Weston General Hospital

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Ratings

Overall rating for this hospital

Are services safe?	
Are services effective?	
Are services well-led?	

Summary of findings

Overall summary of services at Weston General Hospital

We inspected the urgent and emergency service to follow up on concerns identified in a Section 29A Warning Notice served in December 2019 following a comprehensive inspection of the service in February 2019. At that time, the hospital was run by Weston Area Health Trust, which is now part of University Hospitals Bristol and Weston NHS Foundation Trust. When a hospital changes management in this way, we would normally do a comprehensive inspection and give up-to-date ratings for all services. However, during the COVID-19 pandemic we have restricted our inspection activity, resulting in this focused inspection. We did not rate any aspect of the service. We were also concerned about safety in the emergency department, following some recent serious incidents, and a 'never event' (a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them). We therefore extended the scope of this inspection to look at all key lines of enquiry in the safe domain, one area of the effective domain, and most of the well led domain.

Our inspection reports about this service under its previous management are available here: https://www.cqc.org.uk/location/RA301. We will inspect and rate the hospital as part of our normal regulatory processes in due course.

The warning notice (2019) set out the following areas of concern, where significant improvement was required by 31 March 2020:

- Governance systems were still not operating effectively. We had limited assurance that the main governance forum in the emergency department provided good oversight of quality and risk at departmental, division or trust level, in order to support informed decision-making. The risk register was not up to date and was not an effective tool to manage risks or provide assurance that controls were effective. Incident management had improved, and serious incidents were investigated and acted upon within appropriate timescales. However, there remained a significant backlog of other incidents.
- Although junior doctors were mainly positive about the support and supervision they received from senior medical staff, some still told us that the quality of supervision was variable depending on which consultant was in charge. Concerns were expressed about a lack of support and supervision at weekends.
- There was limited assurance that the nursing workforce had the skills and experience to provide safe care and treatment. A training needs analysis was underway, but this still showed numerous training gaps. Training sessions were being provided but these were ad hoc and did not form part of a coordinated and structured training plan. There was still no structured or formal system of nurse supervision, although some progress had been made in identifying teams to be led by senior nurses.

During this inspection we found:

- The quality of data available did not provide assurance that the trust could be confident in mandatory training compliance. The trust found it difficult to provide us with training data that showed nursing or medical staff were compliant with mandatory training.
- At the time of our inspection 56% of nursing staff in the emergency department had completed level three safeguarding training for children.
- The service did not have enough permanent nursing staff. There was a shortage of registered nurses and heavy reliance on bank and agency staff, although they had taken steps to mitigate the risks of short staffing created by effectively managing a pool of temporary staff and using the same agency and bank staff over an extended period of time.

Summary of findings

- The service did not always manage patient safety incidents well. Staff recognised incidents and near misses and reported them. Managers investigated incidents but did not always share lessons learned effectively with the whole team and the wider service.
- There was not an effective process to disseminate actions required following a national patient safety alert to all staff in the emergency department. This meant there was a continued risk that patients may not receive care in line with recommendations in these national alerts.
- The service held a central spreadsheet of all equipment in the emergency department which monitored maintenance and replacement dates. We reviewed this document and saw 40 pieces of equipment outside of their planned preventive maintenance dates, of which, seven pre-dated Covid-19.
- Handover medical meetings did not have a formal structure. We witnessed one handover, and several patients were not discussed because the doctor treating them was not present. We noted and there was no specific teaching or learning included.
- There was heavy reliance on the clinical lead of the emergency department. Whilst we heard of plans to recruit further staff to mitigate this risk, it remained the case that this created a huge vulnerability to all the strands of work currently undertaken by the clinical lead.
- Registrars, junior doctors and nursing staff told us that attending governance meetings was difficult because of operational pressures in the emergency department. It was clear from discussions with these staff that information from the governance meetings was not effectively shared with all staff in the emergency department.

