given to support improvement in these areas.

Despite these concerns, the patients we were able to speak with in the emergency department did describe feeling well cared for and described staff as being kind. Many expressed their awareness of how busy the department was and how hard the staff were working.

During the inspection we identified three wards where the door for entry and exit to the ward had been locked electronically. This prevented any patients or visitors from leaving without the assistance of staff. There was no information or signage on display to advise patients or visitors how to enter or exit the ward. We raised this as a concern with hospital managers who confirmed they were aware of the locked wards and explained the safety reasons for this. One area is locked, when required, to prevent access for patients who were subject to detention under the Mental Health Care and Treatment (Scotland) Act (2003). The other two wards within the newer part of the hospital had a management decision to remain locked at all times, as these were adult wards located close to the children's wards.

During our return inspection we observed posters had been placed on the doors alerting visitors and patients that the doors were locked. Staff would assist them in entering and existing the wards. Within the area that is intermittently locked, we observed a log has been kept of when the door is locked and the reason for this. During discussions, senior managers told us a leaflet is currently being developed to be given to patients and relatives in these areas to explain the locked doors. However, NHS Lothian confirmed it does not have a locked door policy. A requirement has been given to support improvement in this area.

Area of good practice

Domain 2	
1	Patients and relatives we spoke with described kind and compassionate care**.**

Requirements

Domain 2	
3	NHS Lothian must ensure that patient's privacy and dignity is maintained at all times and all patients have access to a call bell.
4	NHS Lothian must ensure when patients are cared for in mixed sex bays, and where there is reduced access to shower facilities, this is regularly risk assessed and suitable mitigations are put in place to maintain patient dignity and quality of care.
5	NHS Lothian must ensure appropriate policies and procedures are in place for instances where it may be appropriate for ward doors to be locked.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

- Quality indicator 5.1 – Safe delivery of care

We observed the majority of ward areas were calm and well organised with good leadership and teamwork to support the safe delivery of care. We observed patients in ward areas looked well cared for. However, serious concerns regarding the safe delivery of care for patients within the emergency department have been escalated to NHS Lothian in a formal letter of non-compliance.

We observed the majority of ward areas were calm and well organised and senior nursing staff were visible. We observed good leadership and teamwork to support the safe delivery of care, despite ward areas and departments being busy and experiencing staff shortages. Staff and patient interactions that were observed

demonstrated a high regard for patient wellbeing and comfort. We observed patients in ward areas looked well cared for. Patients we spoke with described the care they received positively and told us communication was good regarding plans of care.

Documentation of patient care was variable throughout the hospital. In some areas inspected there was evidence of care rounding tools being completed to a good standard. Many of the risk assessments used in the hospital were electronic and in order not to interrupt staff in the ward environment, we were unable to observe them. However, in the few instances where documentation could be easily accessed, gaps in recording accurate information were observed, this included incomplete fluid balance records.

Other gaps in documentation includes the Adults with Incapacity (AWI) section 47 certificate. These are legal documents which assist the patients, their family and staff to make decisions about the patient's care when the patient is unable to do so independently. The section 47 certificate is used to authorise treatment for patients who are unable to consent to treatment themselves. Inspectors only observed a few examples of these in place during the inspection. In one instance the section 47 certificate was out of date. This was raised by inspectors at the time with the nurse in charge to address the issue.

We were able to observe that in some ward areas patients who were identified as a high falls risk had been provided with a falls prevention kit, including yellow socks and blankets which is a quick visual alert to staff of patients assessed as being at risk of falls.

In one area inspected we observed medicines on the floor under several patients' beds. This was highlighted to staff who then disposed of the medicines. During our return inspection we visited this area again and did not observe medication on the floor. However, we did observe patients' medications being dispensed and then left on the patient bedside tables. This may increase the risk of error in the administration of the medicine. For example, the medication may not be taken, be knocked onto the floor or may not be taken at the prescribed time, impacting on the timing of subsequent medicine administration. This is not in line with NHS Lothian's own administration of medicines policy which states 'Doses of medicines must not be left unsupervised on patients' lockers, the practitioner responsible for administering the medicine must supervise the patient until administration is complete'. A requirement has been given to support improvement in this area.

We observed a variety of mealtimes. Within ward areas the majority of these were well organised, patients received assistance and patient choice was promoted. We observed patients being offered alternative choices if a meal was missed and there were good examples of staff being aware of patient's dietary requirements.

