Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Queen Elizabeth University Hospital Emergency Department

NHS Greater Glasgow and Clyde

8 April 2024

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures the methodology was adapted 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 hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for acute hospital safe delivery of care inspections can be found on our website.

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, and
- 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 Queen Elizabeth University Hospital, Glasgow, opened in April 2015. The campus has 1,821 beds with a full range of healthcare specialities, including an emergency department. In addition to the 11-floor Queen Elizabeth University Hospital building, the hospital campus retains a number of other services in adjacent facilities. This includes maternity services, the Royal Hospital for Children, the Institute of Neurological Sciences, and the Langlands Building for medicine of the elderly and rehabilitation.

About this inspection

During week commencing 8 April 2024 we carried out inspections of three hospitals in NHS Greater Glasgow and Clyde in line with our safe delivery of care acute hospital inspection methodology.

We carried out unannounced focused inspections of the emergency departments at the Queen Elizabeth University Hospital on Monday 8 April and Glasgow Royal Infirmary on Tuesday 9 April.

As these inspections were focused specifically on the emergency departments, we did not visit any other areas within the hospitals.

In addition to this, a hospital wide unannounced inspection was carried out at the Royal Alexandra Hospital from Monday 8 to Wednesday 10 April. Full details of this inspection can be found here.

As a result of significant patient safety concerns identified during our inspection of the emergency department at Glasgow Royal Infirmary, an unannounced hospital wide safe delivery of care inspection of Glasgow Royal Infirmary was undertaken in June 2024. A report of our inspection findings for this hospital are expected to be published in August 2024.

On Thursday 4 April 2024 Healthcare Improvement Scotland announced that it was undertaking a review of safety and quality of care at the Emergency Department of Queen Elizabeth University Hospital in response to concerns raised by emergency department consultants at the hospital. The review will also take account of relevant safety considerations across the other main receiving Emergency Departments in NHS Greater Glasgow and Clyde.

This review will consider the full breadth of the leadership, clinical, governance and operational issues, that may impact on the safety and quality of care in the emergency departments in NHS Greater Glasgow and Clyde, as well as consider any wider learning for Emergency Departments across NHS Scotland. Further information about the review and its Terms of Reference can be found here.

This inspection and report are separate to the review and are focused on our inspection of care at the emergency department at the Queen Elizabeth University Hospital on the 8 April 2024.

The results of the wider review will be published at a later date.

During this unannounced inspection to the Queen Elizabeth University Hospital Emergency Department we:

- inspected the emergency department
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and staff, and

- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Greater Glasgow and Clyde 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 Friday 26 April 2024 and Thursday 16 May 2024, we held virtual discussion sessions with key members of NHS Greater Glasgow and Clyde staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the emergency department at the time of this inspection.

We would like to thank NHS Greater Glasgow and Clyde and in particular all staff at Queen Elizabeth University Hospital emergency department for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and 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 this inspection NHS Greater Glasgow and Clyde, much like the rest of NHS Scotland, was experiencing a range of pressures including increased waiting times in the emergency department.

Despite these pressures we observed that staff were focused on the provision of safe and compassionate care and patients were complementary about their care and the staff providing it.

The department was calm and well led with good visibility of senior nurses and hospital managers.

Staff described a number of initiatives to improve patient experience within the department including the introduction of new nursing documentation and a continuous flow model.

Areas for improvement have been identified, these include improvements relating to hand hygiene compliance, the management of used linen and the safe storage of cleaning products.

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

This inspection resulted in six areas of good practice, one recommendation and five requirements.

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.

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

We expect NHS Greater Glasgow and Clyde to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: https://www.healthcareimprovementscotland.scot

Areas of good practice

The unannounced inspection to Queen Elizabeth University Hospital Emergency Department resulted in six areas of good practice.

Domain 1	
1	A number of initiatives have been introduced to improve patient flow and waiting times (see page 15).

Domain 2	
2	Senior nurses and managers demonstrated a good understanding and oversight of patient care (see page 18).
3	Senior nurses were visible and the department was calm and well-coordinated (see page 18).

Domain 4.1	
4	Staff were responsive to patient needs and patients spoke highly of the staff and the care they provided (see page 21).
5	New nursing documentation has been introduced to improve patient safety in response to increasing lengths of stay (see page 21).

Domain 6	
6	We observed the delivery of caring, compassionate care (see page 26).

Recommendation

The unannounced inspection to Queen Elizabeth University Hospital Emergency Department resulted in one recommendation.

Domain 4.3	
1	NHS Greater Glasgow and Clyde should ensure the Emergency Department and Emergency Medicine staffing level tool and professional judgement tool for nursing and medical staff is fully completed as part of the common staffing method (see page 25).

Requirements

The unannounced inspection to Queen Elizabeth University Hospital Emergency Department resulted in five requirements.