However:

- Governance systems had improved. We had assurance that the main governance forum in the emergency department provided good oversight of quality and risk at departmental, division and trust level, in order to support informed decision-making. They were aware of the issues in the department and were putting actions in place to mitigate the concerns.
- The risk register was up to date and was used to manage risks or provide assurance that controls were effective.
- The backlog of incidents, which was a concern at our last inspection, had been reduced significantly.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. This was a significant improvement from our last inspection.
- Junior doctors told us consultant presence in the emergency department had improved and consultants were visible and accessible.
- A training needs analysis of nurse competencies had been completed and taken actions to ensure that nursing staff completed required competencies and put in place processes to support them to do so. A practice development nurse had been appointed to develop and oversee all aspects of nurse training, including mandatory training.
- During a recent outbreak of Covid-19 at the hospital, all staff were tested. Of the 6% of hospital staff who tested positive for the virus, none of these worked in the emergency department. Managers told us staff had been using personal protective equipment (PPE) since January 2020, which they believed had greatly contributed to this result.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Urgent and emergency services

Summary of this service

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) is the newly merged trust comprising what was formerly University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust, which came together on 1 April 2020.

Bringing together a combined workforce of over 13,000 staff, the new trust delivers over 100 different clinical services across 10 different sites, serving a core population of more than 500,000 people. The organisation provides care to the populations of Bristol, North Somerset, South Gloucestershire and surrounding areas.

Urgent and emergency care services are provided in Weston General Hospital's emergency department (ED) seven days a week, 365 days a year. The department is open from 8am until 10pm.

There are two treatment areas in the emergency department. Patients with serious injuries or illness, who mostly arrive by ambulance, are seen and treated in the major treatment area, which has eight cubicles and a resuscitation room. The resuscitation area has four bays, one of which is equipped to treat children. The major treatment area is accessed by a dedicated ambulance entrance. Patients with minor injuries are assessed and treated in the minor treatment area, which has 12 cubicles and a paediatric room. At times of high demand, patients are accommodated in the corridor surrounding the major treatment area. There are designated trolley spaces and temporary curtains are used to provide privacy.

The emergency department is not a designated trauma unit. Severely injured patients are taken by ambulance to trauma centres in Bristol or Taunton.

We inspected the department on 28 July 2020. We spoke with approximately 24 staff, including doctors, nurses, administrative staff and managers. We observed staff handover meetings. We looked at 11 patients' records and observed patients' care.

Is the service safe?

Because this was a focused inspection, we did not rate the service.

- Data provided by the trust showing staff compliance with mandatory training was not reliable and the trust was unable to demonstrate whether nursing and medical staff were up to date with all their mandatory training.
- At the time of our inspection 56% of nursing staff in the emergency department had completed level three safeguarding training for children.
- The service did not have enough permanent nursing staff. There was a shortage of registered nurses and heavy reliance on bank and agency staff, although they had taken steps to mitigate the risks of short staffing created by effectively managing a pool of temporary staff.
- The service did not always manage patient safety incidents well. Staff recognised incidents and near misses and reported them. Managers investigated incidents but did not always share lessons learned effectively with the whole team and the wider service.
- There was not an effective process to disseminate actions required following a national patient safety alert to all staff in the emergency department. This meant there was a continued risk that patients may not receive care in line with recommendations in these national alerts.

Urgent and emergency services

- The service held a central spreadsheet of all equipment in the emergency department which monitored maintenance and replacement dates. We reviewed this document and saw 40 pieces of equipment outside of their planned preventive maintenance dates, of which, seven pre-dated Covid-19 lockdown.
- Medical handover meetings did not have a formal structure apparent. We witnessed one handover, and several patients were not discussed because the doctor treating them was not present. We noted there was no specific teaching or learning included.