However, within the MAU some patients did not receive the required assistance at mealtimes.

A volunteer service supplied patients in the emergency department with fluids and nutrition. However, patients did not receive assistance with drinks or meals. We observed patients struggling to open sandwich packets, patients trying to eat while lying flat on trolleys, or struggling with drinks due to lack of availability or space for bedside tables. Within the incident reports provided relating to the emergency department, we observed safety incidents had been reported by staff in relation to the provision of fluid and nutrition such as burns from hot drinks, or choking when lying flat and eating. A requirement has been given to support improvement in this area.

We observed the space and facilities available in the emergency department impacted on the opportunities for staff to provide the level of care required for patients who require admission to the hospital.

As described earlier in this report, we observed patients being cared for on trolleys in the emergency department for extended periods of time. Some patients remained in the department overnight and for in excess of 20 hours. Staff told us they try to organise a hospital bed for patients who remain in the department for long periods. However, due to the limited space and the amount of patients being cared for in corridor areas and around the nursing station we observed the majority of patients, including those who already had skin damage, remained on trolleys. A requirement has been given to support improvement in this area.

We observed that the majority of patients on trolleys, including those who were independently mobile, had the side rails in the upright position without risk assessments in place. NHS Lothian have provided a policy on the use of bed rails that explains when patients are on a trolley the rails should be in place. However, this does not appear to take account of patients being cared for on trolleys for extended periods of time along with other patient risk factors. Patients we spoke with who were fully mobile described pushing themselves to the bottom of the trolley to get off to go to the toilet. As previously discussed, through the incident reports we observed evidence of patients falling over the trolley side rails, in addition to the incident where the inspector had to intervene to prevent a patient falling when pushing themselves over the trolley side rails to get to the toilet. We have shared these concerns with the Health and Safety Executive in line with our agreed memorandum of understanding. A requirement has been given to support improvement in this area.

Inspectors observed an uncoordinated approach to patient care in the emergency department, with a lack of direction to ensure that fundamental patient care needs are met and patient safety risks assessed and mitigated. There appeared to be a lack of effective delegation of activities and supervision of junior and supplementary

staff. Some staff were unsure which patients they were caring for, or which patients required assistance.

To support the delivery of fundamental care within the emergency department a new care rounding tool had been implemented. However, the first day of this inspection was also the first day of the tool being implemented, therefore staff were still building skills in using the tool.

Care rounding is intended to increase patient comfort and promote a coordinated care environment as it anticipates the care needs of the patient. However, during our return visit we were not assured of its effectiveness in assessing and meeting the patient care needs. For example, inspectors noted several patients inaccurately assessed as being self-caring, or requiring some assistance who were not independently mobile or required full assistance with their care. We observed examples of patients who had documented care rounding in place with incomplete patient identifiable information recorded.

In one instance we observed a patient who had been assessed as independent with their care needs, however we observed they required the assistance of two staff members when mobilising. Or the example already discussed, where an inspector had to intervene to prevent the patient falling over the trolley rails who had also been assessed as independent. A requirement has been given to support improvement in this area.

Effective care rounding was further impacted by the regular moving of patients around the emergency department. This made it difficult for staff to locate individual patients as many were being cared for in non-standard care areas around the nursing station, or in corridors.

Inspectors were unable to ascertain if patients with extended stays in the emergency department were receiving their own prescribed medications at the correct intervals or dosage. We were told that staff often had to leave the department to source these medications for patients.

We asked NHS Lothian to provide evidence that time critical medications were being administered to patients in a timely manner. These medications include anti-convulsants, anti-psychotics, medications for Parkinson's disease and insulin. NHS Lothian told us they are considering alternative ways to ensure these medications are available and have developed a standard operating procedure (SOP) to minimise the omission of these medications commencing by mid-April 2023. A requirement has been given to support improvement in this area.

During both inspection visits within the emergency department, we observed a number of intravenous infusions had run dry and remained connected to these patients. We also observed intravenous infusions being connected without staff carrying out hand hygiene, or cleaning the cannula port prior to connection of an intravenous giving set. We discussed this with senior emergency department

managers who explained this was an effect of the pressures within the department and staff workloads. We were told posters had been developed to be displayed throughout all clinical areas of the hospital to educate staff on the safe use of intravenous access as an immediate response to the concerns raised from our observations. We were also told work relating to the safe management of invasive devices and intravenous lines that was paused due to the COVID-19 pandemic, would now be restarted. A requirement has been given to support improvement in this area.