Domain 4.1	
1	NHS Greater Glasgow and Clyde must ensure all patients have call bells within easy reach (see page 21). This will support compliance with Quality Assurance Framework (2022) Indicator 4.1 and Health and Social Care Standards (2017) Criteria 1.24
2	NHS Greater Glasgow and Clyde must ensure all staff comply with hand hygiene guidance (see page 21). This will support compliance with: National Infection Prevention and Control Manual (2023).
3	NHS Greater Glasgow and Clyde must ensure that cleaning products are stored safely and securely (see page 21). This will comply with the Control of Substances Hazardous to Health (COSHH) Regulations (2002).
4	NHS Greater Glasgow and Clyde must ensure the care environment is in a good state of repair and maintained to support effective cleaning (see page 21). This will support compliance with the National Infection Prevention and Control Manual (2023) and Standard 8.1 and 7.2 of Healthcare Improvement Scotland's Infection Prevention and Control Standards and Healthcare Associated Infection (HAI) standards (2015) Criteria 8.1.
5	NHS Greater Glasgow and Clyde must ensure all staff comply with the safe management of linen (see page 21).

This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022) and Healthcare Associated Infection (HAI) standards (2015).

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Despite increased pressures within the emergency department, it was calm and well led with staff working hard to deliver care. The emergency department is supported by the frailty team and an advanced frailty practitioner who visits the department regularly. We observed a proactive approach to signposting patients to ensure patients receive care in the most appropriate setting while helping to improve waiting times and delays in the emergency department and acute admission units.

At the time of this inspection NHS Greater Glasgow and Clyde like much of NHS Scotland, was experiencing significant pressures including increased hospital capacity and increased waiting times within the emergency department.

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 before admission, discharge or transfer for other treatment. Across NHS Scotland for the week ending 14 April, 64.3% of patients were seen within the four-hour target with 53.0% of patients seen within the four hour target at the Queen Elizabeth University Hospital.

Further information on emergency department attendances can be found at NHS Perform NHS Performs | Home.

During the morning of our onsite inspection the emergency department was operating under significant pressure with an 11 hour wait for patients to be transferred to inpatient areas and a two hour waiting time for first assessment by a clinician. Staff advised us that when there is a delay in first assessment that patients will be further prioritised and may be seen out of time order if assessed as clinically required during triage, or if their condition deteriorates. Despite this we did not observe any patients being cared for in the corridors or ambulances queuing outside and inspectors were told by staff that patients were being triaged within 15 minutes.

Triage is an essential part of emergency department care. On a patient's arrival to the emergency department, the person responsible for triage assesses the patient's needs and assigns the priority of treatment required. There is no standardised triage system

in Scotland. However, the Royal College of Emergency Medicine advises that triage should occur within 15 minutes of presentation. More information can be found at [Initial assessment of emergency department patients (rcem.ac.uk).](rcem.ac.uk) We can see in evidence provided that the average time to triage has reduced since January 2024 and was under 30 minutes for the last two weeks of April.

NHS Greater Glasgow and Clyde introduced the Glasgow Continuous Flow model (GlasFLOW) in December 2022 to improve flow from the emergency department and reduce delays in ambulance turnaround times. The continuous flow model enables transfer of patients from the emergency department to ward areas twice throughout the day. The aim is to manage and share the risks related to over occupancy beyond the emergency department. Patients may be transferred to a ward area to wait in the ward waiting room until a bed becomes available. The Queen Elizabeth University Hospital uses an electronic patient record system and patients who are identified for GlasFLOW are highlighted on this system. Patients who have been waiting longest for an inpatient bed in the emergency department are moved first unless there is a clinical requirement to select another patient. If a patient's clinical need indicates that they are not suitable to wait in the waiting room of the ward and need to be transferred directly to a bed space this is highlighted by the use of a red traffic light icon on the electronic system.

Evidence provided includes the Standard Operating Procedure for GlasFLOW which documents the criteria for patients who should only be moved directly to a bed. This includes patients who require end of life care, cardiac monitoring or isolation as at risk of developing or have an infection. It also considers patients who have severely restricted mobility therefore making accessing bathroom facilities difficult. Patients with a National Early Warning Score 2 (NEWS2) of 4 or above are also required to be transferred directly into a bed space. The National Early Warning Score 2 is a scoring system allocated to physiological measurements such as blood pressure and pulse. Its purpose is to improve the detection and response to patients who are at risk of or have become more unwell. Patients who are admitted via the continuous flow model are provided with an information leaflet describing GlasFLOW and the reason they may be waiting for a bed within the ward.

Hospital managers advised us that since the introduction of the Glasgow Continuous Flow model that there has been an overall reduction in the number of patients waiting over 12 hours for admission, discharge or transfer. We can see from evidence provided that 12 hour waits have reduced by 39% in the 12 months since the implementation of the model. We did not see any patients waiting over 12 hours on the day of our inspection.