However:

- The backlog of incidents and actions arising from incidents, which was a concern at our last inspection had been reduced significantly.
- Junior doctors told us consultant presence in the emergency department had improved and that consultants were visible and accessible.
- A training needs analysis of nurse competencies had been completed and taken actions to ensure that nursing staff completed required competencies and put in place processes to support them to do so. A practice development nurse had been appointed to develop and oversee all aspects of nurse training, including mandatory training.
- During a recent outbreak of Covid-19 at the hospital, all staff were tested. Of the 6% of hospital staff who tested positive for the virus, none of these worked in the emergency department. Managers told us staff had been using personal protective equipment (PPE) since January 2020, which they believed had greatly contributed to this result.

Is the service effective?

Because this was a focused inspection, we did not rate the service. In this section we only inspected against the key lines of enquiry relevant to the concerns raised in the previous warning notice.

- Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. Both junior and senior staff we spoke with told us there was not yet a formal system of clinical supervision and staff sought advice and guidance from senior staff as and when they needed it.
- Managers made sure staff attended team meetings but did not ensure staff had access to full notes when they could not attend.

However:

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Since our last inspection, a practice development nurse had been employed, and had implemented a training needs analysis spreadsheet and a nursing competency framework using Royal College of Nursing (RCN) guidance. At our previous inspection, some staff had told us they were asked to perform tasks they did not feel comfortable or trained to undertake. At this inspection, we did not find this to be the case.
- Managers identified poor staff performance promptly and supported staff to improve. We saw as part of the new starter induction booklet, nurses were required to have periodic sessions with their assigned mentors. Senior staff told us the frequency of these meetings in the first year of employment made it easy to identify any issues early on and provide support if needed.

Is the service well-led?

Because this was a focused inspection, we did not rate the service.

Urgent and emergency services

- There was heavy reliance on the clinical lead of the emergency department. Whilst we heard of plans to recruit further staff to mitigate this risk, it remained the case that this created a vulnerability to all the strands of work undertaken by the clinical lead.
- Registrars, junior doctors and nursing staff told us that attending governance meetings was difficult because of operational pressures in the emergency department. It was clear from discussions with these staff that information from the governance meetings was not effectively shared with all staff in the emergency department.

However:

- Governance systems had improved. We were assured that the main governance forum in the emergency department provided good oversight of quality and risk at departmental, division and trust level, in order to support informed decision-making. They were aware of the issues in the department and were putting actions in place to mitigate the concerns.
- The risk register was up to date and was used to manage risks or provide assurance that controls were effective.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. This was a significant improvement from our last inspection.

Detailed findings from this inspection

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff; however, they did not make sure everyone completed it.

Mandatory training completion rates

At the time of our inspection we asked the trust to provide data to demonstrate staff compliance with mandatory training. This data was collected from the trust's electronic staff record (ESR) system. The data provided showed 82% of nursing staff and 75% of medical staff were up to date with mandatory training courses.

Since our last inspection, a practice development nurse had been appointed to develop and oversee all aspects of nurse training, including mandatory training. They had devised a comprehensive spreadsheet which showed training subjects, applicable staff and renewal dates. We heard how, whilst the department was shut due to a Covid-19 outbreak, staff had been encouraged to use the time to catch up with outstanding training. This had served to improve compliance in a number of areas. However, for training where face to face activities were required, there were ongoing low levels of compliance. Face to face training had been cancelled due to the Covid-19 pandemic, and additional life support classes had been arranged for August 2020.

There were also other areas particularly relating to the medical workforce where compliance with mandatory training was poor. Managers in the department were taking actions to improve training compliance.

Urgent and emergency services

All registered nurses were responsible for staying up to date with mandatory training and could access their training records via the electronic staff record on the trust's intranet. Some senior staff told us staff did not always do this. However, the practice development nurse told us they were now monitoring staff training compliance via their training matrix spreadsheet and were following up outstanding training directly with the staff concerned.

Junior doctors in the emergency department received protected teaching time. They were encouraged to attend, and medical cover was organised for the department. Junior doctors told us they could attend online training meetings during the Covid-19 pandemic, instead of meeting face to face for training. This had increased the attendance rate so the department planned to continue this. Staff told us the teaching was of good quality.