In other instances we observed patients who were receiving intravenous medication in the corridor area of the emergency department. We discussed this with senior nursing staff who confirmed the administration of this medication should require the patient being monitored on a cardiac monitor. This was raised with staff at the time of the inspection and the patients were moved as soon as staff were alerted. A requirement has been given to support improvement in this area.

In response to the serious concerns relating to the safe delivery of care in the emergency department we escalated, NHS Lothian have provided an improvement action plan. This includes detail on support and training for staff, weekly audits of the care rounding tools, role descriptors for staff and additional senior staff put in place to support improvements in the emergency department. The action plan also refers to improving access to bed rail risk assessments and the commencement of a meal co-ordinator role within the department. In addition, NHS Lothian are in the process of recruiting staff into the emergency department whose primary role will be to ensure patients receive fundamental care.

Standard infection control precautions (SICPs) should be used by all staff at all times. These include the appropriate use of personal protective equipment (PPE), hand hygiene, management of both care equipment and the environment and the safe management of used linen and prevention of sharps injuries.

Compliance with hand hygiene reduces the risk of the spread of infection. We observed that there was a good supply of alcohol-based hand rub (ABHR) throughout the hospital environment and there was signage to promote the use of this for visitors. However, in the majority of areas we observed poor compliance with hand hygiene with either missed opportunities or the wrong technique being observed. Some staff were not bare below the elbows which is against current guidance as it can prevent effective hand hygiene. There were also missed opportunities to promote patient hand hygiene prior to meal times. A requirement has been given to support improvement in this area.

In all areas there was a good supply of PPE such as aprons and gloves and it was stored to prevent contamination. The majority of staff followed guidance in the correct use and disposal of PPE.

Current Scottish Government guidance on the use of face masks strongly recommends staff wear fluid-resistant face masks throughout the hospital setting. NHS Lothian's current advice to staff is that the use of these masks is expected when providing direct or close proximity contact with patients. We observed some staff were not complying with the NHS Lothian's advice and other instances where masks were worn incorrectly. A recommendation has been given for consideration.

We observed generally good compliance with safe management of linen and sharps management where sharps bins were taken to point of use which reduces the risk of a sharps injury. However, it was seen that the temporary closures for these bins were not always closed.

Transmission based precautions (TBPs) are the additional precautions that should be used by staff when caring for a patient with a known or suspected infection. In ward areas we observed good compliance with TBPs for patients with a suspected or confirmed infection. In the emergency department staff were observed moving between patients without changing PPE in line with guidance.

In the majority of areas we observed signage in place to identify which areas required TBPs including advice on correct PPE.

However, we observed a lack of clear signage in the emergency department for patients requiring these additional precautions. This was raised at the time with the nurse in charge of the areas and the signage was rectified quickly.

In a number of areas inspected patient use equipment was not clean. This included dusty equipment such as resuscitation trolleys, Electrocardiogram (ECG) machines and many intravenous drip stands with dirty bases and wheels. Other equipment, including a vital signs observation machine and a suction machine, were visibly contaminated. A requirement has been given to support improvement in this area.

In one area we observed daily resuscitation trolley checks were not being carried out. During our return visit this had been actioned and daily checks were now in place.

The majority of the wards were well maintained and the ward environments appeared clean. One ward was identified where several elements of the environment were in need of repair, such as damaged flooring and work surfaces as well as broken units. We were provided with evidence from NHS Lothian that these repairs have been outstanding since May 2022. However, we have not been provided with a timescale for these repairs to be completed. This was fed back to the senior management team onsite and also during the discussion session. A requirement has been given to support the improvement of this area.

Area of good practice

Domain 5	
2	Staff patient interactions in ward areas demonstrated a high regard for patient well-being and comfort.

Recommendation

Domain 5	
1	NHS Lothian should continue to raise awareness with staff about the Scottish Government's current guidance regarding the use of fluid-resistant face masks or face coverings in non-clinical areas.