Staff spoke positively of the continuous flow model and its impact on the flow of patients throughout the department but highlighted that flow was reduced following the last transfer of patients from the department as part of GlasFLOW at 18:00.

As this inspection was focused solely on the emergency department, we did not observe the impact of the continuous flow model throughout the hospital.

The emergency department is supported by the frailty team and an advanced frailty practitioner visits the department to assess patients who have been referred to them by emergency department staff. Patients' needs such as mobility requirements are assessed to prevent unnecessary admissions to the hospital which can impact a patient's long-term recovery. Evidence provided includes the referral pathway for the frailty practitioner which shows that they can refer patients who are being discharged to community services such as hospital at home, community frailty teams and home care. Inspectors spoke with members of the frailty team who described feeling valued within the team and that the emergency department staff are proactive in referring patients to them.

Staff also spoke positively of the impact of the morning ward round by the cardiology team which enabled patients to be discharged directly from the emergency department.

Inspectors observed that despite the emergency department being busier during the afternoon of the onsite inspection, the longest wait for an inpatient bed had reduced from 11 to nine hours.

Whilst we did not see any patients being cared for in corridors and therefore did not have concerns about the impact on fire evacuation safety, we were provided with the fire evacuation and action plan for the emergency department which was completed in July 2023.

Scottish Government emergency signposting guidance seeks to ensure patients receive care in the most appropriate setting while helping to improve waiting times and delays in emergency departments and acute admission units.

NHS Greater Glasgow and Clyde has introduced a signposting and redirection policy which incorporates the emergency department at the Queen Elizabeth University Hospital. Evidence provided highlights that the "signposting nurse" role is delivered by an Emergency Nurse Practitioner who is based in the reception of the emergency department with visibility of the waiting area. The specific standard operating procedure for redirection for the Queen Elizabeth University Hospital highlights that the signposting nurse will assess if the patient is suitable for signposting to other services. These include but are not exhaustive of dentist, general practitioner, community optometry and minor injuries unit. Patients who are redirected are provided with an information booklet describing these services and how to contact them. Staff also described that the signposting nurse works with a health care assistant both of whom are responsible for observation of the waiting room which enables patients waiting to have a point of contact if they raise concerns such as requiring pain relief. Senior managers advised that patients who are suitable for redirection/signposting will be registered on the electronic patient record system. This

generates a letter which is then sent to the patient's general practitioner. Senior Emergency department medical and nursing staff are available to provide support and further assessment if required by the signposting nurse. Inspectors observed that the signposting nurse was available in the reception area during the day of this inspection.

Patients who are assessed as not suitable for signposting will be redirected to reception where they will be booked in as an emergency department patient and then triaged. Triage is an essential part of emergency department care. On a patient's arrival to the emergency department, the person responsible for triage assesses the patient's clinical needs and assigns the priority of treatment required. Patients who are not suitable for signposting may still be suitable for redirection to other services. It is the role of the triage nurse to identify patients who may be suitable for redirection and discuss this with a senior clinician.

Triage staff told us that patients can be directed to other specialities via direct to speciality pathways. These include general practitioner out of hours, early pregnancy assessment unit and ambulatory care. The ambulatory care unit is open from 07:30–18:00 and has pathways to assess and treat patients such as those who have simple chest pain and deep vein thrombosis. Triage staff can also refer directly to mental health services and complete a mental health triage and risk assessment tool which gives a high/moderate/low risk score for self-harm, violence or absconding. This tool documents where patients should be cared for depending on risk level, for example high risk patients should be accompanied whilst waiting in the clinical area.

We can see in evidence provided that since the launch of the redirection policy in October 2023 and up until the beginning of April 2024 that a total of 4,896 patients have been redirected across all of NHS Greater Glasgow and Clyde.

We observed a poster in the waiting room showing how many nursing and medical staff are required for standby calls from the ambulance service for medical or trauma emergencies. We discussed this with nursing staff who told us this was developed by a member of staff to inform people in the waiting room of how many staff are needed if they hear a tannoy call for this type of emergency. This is a proactive way of informing those waiting of the potential impact these situations may have on waiting times. Staff also told us that television screens have been ordered for the waiting room to display waiting times including triage times.

As discussed earlier we did not observe any ambulances queuing to bring patients into the department in the morning of the inspection. However, we did observe that there were nine ambulances waiting outside the department in the afternoon. Ambulance crews we spoke with advised that emergency department staff are responsive when they require to escalate concerns about a deteriorating patient awaiting admission to the emergency department. We were also told that staff will review patients in the ambulance if required. We were told by emergency department staff we spoke with that ambulance staff discuss all patients with the nurse in charge prior to bringing the

patient into the department to ensure the patient waits in the most appropriate place. Inspectors observed ambulance staff discussing patients with the nurse in charge including if they were well enough to wait in the waiting room. Evidence provided includes the template the nurse in charge completes when taking details from ambulance crews for patients who are waiting in the ambulance. This includes time of arrival, presenting complaint and National Early Warning Score 2 score (NEWS2). The NEWS2 is a scoring system allocated to physiological measurements such as blood pressure and pulse. Its purpose is to improve the detection and response to patients who are at risk of or have become more unwell.