Junior doctors told us bedside teaching was more variable. Some consultants were proactive and used quiet moments to provide teaching sessions and scenario learning. However, they also told us that the quality and quantity of training provided by registrars was more variable. They also told us they would all recommend the department for teaching and commented this had improved over the last six months.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training needs matrix was reviewed on a monthly basis, and the practice development nurse followed up out of date training with individual staff. Staff also received emails to alert them to training which needed to be renewed or updated.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Data provided by the division showed 95% of nursing staff had completed level 2 safeguarding adults training, and 97% had completed level 2 safeguarding children training.

Intercollegiate Guidance for Adult Safeguarding, Children and Young People: Roles and Competencies for Healthcare Staff (2018) states that registered health care staff who engage in assessing, planning, intervening and evaluating the needs of children where there are safeguarding concerns must complete level three training. At the time of our inspection 56% of nursing staff had completed the safeguarding children level three training course. A further teaching session had been cancelled due to the Covid-19 pandemic. The division had planned training sessions, but dates had yet to be agreed. However, staff knew how to identify children at risk of, or suffering, significant harm.

Staff in the emergency department were supported by a paediatric nurse and consultant who were based on the children's unit. Nursing support was available Monday to Friday from 8am to 8pm and consultant support 9am to 7pm. Outside of these hours, an emergency department consultant was on duty until 10pm who was trained in level three safeguarding and advanced paediatric life support. At the weekend during the pandemic period, two paediatric nurses had worked in the department from 9am to 5pm.However we were told this had recently stopped, and no children were admitted via ambulance after 8pm or over the weekend.

All consultant doctors and middle grade substantive doctors had undertaken level three safeguarding children training. Data submitted by the trust showed of the 11 doctors working in the emergency department, nine were up to date with their level three safeguarding training.

Since our last inspection, the service had worked to improve the availability of safeguarding information for staff on the trust intranet. This had included making the information easier to find and ensuring that links were available to support staff to make referrals to the appropriate agencies.

Senior nursing staff explained that emergency department staff were able to access information on electronic patient records which flagged whether children were known to be at risk – for example from previous attendances. This information was then "stamped" on the child's department record so that others could easily identify the risk status of these patients and take the necessary actions.

Urgent and emergency services

Since our last inspection, processes had been implemented to further review the quality of safeguarding referrals made. The senior sister met regularly with the child safeguarding lead to review all the attendance records of children in the emergency department and check that action had been taken on the basis of the information available.

Since becoming part of University Hospitals Bristol and Weston, staff at the Weston hospital site had been using new safeguarding referral forms introduced by the team in Bristol. Training had been provided, and support offered to all the staff in the emergency department to ensure they felt confident and competent in their use. We heard that the quality of referrals had improved since our last inspection, indicating that the use of the newer form had not had a detrimental effect.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing and medical staff we spoke with were all confident to raise safeguarding concerns and could identify who to go to for advice or support.

We spoke with staff of all levels, who told us they were confident to discuss and raise safeguarding concerns. One healthcare assistant told us how they had escalated concerns about unattended children at the home of a patient and explained how all staff, including doctors, and the local authority had worked together to provide support for the family concerned.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Recent changes to online referral forms had made making children's referrals a lot easier. Staff told us there had previously been a different form for each local authority area which had been confusing.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. There was no formal dementia awareness training, however, staff were aware of various pictorial schemes, including the sunflower scheme for hidden disabilities. Staff told us they had access to additional support from a learning disabilities lead. One member of staff described how they accessed additional support to provide one to one nursing care for a patient in the department with suspected dementia.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The lead nurse on shift completed a checklist to identify how many doctors on shift had advanced paediatric life support training and any emergency department trained nurse on shift. If there was a gap in the rota from Monday to Friday, the lead nurse would liaise with the paediatric unit at the hospital informing them that the emergency department would require their support during the day to help with this gap. At weekends the paediatric nurses from the paediatric unit worked in the emergency department.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept most equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All areas we visited were visibly clean and this was supported by cleaning rotas we saw. In the corridor, each bay was separated by a disposable curtain which were labelled to show the date they were last changed. Staff explained that the emergency department had its own cleaning staff who worked shifts to provide support. Staff explained that when the department was closed overnight, if they required deep cleaning, staff contacted the site team. Staff told us they usually did not have to wait long too obtain deep cleaning following an infectious patient.