Requirements

Domain 5	
6	NHS Lothian must ensure safe intravenous line care practice to prevent the risk of infection and to ensure effective intravenous fluid management.
7	NHS Lothian must ensure an accurate assessment of patients care needs and make sure fundamental care needs are met. This includes pressure area care, food, fluid and nutrition and assistance with mobility.
8	NHS Lothian must ensure the appropriate management and monitoring is in place to ensure the safe administration of medicines.
9	NHS Lothian must ensure patients' safety when patients are cared for on trolleys for extended periods of time.
10	NHS Lothian must ensure that staff carry out hand hygiene and change PPE in line with current guidance.
11	NHS Lothian must ensure that patient equipment is clean and ready for use and that the care environment is maintained to support effective cleaning.

Domain 7 – Workforce management and support

- Quality indicator 7.2 – Workforce planning, monitoring and deployment
- Quality indicator 7.3 – Communication and team working

We reviewed workforce data for Nursing, Medical and Allied Health Professional staff groups at the Royal Infirmary of Edinburgh. This demonstrated high levels of vacancies, particularly within the registered nursing staff group.

The emergency department was observed to be an area of significant concerns, with some staff reporting risks around the reduced staffing levels, skill mix and the adverse impact on patient care and staff wellbeing.

We observed several initiatives to promote communication in order to support an open and transparent culture within the hospital.

NHS Scotland continues to experience significant pressures compounded by staffing vacancies and recruitment challenges. We reviewed workforce data for nursing, medical and allied health professional staff groups which showed high levels of vacancies, particularly within the registered nursing staff group.

Nursing and medical teams within the emergency department stated that, at times, they were working with less that optimal staffing levels and the necessary skill mix to fully support the delivery of safe and effective care. However, there was evidence of teamwork and person-centred care within the inpatient wards and nursing teams reported feeling supported by the leadership teams.

In preparation for the Health and Care (Staffing) (Scotland) Act 2019, which was legislated to support safe staffing, the Royal Infirmary of Edinburgh uses a nursing daily staffing template which records a real time risk status for staffing. This approach supports the whole system in recording, reporting and managing staffing risks. The safe to start approach has an automated red, amber and green (RAG) rating built-in to help senior leaders to understand the areas reporting staffing risk due to shortages.

We observed that the nursing staffing template used within the hospital huddle had a strong focus on areas under pressure due to depleted staffing levels and patients of concern. There are clear processes and guidance in place which supports staff using their professional judgement in their decision making and ensures a consistent hospital wide approach. However, the template did not record patient dependency or complexity, which would have further enhanced teams in their professional judgement.

We observed real time staffing discussions which took place during the safety huddles at agreed times throughout the day. The purpose of the safety huddles is to

provide site situation awareness, understand patient flow and raise issues such as patient safety concerns, review available staffing and identify wards or departments at risk due to reduced staffing.

These huddles have been extended to other clinical and hospital groups. However, some staff groups do not regularly attend these huddles. For example, representative from estates, domestic or portering services. Having a strategic overview of the site status and staffing pressures can ensure a whole system approach to mitigating risks. We were informed that the duty manager will take the actions of the day and report these to the relevant departments.

Allied health professionals (AHP) have recently started to attend the morning huddle but view this as a mechanism to focus on where they can provide support to the nursing staff, rather than highlighting their staffing risks and priorities. The AHP teams have their own internal staff huddles where they discuss workload, staff availability and priorities with awareness for escalation. There is no consistent recording of mitigations and escalations in place. However, we were told there is work ongoing to ensure that they have a robust process.

Movement of staff across the hospital was recorded separately, but no other mitigations discussed for nursing staff were documented. A more robust approach is recommended to make certain that the staffing mitigations and escalations are recorded more consistently. This will support identifying recurrent risks and themes. A requirement has been given to support improvement in this area.

As previously described the emergency department had more patients than available space. A third of the staff on duty were supplementary staff, there was a lack of coordination within the department, and staff were not clear on their specific responsibilities and priorities for the patients in their care. This had a negative impact on the safe delivery of care. Due to the pressures within the department the senior staff member on duty did not have time to oversee the whole department and monitor the quality of care being delivered.

Supplementary staffing includes substantive staff working additional hours, staff from the NHS boards' staff bank or staff from an external agency. Supplementary staffing was being used to support staffing gaps and clinical areas experiencing increased service demands.