The emergency department has a cohort area which is a room with space for two patient trolleys. Staff described that ambulance crews can transfer patients to this area if there are no available cubicle spaces within the department, or if a patient is not well enough to sit in the waiting room. This enables improved ambulance turnaround times and helps to reduce the number of ambulances queuing outside. We did not observe any patients being cared for in this area at the time of the inspection. Evidence provided includes the patient exclusion criteria for the area which include patients who are clinically unwell with raised NEWS2 scores, require constant cardiac monitoring, patients with infections and patients who are intoxicated.

Inspectors observed that there were no patient call bells available in this room however, staff advised that there was always a member of emergency department staff based in the cohort room.

Inspectors also observed a small waiting area within the main department which staff described as an area for patients who were well enough to sit but required closer observation than the waiting room. We observed that there was an available call bell in this area for patients.

We asked NHS Greater Glasgow and Clyde to provide evidence of any incidents or adverse events reported by staff through the incident reporting system in relation to the emergency department at the Queen Elizabeth University Hospital for the three months prior to this inspection. The learning from adverse events national framework indicates that all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Further information on the national framework can be found at [Learning from adverse events through reporting and review - a national framework for Scotland.]

We asked senior managers how outcomes from reported incidents are shared with staff to enable learning and mitigate risk. We were advised that the education team share information via a weekly newsletter and e-mail to all staff levels and also an education board in the staff rest room. Safety briefs and “topics of the week” are utilised to share learning points from incident reports. Feedback is also shared at staff meetings.

Senior managers told us that there had previously been a high number of outstanding incidents awaiting review. To address this, a focus group has been established which has seen a significant reduction in outstanding reports. New incidents are reviewed daily by the department lead nurses who receive e-mail notifications of all reported incidents. Incidents classified as major or moderate harm are highlighted to senior nurses who discuss with the lead nurses for the department. Evidence provided includes the incident report flowchart for the emergency department. This includes the pathway for sharing learning either via departmental learning or individual learning for staff members involved. Further evidence provided includes the minutes of the bi-monthly senior charge nurse and charge nurse meetings. It is documented in these that the number of outstanding incident reviews has reduced significantly.

We observed some incidents relating to delays in triage and consequential delays in patients having initial electrocardiograms recorded. An electrocardiogram monitors and records the hearts electrical activity and can show arrhythmias and cardiac damage such as a heart attack. We discussed these incidents with senior managers who described that staff will be moved from other areas in the department to help with triage if delays increase. Staff we spoke with told us they use 'see and treat' rooms to enable tests such as electrocardiograms and blood tests to be undertaken on patients who are waiting in the waiting rooms. This reduces delays in performing essential tests for patients who have not yet moved to a cubicle within the main department.

The minor injuries unit at the Queen Elizabeth University Hospital is based in a separate building directly outside the emergency department. Incident reports provided included one where a patient with a significant injury had self-presented to the minor injuries unit and had therefore not been seen by the signposting or triage nurse and was not assessed for a further three hours. We discussed this incident with senior managers who told us that a triage nurse has been introduced at the minor injuries unit at the Greater Glasgow and Clyde New Victoria Hospital and that it is planned to replicate this at the Queen Elizabeth University Hospital.

Area of good practice

Domain 1	
1	A number of initiatives have been introduced to improve patient flow and waiting times.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Despite increased pressures we observed that the emergency department was calm and well organised. Nursing staff told us they felt supported by senior colleagues and managers and described a culture of teamwork.

Inspectors observed that the department was calm and that senior nurses were visible and accessible. Staff told us that each area within the department had an allocated team of staff each shift and when able this included a charge nurse or senior charge nurse for each area. Patients and relatives we spoke with were complimentary about the care provided.

Despite ongoing pressures due to increased numbers of patients all of the nursing staff we spoke with described the emergency department as a good place to work. Nursing staff of all grades told us they felt supported by senior colleagues and managers and described a culture of teamwork where the nursing team and medical staff work well together to aim to provide good care. Nursing staff also told inspectors that they feel supported to raise concerns with senior managers including through the electronic incident reporting system. Senior nurses were visible in the department including assisting with recording patient observations.

Senior nursing staff told us of staff wellbeing initiatives within the department including bi-monthly visits to the department by a psychologist and also visits by a pet therapy dog. Pet therapy has been shown to improve anxiety and stress. We were also told that the department has had team development days for charge nurses and senior charge nurses. These included a focus on leadership including wellbeing, kindness and respect amongst staff and absence management. We were also told of the use of a nomination form which staff can utilise to say thank you to each other.