There was no visual system to alert staff if they had an infectious patient in the department. Staff told us they obtained information about patients from their notes but did not display any signs or warning symbols to warn others about a patient's infection status. Where highly infectious or suspected infectious patients came into the emergency department, two designated isolation rooms had been designated to isolate them from the rest of the department.

Staff followed infection control principles, including the use of personal protective equipment (PPE). At every entrance to the major and minor clinical areas there were supplies of alcohol gel, gloves, masks and aprons. We saw staff who delivered care washed their hands or used alcohol gel before and after each patient contact. Staff we spoke with could also explain the limitations of gel and why hand washing was always preferable. Staff reported no issues with obtaining and using PPE and explained additional training had been given during the Covid-19 pandemic.

During a recent outbreak of Covid-19 at the hospital, all staff were tested. Of the 6% of hospital staff who tested positive for the virus, none of these worked in the emergency department. Managers told us staff had been using personal protective equipment (PPE) since January 2020, which they believed had greatly contributed to this result.

Staff did not always clean equipment after patient contact and equipment was not always labelled to show when it was last cleaned. During the inspection we saw a standing aid which was covered in brown marks and food debris, and four walking frames which were not labelled to show when they had last been cleaned. We raised this with managers in the department and noted that these items had been removed from the equipment room by the end of the day. On a later walk around we saw that all the patient trolleys in the corridor had been labelled with green 'I am clean' stickers.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well. Patients could reach call bells and staff responded quickly when called.

Staff mostly carried out daily safety checks of specialist equipment. We checked two adult resuscitation trolleys and one paediatric trolley. We found the adult trolleys were up to date, with all necessary safety checks complete. However, the paediatric trolley had not been checked on one day in January 2020 and one day in June 2020.

The service had enough suitable equipment to help them to safely care for patients. However not all equipment was up to date with electrical safety testing or planned maintenance. We looked at 15 pieces of equipment including computers and clinical equipment and found a fan with no electrical safety test sticker and a computer and printer with a safety test date of September 2018.

The service held a central spreadsheet of all equipment in the emergency department which monitored maintenance and replacement dates. We reviewed this document and saw 40 pieces of equipment outside of their planned preventive maintenance dates. The data also showed the 'finite life length' of equipment which was the date after which it should not be used. We noted 52 items that had passed this date, 10 of which were prior to 2010. We discussed this with the trust during the inspection and a subsequent investigation by the trust showed that some out of date equipment was not being used in the department and had been replaced. Following our inspection, senior staff had undertaken a review of equipment held in the emergency department and could not find any equipment that was past its service or past the end of its working life. Following our inspection, a data cleanse was planned to identify and locate the equipment mentioned on the spreadsheet to ensure it had been removed from use.

Staff disposed of clinical waste safely. Staff disposed of clinical waste safely using a colour coded bag system to separate domestic, infectious and general clinical waste. Staff told us they understood the importance of ensuring the correct waste was disposed of in the correct bag.

Assessing and responding to patient risk

Urgent and emergency services

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

All patients who attended via ambulance were triaged by a senior nurse on duty. There was also a consultant doctor present in the department and available via a bleep system if needed. The trust used a dedicated triage computer system to clerk and assess patients which included initial observations and National Early Warning Scores to determine where they should be admitted.

When very ill patients arrived at the department, trust policy directed that they were fully assessed in the department before further decisions about their care were decided. Staff we spoke with were clear that this was their understanding about actions required in these instances.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There was consistent recording of National Early Warning Score (NEWS). The use of NEWS improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. We noted the use of the safety checklist which was completed in line with standard guidance in all the patient records we reviewed. Staff were clear about escalation and gave us good examples of alternative routes. If the consultant in charge was not available or busy then staff had an established mechanism to contact other senior emergency department staff or to contact the medical team on call, so there were systems to ensure a response once the deterioration was highlighted. Regular audits also were undertaken of the management of deteriorating patients.

Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools. Patients who attended the area of the department where minor injuries were treated were triaged within 15 minutes of arrival by a suitably trained nurse. They were often supported by emergency nurse practitioners, who were in addition to the planned staffing.

The band 6 nurse in charge undertook two hourly safety rounds, during which they reviewed the nursing records of the five longest stay patients. The nurse checked that NEWS score had been completed, pressure sore risk, pain score, if the patient had a call bell and finally checked if they needed any food or drink. We reviewed records for the past 14 days prior to the inspection and saw these rounds had been completed every day and actions documented. Nurses reported this to be useful but noted that it depended on the individual as to how challenging it was when actions had not been completed. Some nurses told us that when some senior nurses did the checking it was not necessarily fed back to the individuals who had not completed actions, but in the majority of cases they felt this feedback was done and in a constructive manner.

The emergency department held medical handover meetings twice daily at shift start and end for staff, although there was no apparent formal structure. We witnessed one handover, and several patients were not discussed because the doctor treating them was not present. There was a lack of challenge about clinical decision making and there was no specific teaching or learning included. However, there was a good review of resources and staffing issues.

Staff knew about and dealt with any specific risk issues including pressure ulcer care and documentation. The policy for the management of pressure ulcers had been updated to include those of a lower grade. This meant that staff could assess more accurately any deterioration in pressure areas whilst patients were being treated in the department. We reviewed three records which showed this was clearly documented alongside the patient's consent to photograph the areas.

In June 2020 when the emergency department was closed a sepsis teaching session was provided to 14 staff. This was followed by a teaching session by the oncology team on neutropenic sepsis to 13 staff. The department planned to offer sepsis teaching at the monthly nurse study day.

Reception staff told us they had not received any formal training to identify self-presenting patients who may require urgent clinical assistance. The reception staff we spoke with told us they learnt on the job but could not give us any

examples where patients had attended and had been identified as needing immediate attention. We later spoke with nursing staff who told us reception staff were aware of a neutropenic card scheme for patients with low white blood cells, who were at an increased risk of infection. When prompted, reception staff did tell us they immediately escalated neutropenic patients to clinical staff and isolated them in a triage room next to reception.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff we spoke with were all aware of the on-call psychiatric liaison team and could tell us how to contact them. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff explained they had an online matrix to help them assess and refer patients to the psychiatric team which was comprehensive and provided all the necessary initial information for the team to make a decision. Staff told us the system was sometimes a bit slow and during Covid 19 pandemic, the psychiatric team had stopped visiting the department in person, carrying out assessments by phone instead. Staff told us there was sometimes a gap in services between 8pm and 10pm when the onsite psychiatric team handed over to the out of hours crisis team who provided support overnight if needed. This had been identified as a gap in the service and raised as a risk on the risk register.

The department had access to a paediatric team on site. There was no paediatric specific consultant employed in the emergency department at the time of our inspection. Staff told us there was a paediatric consultant who normally worked in the emergency department but was working in a paediatric intensive care unit during the Covid-19 pandemic. Medical staff told us there was always a trained paediatric doctor on duty in the hospital, and that the hospital inpatient team was called for paediatric emergencies.

The paediatric team had been taking many patients direct from triage to the paediatric admissions unit during Covid-19. Staff told us this had been very positive for the emergency department which was not well equipped for children and they felt this had improved the quality of care. There were concerns expressed that this may change in the future.

Nurse staffing

The service did not have enough permanent nursing staff. There was a shortage of registered nurses and heavy reliance on bank and agency staff, although they had taken steps to mitigate the risks short staffing created by effectively managing a pool of temporary staff.