A benchmarking exercise using Royal College of Nursing Workforce Standards for Type 1 Emergency Departments (RCN 2020) has been completed. This has highlighted that there are a low level of staff in leadership roles and a higher number of staff nurses. Based on the workforce standards developed, this is below the recommended skill mix. There has been some progress in rebalancing the skill mix and reducing reliance on junior staff with additional staff recruitment into senior posts and provision of management time. However, several recommendations

remain outstanding or have not been fully addressed. We were informed that work continues to progress these.

Staff within the emergency department have reported concerns around staffing and the impact this has on patient care and staff wellbeing. A review of staffing using a mandated specialty specific staffing tool for emergency departments did not capture the robust data needed to help inform decisions in regard to staffing. The data collected using this tool calculates the recommended workforce for nursing and medical staff using both the tool and staffs' professional judgement to ensure safe staffing. We were assured that NHS Lothian plan to repeat this. A recommendation has been given for consideration.

Due to the system pressures within the hospital, it has been challenging for the senior charge nurses to have regular time to lead. Having dedicated time supports leaders to have oversight and provide support to the teams to deliver high quality safe and effective care. The absence of dedicated time appears to have had an impact on NHS Lothian's Accreditation and Care Assurance Standards, which shows a reduction of quality in some areas of the agreed quality indicators.

There are proactive recruitment processes in place to help address some of the pressure. This includes offering final year students part time contracts and allocating them to areas of highest vacancies, developing the present workforce into band 4 posts and recruitment of international nurses. Despite this it remains challenging to recruit to nursing vacancies across NHS Scotland.

While AHP vacancies are not of concern at present, it has been noted that there has been a higher level of staff turnover as staff have pursued career options abroad. The AHP teams are finding it more challenging to recruit to leadership roles but have processes in place to provide internal staff development with the aim of encouraging career progression within NHS Lothian.

We observed several initiatives to promote communication in order to support an open and transparent culture within the hospital campus. For example:

- Transparency around the assessment of staffing risk each day.
- Visible leadership and open discussions within wards, with feedback given from main staff huddles.
- Multidisciplinary team collaboration and communication strategies between all professional groups such as allied health professionals. This was particularly evident in wards.
- Staff wellbeing initiatives advertised and staff awareness of these.
- Student nurses being supported and given opportunities to learn.
- Reminders within wards to ensure supplementary staff were welcomed and supported.

Despite the staff shortages, inspectors observed wards were well managed. We observed effective leadership and communication, and staff were focused on the provision of safe and compassionate care to patients. The majority of nursing staff informed us that they were well supported by leadership.

Areas of good practice

Domain 7	
3	Nursing staff described being well supported by senior nursing leadership.
4	There was visible nursing leadership in ward areas.

Recommendation

Domain 7	
2	NHS Lothian should prioritise repeating the emergency department, Emergency Medicine specialty specific staffing and professional judgement tools to understand their workforce requirements.

Requirement

Domain 7	
12	NHS Lothian must ensure that they consistently report and record staffing risks, as well as robustly recording mitigations and recurring risks in line with good governance processes.

Domain 9 – Quality improvement-focused leadership

- Quality indicator 9.2 – Motivating and inspiring leadership

In all areas inspected nursing staff described feeling supported in their roles and complimentary about senior management support. However, within the emergency department medical staff described a less positive culture, with a lack of visible senior management, and expressing frustration at the capacity and safety issues within the department. Concerns about leadership, coordination of care and staff well-being were escalated to NHS Lothian in a formal letter of non-compliance.

We observed the hospital wide safety huddles were led by senior managers and had good clinical representation attending and contributing to the huddle. These huddles focused on flow, hospital pressures and on patient safety and care needs. In all areas inspected, nursing staff described feeling supported in their roles and complimentary

about senior management support. All of the wards visited appeared to be calm, well led and organised with clinical nurse managers visible in all areas.

However, leadership and oversight of care within the emergency department was not effective. As already discussed, we observed uncoordinated care leaving gaps in fundamental care delivery, patient dignity and patient safety concerns. The majority of nursing staff in this area described feeling supported by nursing managers however some nursing staff described being overwhelmed. Senior nursing managers explained to inspectors this was impacted by the overcapacity of the department and that many of the nursing staff within the department were less experienced or newly qualified, however there appeared to be a lack of effective delegation of activities and supervision of junior and supplementary staff.