Some medical staff, however, raised concerns regarding the increased waiting times for first assessment and the need for the provision of inpatient care due to long lengths of stay in the department. Whilst medical staff told us senior managers listen to these concerns, they felt effective action was not always taken to address these concerns. We were, however also told by medical staff we spoke with that new initiatives such as GlasFlOW and the cardiology and frailty team in reach were having a positive impact on safety and flow within the department. We were told that concerns had been raised regarding consultant medical staff resource being used to undertake activities such as taking blood from patients due to increased pressure within the department. Some nursing and medical staff we spoke with described resistance by some medical staff to engage with colleagues, including senior managers to support change and improvement within the department.

Evidence provided included several incident reports relating to communication or lack of handover when patients are transferred from the emergency department to the

acute receiving units. We discussed this with senior managers who advised that the clinical educators are now working across both the emergency department and acute receiving units to share learning and improve the patient journey. Staff spoke highly of the education team who provide regular in-house learning including weekly skills and drills which are 15 - 20 minute sessions to enable staff to attend if working. The education team also works with the acute receiving units to increase staff awareness of the complexities in each area and improve the patient journey.

We were also advised that that an SBAR (situation, background, assessment, recommendation) is completed on the patient's electronic record prior to transfer. An SBAR is a verbal or written tool that provides concise structured communication. Hospital managers also advise that a verbal handover will also be provided on transfer and that any patients with a National Early Warning Score 2 of five or above is discussed with the receiving unit prior to transfer.

As part of the onsite inspection, we were able to attend one of the two hourly emergency department safety pauses. We observed that this was coordinated and well led. Medical and nursing staff were included and safety checks on all areas within the department were discussed. Communication was clear and updates were provided by the nurse in charge of each area, this included discussion regarding transport home for a patient and environmental issues being highlighted regarding a broken door. The pause was clear and concise with next steps discussed.

Staff told us that as well as the two-hour safety pauses within the department that there is a ground floor morning safety huddle which includes the emergency department and acute receiving units. This is followed by a lead nurse safety huddle and site safety huddle.

We attended part of the lunchtime site wide safety huddle where emergency department staff discussed that 15 emergency department patients were waiting for transfer to an inpatient bed with the longest wait being 9 and a half hours. Staff highlighted the time to triage was 40 mins and that this was due to triaging a patient out of time order due to clinical need.

We observed a proactive response by hospital managers and the multidisciplinary team towards improving flow within the emergency department during the site safety huddle. This included the use of the discharge lounge to enable available beds on the wards and the ambulatory care team assessing if any patients waiting within the emergency department could be reviewed in ambulatory care for assessment. Staff were asked to identify one patient per ward who would be suitable to be transferred to wards out with their speciality, for example patients with medical conditions being transferred to non-medical wards. Hospital managers also highlighted that discussions should take place with patients that due to increased capacity and the need to improve flow within the emergency department that they may be required to wait for a bed once they arrive on a ward.

Within the evidence provided we observed several incident reports where staff had been subject to violence and aggression by patients. Senior managers advised that the review of these incidents had highlighted that some were due to increased waiting times. We were also told the number of incidents relating to violence and aggression had reduced since there had been a focus on improving time to triage. This focus has also included ensuring patients receive timely analgesia at triage.

Hospital managers described the processes in place to support staff who had been subject to violence and aggression. This includes the provision of peer and lead nurse support and feedback. There are regular education sessions provided by the hospital violence and aggression team and we were told that these are well attended by staff. As previously discussed, a psychologist also holds drop-in sessions within the emergency department for staff. Queen Elizabeth University Hospital also have two campus police who are a whole site resource but have an office close to the emergency department.

Areas of good practice

Domain 2	
2	Senior nurses and managers demonstrated a good understanding and oversight of patient care.
3	Senior nurses were visible and the department was calm and well-coordinated.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed staff working hard to provide fundamentals of care. Patients appeared well cared for and had access to food and fluids, patients we spoke with told inspectors they had received pain relief if required and that staff were attentive to their needs. We observed that some cleaning products were not stored securely and there were missed hand hygiene opportunities.

Despite the department being busy with a large number of patients being cared for, admitted and transferred to and from the department, all areas were calm and coordinated. Patient flow throughout the department was continuous, no patients were being cared for in corridor areas and all patients within the department were cared for within cubicles.

Inspectors observed that the waiting area remained calm throughout the inspection with the placement of the triage rooms enabling good oversight of the waiting area by the triage nurse.