The service had high vacancy rates. Vacancy rates for nursing staff within the emergency department remained high at 22.8%. The department had improved it's staffing position since our last inspection. Whilst nursing vacancies were at 22.8% at the time of our inspection, three full time registered nurses had been recruited and were waiting to start.

At the time of our inspection there were 11.6 whole time equivalent (WTE) band 5 registered nurse vacancies in the emergency department and the service was heavily reliant on temporary (bank and agency) staff. The service had taken steps to mitigate the risks associated with employment of temporary staff. There were block bookings with agencies to ensure, where possible, there was consistency and continuity. Staffing agencies were used that provided staff with appropriate skills and experience in urgent and emergency care.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The staffing establishment per shift was nine registered nurses, four nursing assistants and one senior (band 7) nurse. We reviewed staffing rotas for the past three months and saw that on 219 occasions the establishment had not been met. However, the data included a period of time when the hospital was closed due to Covid-19 and the rotas were altered to demonstrate the nursing team working non clinically, reporting a lot of unfilled shifts. We saw that a band 7 nurse would work clinically in the emergency department and support if the department had any unfilled long day shifts which had not been allocated to bank or agency.

Junior doctors told us they were picking up tasks traditionally undertaken by nursing staff, such as taking patient blood samples, because of nurse staffing shortages.

Urgent and emergency services

The emergency department matron limited their use of bank and agency staff as much as possible and requested staff who were familiar with the service. Vacancy levels often meant that the emergency department relied on temporary bank and agency staffing. However, systems supported teams to secure the same staff who were familiar with the department, and staff told us this worked well. In the first instance, the matron requested bank staff from within the hospital with experience of working in an emergency department. Staff told us the trust now allocated shifts to agency staff on arrival as some staff had refused to work in the emergency department when told in advance.

The trust leadership supported agency nursing requests if the department shifts were unfilled. The department would also move band 5 nurses from other wards and outpatient areas to support the emergency department when required.

The senior nurse in charge could adjust staffing levels daily according to the needs of patients. Senior staff explained they reviewed vacant shifts three times a day and took their staffing requests to the site bed meeting for approval. Staff explained there were four tiers, starting with hospital bank, progressing up to different agency nurses based on cost. Senior staff expressed concern that sometimes the decision to escalate up the tiers was slow and sometimes left shifts uncovered. Senior staff explained that the decision for escalating a shift vacancy was made by the matron in charge for the day and could sometimes take time to receive an answer or to progress to the next tier in the process. Senior staff also felt there was a wider issue in that on two occasions when a locum doctor had been sought, there had been no staff available from the usual agencies at all tiers of escalation.

The service had low sickness rates. Sickness rates for the year at the point of the inspection were at 2.5%, against a trust target of below 3.9%.

The emergency department matron made sure all bank and agency staff had a full induction and understood the service. Temporary staff were required to complete an orientation and induction checklist when they started work in the emergency department and this was repeated if they worked in the department infrequently.Senior staff told us new agency staff were given an induction while on shift. If concerns arose around an agency nurse's competence, senior staff told us they would not be booked again. Senior staff told us they relied on the agency to ensure agency staff had complete skill set necessary to work in the department. All agency staff new to the department completed an induction orientation form.

There was not always a dedicated paediatric nurse on duty in the emergency department. Staff told us they that between 9am and 7pm they were supported by specialist children's nurses from the inpatient paediatric unit, and this had been extended to cover weekend shifts. As the emergency department closed at 10pm each night, this meant there was sometimes a gap where a dedicated paediatric nurse was not available on shift. Staff explained that the ambulance service rang ahead if they had an unwell child to determine the most appropriate department to take them to.

Medical staffing

The service did not have enough permanent medical staff. There was heavy reliance on temporary staff at registrar level. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The trust employed seven consultants, which amounted to six whole time equivalent posts. However, the department only employed three registrars, with six vacant posts. At the time of our inspection four further registrars and a junior doctor had been recruited. The emergency department registrar job description was under review and being transferred to the new organisation's format in preparation for advertisement. To support the gaps in registrar staffing the department booked long-term locum staff.