Senior medical staff described the department was operating beyond its original scope and intention, highlighting senior managers were not visible in the department. They expressed frustration with the overcrowding and that risks to patients and staff as a result were not being addressed and were openly critical of senior leaders in discussions with inspectors. A requirement has been given to support improvement in this area.

Senior managers responded quickly to the serious concerns we raised with them and produced an action plan detailing the immediate actions that would be taken. However, as described throughout this report, during our return visit we were not assured the actions had been sufficient to reduce risks and improve patient care and safety.

During discussion and subsequent response to the concerns we escalated**,** NHS Lothian senior managers have shared further actions being taken to improve the coordination and delivery of care in the emergency department. Some examples include the introduction of safety pauses in each pod within the department in addition to the wider emergency department safety pause, clear role allocation, senior nursing staff leading each shift, additional senior management support for the area and the introduction of a SOP for the administration of regular medications. At the time of our inspection many of these initiatives were not implemented therefore their impact and effectiveness could not be assessed. However, we recognise that NHS Lothian have responded with improvement actions to address the concerns raised.

Senior managers shared work underway to improve the flow and capacity within the emergency department. This is contained within the emergency access project board 26-week plan, which includes work streams focused on individual projects to improve the delivery of safe and timely care to patients presenting to the emergency department. The plan was underway at the start of the inspection commencing on 20 February and is due to be completed in August 2023. The work streams focus on projects such as accommodation and reconfiguration, patient flow and pathways. In

response to concerns raised following our initial inspection feedback, a further sixth work stream was added to this plan. This works stream is focused on the fundamentals of care.

NHS Lothian have introduced an improved quality assurance system framework to provide assurance to the organisation and service user that high quality person-centred care is being delivered consistently across all NHS Lothian's services. However, the emergency department has not been included within this framework. Senior managers explained the rationale for excluding the emergency department from this framework was to allow the department to focus on improving the delivery of fundamental patient care. However, the framework covers fundamental patient care topics such as pressure area care, food, fluid and nutrition and person-centred care. Not including the emergency department within this quality assurance system may be a missed opportunity to support improvement in fundamental care delivery within this area. A recommendation has been given for consideration.

We were provided with evidence of the scores from the first two round of assessments that have taken place across the hospital. We observed that many of the compliance rates scores were low and senior managers told us they felt these were accurate assessments of the care being delivered at the time. From the report we could see areas of good practice are identified along with areas for improvement to allow staff and teams to focus on improvements and build on the levels of care. Within the report it is acknowledged that NHS Lothian were open and transparent about not able to provide assurance that consistent high quality person-centred care is being delivered across all areas at this time of report production.

Findings of this inspection have not provided assurance of the safe delivery of care within the emergency department. However, we recognise there has been positive engagement with the inspection process from the NHS Lothian executive and senior management team. NHS Lothian have sought to understand the findings from this inspection in order to make the necessary improvements. We will seek assurance on progress with planned improvement actions in accordance with our published inspection methodology.

Area of good practice

Domain 9	
5	An open and transparent quality assurance system is being implemented to assess and improve the quality of person-centred care.

Recommendation

Domain 9	
3	NHS Lothian should consider including the emergency department within the Royal Infirmary of Edinburgh within the quality assurance system framework, to support improvement in fundamental care delivery.

Requirement

Domain 9	
13	NHS Lothian must ensure effective senior management oversight and support, to reduce the risks for staff and patients receiving care at times of extreme pressure within the emergency department.

Appendix 1 – List of national guidance

The following national standards, guidance and best practice were current at the time of this inspection. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, January 2016)
- Care of Older People in Hospital Standards (Healthcare Improvement Scotland, June 2015)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards (Healthcare Improvement Scotland, 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, March 2023)
- Operating Framework - Healthcare Improvement Scotland and Scottish Government (Healthcare Improvement Scotland, Nov 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Right to treat (mwcscot.org.uk) Right to Treat Delivering Physical Healthcare to people who lack capacity and refuse or resist treatment Good practice guide(Mental Welfare Commission Scotland Feb 2022)
- The Quality Framework: September 2022 (Healthcare Improvement Scotland, September 2022)
- Staff governance covid-19 guidance for staff and managers (NHS Scotland, January 2022)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

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