Staff we spoke with explained new nursing documentation has been introduced in response to increased delays in patients being discharged or transferred to an appropriate area and therefore remaining for longer periods of time in the emergency

department. The “Emergency Care Nursing Documentation” includes a “care rounds” checklist. This includes elimination need, skin assessment, foods fluid and nutrition, pain assessment, if call bell is available and if the environment is clutter free. The frequency of need for the care round check list is assessed and documented as 1, 2, 3 of 4 hourly. The document also includes the” Pressure Ulcer Daily Risk Assessment” (PUDRA) which assesses risk of developing pressure damage. On going care is included within the document and is commenced once patients have been in the department for over 4 hours. This includes if patients are on intravenous antibiotics, if regular medications are required, falls and skin risk assessment and if the patient and relatives have been updated. The ongoing care section should be completed hourly. Staff told inspectors that the Parkinson’s link nurse worked closely with the department and that a supply of time critical medication for patients with Parkinson’s disease is kept in the emergency department to prevent delays in obtaining and administration of medication. Inspectors observed that documentation was in place and was well completed. We also observed that National Early Warning Score 2 charts were completed fully, accurately and within appropriate timescales.

Evidence provided includes the feedback from the emergency department care assurance tool for August 2023 and February 2024 these were corporate care assurance visits and therefore completed by independent staff who are external to the department. The care assurance tool provides an audit of the emergency department and includes but is not exhaustive of, staff and patient interactions, respect and dignity, cleanliness, documentation and that there is evidence of visible leadership. Senior nursing staff told us that emergency department staff complete care assurance reviews every 6-8 weeks. We can see from the provided corporate care assurance tools that the overall score for the department has increased from 91% in August 2023 to 97% in January 2024.

At the time of the inspection all patients appeared well cared for and had access to food and fluids. Staff told inspectors that a clinical healthcare support worker is allocated to each area to ensure patients receive fluids and nutrition if appropriate. All patients we spoke with told inspectors they had received pain relief if required and that staff were attentive to their needs. We observed that call bells were answered in a timely manner. However, not all patients had call bells within easy reach. During our corresponding inspection at the Royal Alexandra Hospital, we also observed that patients in the emergency department did not have available call bells. A requirement has been given in both inspection reports to support improvement in this area.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. Standard infection control precautions include patient placement, hand hygiene, the use of personal protective equipment (such as aprons and gloves), management of patient care equipment and the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

One of the key precautions in infection prevention and control is the practice of good hand hygiene. We observed staff wearing personal protective equipment where required, however on several occasions we observed gloves being worn between tasks and therefore, staff not taking the opportunity to perform hand hygiene in line with guidance. Inspectors also observed missed hand hygiene opportunities when staff were recording patients' observations. NHS Greater Glasgow and Clyde have previously been given a requirement to support improvement with hand hygiene compliance during the safe delivery of care inspection at Gartnavel General Hospital in 2023.

During our corresponding inspection at the Royal Alexandra Hospital on Monday 8 to Wednesday 10 April, we also observed that there were missed hand hygiene opportunities. A requirement has been given in both inspection reports to support improvement in this area.

We observed that whilst cleaning products and patient use razors were in a lockable cupboard within the sluice area of the department that the cupboard was not locked and could therefore be accessed by patients or members of the public. This was fedback to senior nursing staff at the time of inspection. Cleaning products should be stored securely in line with the control of substances hazardous to health regulations.

NHS Greater Glasgow and Clyde have previously been given a requirement to support improvement with the safe storage of cleaning products during the safe delivery of care inspection at Gartnavel General Hospital in 2023.

During our corresponding inspection at the Royal Alexandra Hospital on Monday 8 to Wednesday 10 April, we also observed that cleaning products were not stored securely. A requirement has been given in both inspection reports to support improvement in this area.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. Inspectors observed that patient care equipment was clean and ready to use. We observed staff cleaning cubicles and patient trolleys between use.

The department appeared clean and uncluttered and domestic staff we spoke with described having sufficient equipment to carry out their duties.

Whilst the department environment was clean there were some signs of wear and tear, such as chipped work surfaces, chipped walls and several cupboard doors were damaged or missing. The hospital environment must be well maintained to support effective cleaning.

During our corresponding inspection at the Royal Alexandra Hospital on Monday 8 to Wednesday 10 April, we also observed some wear and tear to the hospital

environment which required maintenance work. A requirement has been given in both inspection reports to support improvement in this area.

Other standard infection control precautions include the safe management of waste including linen and sharps. Inspectors observed that sharps bins were labelled in line with guidance, were not over full and had temporary closures in place. Temporary closure prevents needles or sharps protruding from the boxes, or from falling out if the box is dropped. However, we also observed that the used linen trolley was not always taken to the point of care in line with current guidance.

During our corresponding inspection at the Royal Alexandra Hospital on Monday 8 to Wednesday 10 April, we also observed that used linen was not always managed in line with current guidelines. A requirement has been given in both inspection reports to support improvement in this area.

Areas of good practice

Domain 4.1	
4	Staff were responsive to patient needs and patients spoke highly of the staff and the care they provided.
5	New nursing documentation has been introduced to improve patient safety in response to increasing lengths of stay.

Requirements

Domain 4.1	
1	NHS Greater Glasgow and Clyde must ensure all patients have call bells within easy reach.
2	NHS Greater Glasgow and Clyde must ensure all staff comply with hand hygiene guidance.
3	NHS Greater Glasgow and Clyde must ensure that cleaning products are stored safely and securely.
4	NHS Greater Glasgow and Clyde must ensure the care environment is in a good state of repair and maintained to support effective cleaning.
5	NHS Greater Glasgow and Clyde must ensure all staff comply with the safe management of linen.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Both senior managers and senior nursing staff were visible within the department.

As this inspection was focused on the safe delivery of care within the emergency department inspectors did not attend wider site staffing huddles. We observed within evidence provided that NHS Greater Glasgow and Clyde use a "safe to start" red, amber, green (RAG status) classification system to identify nursing staffing levels for each area throughout the hospital, with red areas being those areas most at risk. The nurse in charge of each area utilises professional judgement to determine the status of the area at the beginning of each shift. Considerations include skill mix, patient activity (for example discharges, admissions, treatments), patient acuity and patient dependency. The RAG status is discussed at local departmental huddles and is then shared at the hospital wide huddles.

The guidance provided includes actions to be taken for areas that are classified as amber or red. These include escalation to lead nurses and hospital managers to enable early resolution and the use of staffing huddles to re deploy staff to areas most in need. In situations where risk cannot be mitigated, and an area remains "red" actions include documentation of unresolved red status and further escalation to chief nurse and general manager.

Workforce data submitted by NHS Greater Glasgow and Clyde included the current vacancy level within the nursing and medical workforce for the emergency department at the Queen Elizabeth University Hospital. This demonstrates the overall vacancy rate for nursing staff as being 5.0 full time equivalent posts with three of these being registered nurse vacancies and the other two healthcare support worker vacancies. There are 2.5 full time equivalent senior medical staff vacancies and 3.8 junior medical staff vacancies.

We were provided with the sickness absence data for the department for both nursing and medical staff. The total sickness rate for nursing staff in April 2024 was 9.69 with 4.61% of this being attributed to long term sickness. However, this has dropped from an overall sickness rate of 14.29% in Jan 2024 with 9.30% of this being attributed to long term sickness. Narrative provided by hospital managers highlights the provision of focussed support by the human resources department to support the lead nurses and senior charge nurses to manage and reduce nursing sickness absence. Medical staffing sickness data identifies a total sickness percentage of 3.44% for April 2024 with 3.05% being long term sickness.

Evidence requested as part of this inspection included the emergency department medical and nursing shift reports for the month prior to this inspection. These reports contained information that several shifts had reduced medical and nursing staffing due to sickness, or supplementary staff not attending despite being booked for the shift. The shift reports document when mitigations have been put in place such as

redeploying staff from critical care to the emergency department or moving staff within the department to cover the area most in need such as triage or resuscitation.

Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's own staff bank or from an external agency. Workforce data for the emergency department shows 18.7 full time equivalent nurse bank use during April 2024 and 7.5 agency use. In March there was a total loss of nursing staff availability of 38.30% due to all leave including sickness. Narrative provided by hospital managers highlights that the high percentage of annual leave taken in March was due to staff returning from maternity and sickness absence. We were advised by hospital managers that there had been nine nursing staff recently on maternity leave.

Shift reports provided as evidence document several shifts where there is reduced nursing skill mix due to the number of staff on duty who were unable to administer intravenous medication or take blood samples. We asked hospital managers what processes are in place to provide support if there is an increase in acuity and dependency within the department. We were advised that nursing skill mix is discussed at lead nurse level via staffing huddles and that staff will be redeployed accordingly. We were also advised that the emergency department utilises supplementary staff from Greater Glasgow and Clyde nurse bank who are familiar with the department. Supplementary staff are included in the department "skills and drills" training sessions. These are 15-20 minute education sessions provided by the education team. During the inspection we spoke with supplementary staff on shift, who were very familiar with the department as they were previous staff members and explained they often work shifts within the department.

Senior managers described daily reviews of the nursing rota to enable a proactive approach to managing nursing skill mix. There is a clinical nurse coordinator available for the site to review staffing and redeploy staff as required. Hospital managers also advised of a recent test of change where lead nurses were available to provide additional support on the late shift with the aim of introducing this on a permanent basis.

We can see in evidence provided that on the day of our inspection (Monday 8 April) there was one registered nurse gap due to a member of supplementary staff not attending despite being booked on shift. There was a full complement of health care support workers. Of the 43 medical staffing shifts there was potentially 10 gaps, two of which were senior medical staff. We can see in evidence provided that eight of these were covered leaving one senior medical gap.

Medical shift reports for the month prior to this inspection document numerous shifts with medical staff sickness and high levels of locum staff, particularly during the early part of March. There were some discrepancies between the medical shift reports and additional data provided by NHS Greater Glasgow and Clyde regarding the level of locum medical staff on individual shifts. We asked hospital managers what processes

are in place to orientate supplementary staff to the department. We were advised that all medical and nursing supplementary staff are orientated to the department at the beginning of their shift, including ensuring IT access, familiarisation of departmental protocols and other safety issues such as fire procedures. We asked for further evidence regarding how risk was mitigated when there are increased numbers of supplementary medical staff on shift who may not be familiar with the department. Narrative provided by senior managers highlights that medical staffing is discussed at the site safety huddles three times a day. The medical staffing position is also discussed proactively throughout the week including a review of upcoming weekend cover.

Despite the number of shift reports documenting reduced medical and staffing availability and increased acuity and dependency for the month of March, only a small number of incident reports have been submitted in relation to this. One of these highlights reduced senior nurse staffing availability for a trauma patient, another highlights increased acuity and dependency and increased number of patients and one highlights a delay in triage. Review, oversight and management of incident reports are discussed in domain 2 of this report.

Evidence provided includes the Queen Elizabeth University Hospital's emergency department nursing workforce needs analysis from March 2023. This documents that the nursing establishment was increased by 17.71 full time equivalent posts in August 2021 in response to becoming a major trauma centre. This included the introduction of an Associate Lead Nurse post for the department. The workforce analysis included where able comparison with similar sized emergency departments who provide major trauma facilities. Recommendations from the review include maintaining the nursing establishment as is, and to split staffing into core emergency department and minor injuries staff. It also documents that an Emergency Department and Emergency Medicine (EDEM) staffing tool will be completed biannually to provide a frequent review of safe staffing. We can see that an EDEM tool was completed in October 2023 however, the tool has been unable to calculate required staffing levels due to incomplete data. Hospital managers told us that a further EDEM staffing tool will be completed in July this year. A recommendation has been given to support improvement in application of the Common Staffing Method to inform appropriate staffing in line with the Health and Care (Staffing) (Scotland) Act 2019.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that Health Boards have a duty to follow the Common Staffing Method following a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tools supports NHS Boards to ensure appropriate staffing, and the health, wellbeing and safety of patients and the provision of safe and high-quality care. NHS Greater Glasgow and Clyde have developed a Health and Care Staffing (Scotland) Programme Board to complete testing of The Common Staffing Method. Evidence provided also discusses the NHS Greater Glasgow and Clyde Nursing and Midwifery Workforce

Group which has the aim of ensuring robust governance and professional oversight of nursing and midwifery staffing. This includes the focus on recruitment and retention and development of career pathways to promote NHS Greater Glasgow and Clyde as an employer of choice.

Staff told inspectors that although a staffing level tool was run in September 2023 that they had not yet received feedback from this. We were advised by hospital managers that another staffing level tool run was due to take place in July of this year.

Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide the delivery of safe, high quality and person centred healthcare. Evidence provided documents that senior charge nurses in NHS Greater Glasgow and Clyde are allocated 15 hours weekly for time to lead. If acuity and dependency of the area results in staff being unable to take time to lead this is escalated to the lead nurse. Evidence further highlights that processes are in place to implement a system whereby if a time to lead shift is removed from the electronic staffing system that information can be added as to the reason why. We were unable to speak with the senior charge nurse on duty during our onsite inspection as they were clinically coordinating the department.

Recommendation

Domain 4.3	
1	NHS Greater Glasgow and Clyde should ensure the Emergency Department and Emergency Medicine staffing level tool and professional judgement tool for nursing and medical staff is fully completed as part of the Common Staffing Method.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed staff providing compassionate responsive care with staff treating patients with dignity and respect.

Inspectors observed that all staff and patient interactions were kind and compassionate, cubicle curtains were used to maintain patient privacy and dignity.

Patients and relatives we spoke with were positive about the care provided with one patient telling inspectors they couldn't fault the care explaining they had several visits to the department and described frustration regarding the negative press about the hospital and told inspectors that it was a good hospital with great staff.

We were told by another patient and their family that they had needed to attend the department several times recently and that the care had been excellent at all times.

We observed staff were attentive to patients' needs and all patients looked well cared for and comfortable.

Inspectors observed staff taking time to provide information to patients about their care.

Senior managers told inspectors of the introduction of the navigator service within the department. Navigators provide psychological support to patients who may require additional support for a variety of reasons including homelessness, drug and alcohol abuse or debt issues. The navigators can also help to connect patients who are being discharged with mental health and addiction services.

Area of good practice

Domain 6	
6	We observed the delivery of caring, compassionate care.

Appendix 1 - List of national guidance

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

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2023)
- 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, January 2023)
- Operating Framework: Healthcare Improvement Scotland and Scottish Government (Healthcare Improvement Scotland, November 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)
- The Quality Assurance System (healthcareimprovementscotland.org) (Healthcare Improvement Scotland, September 2022)
- Staff governance covid-19 guidance for staff and managers (NHS Scotland, August 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

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