The department had one vacant consultant post at the time of the inspection, which was being filled by a locum doctor. Consultants told us it could sometimes be challenging to cover annual leave or sick leave. However, both senior managers and staff told us consultants had been more visible within then department in recent months.

Urgent and emergency services

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patients records were comprehensive, and all staff could access them easily. We looked at a sample of 11 patient records. All of the records we reviewed were completed in full, contained the necessary information to support patients, and were signed and dated in legible handwriting.

Patients' records were located either at the end of their bays – for nursing notes – or in lockable cabinets. However, we did not find that any of these cabinets were locked. It should be noted that these cabinets were in areas of the department that were heavily populated by staff and so at the time of our inspection this did not pose an obvious risk. However, risk could be present at quieter times when fewer staff were available.

Medicines

The service followed good practice when prescribing, giving, recording and storing medicines.

There were suitable arrangements for the storage of medicines, including controlled drugs. Medicines requiring disposal were locked away and non-clinical staff had access to the treatment room where they were stored. There was an electronic key system used to access drug cupboards. The central pharmacy stores team completed weekly stock top-ups and pharmacists were involved in reviewing stock held.

There were suitable arrangements for the storage and management of controlled drugs. A stock balance was completed daily by two nurses. Quarterly audits of controlled drugs were completed by pharmacy staff.

Blank prescription pads were stored securely and there was a system to monitor their use.

Emergency medicines were available and were stored securely, sealed and checked regularly.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service did not always manage patient safety incidents well. Staff recognised incidents and near misses and reported them. Managers investigated incidents but did not always share lessons learned effectively with the whole team and the wider service. When things went wrong, staff apologised and gave patients information and support. Managers did not ensure that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with could tell us what constituted an incident and were supported to report them. They told us systems were easy to use. However, most staff told us they received little or no feedback.

Staff did not always hear about learning from investigation of incidents, both internal and external to the service. Following some recent serious and higher profile incidents, staff were able to talk to us about learning from these and this had been clearly shared. However, we were not assured that the systems used supported the sharing of information following all incidents. There was reliance on processes that were not consistently followed by staff in the emergency department. For example, we learned that following incidents, learning was shared in the morning "safety huddle" – a nursing handover, and during the afternoon medical handover. However, in the medical handover we observed, learning from incidents was not covered, even though it should have formed a standard part of that meeting. This reliance on "people-based" compliance meant that this format of sharing learning from incidents was fragile and not consistently implemented. None of the staff we spoke with were able to describe learning from incidents in other parts of the hospital, or from other organisations.

Urgent and emergency services

One member of staff told us of an online messaging service set up by senior nurses to communicate significant incidents and learning. Staff had been alerted to the recent never event via this group and said it was very useful as they did not have to log into emails on a computer to view updates. Staff told us they found the group effective, but there was no record for senior staff to know who had and had not read messages. Senior staff told us the group was designed as a supplementary system to other methods of dissemination.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2019 to July 2020, the trust reported one incident classified as never events for urgent and emergency care.

This incident occurred when staff connected a patient to an air outlet. A 72-hour report had been produced, which described initial findings and actions taken. The trust reported this never event to CQC immediately after the incident and had planned a review of all patient safety alerts issued in the past five years related to nationally defined Never Events to check that the department was compliant with them.

A full root cause analysis was underway at the time of our inspection.

Following the never event in the department, we asked staff about their awareness of National Patient Safety Alerts. New or under-recognised patient safety issues that require national action are identified through a clinical review of incidents reported to NHS Improvement or the Royal College of Emergency Medicine (RCEM). If required, they will issue a National Patient Safety Alert that sets out actions healthcare organisations must take to reduce the risk. Patient safety alerts were discussed at monthly department governance meetings, which were attended by consultants. The minutes of these meetings did not state how this information was to be shared with other staff in the emergency department. Junior medical staff told us they had had discussions about incidents within the department but had not seen any external safety alerts. We asked them about the alert from the Royal College of Emergency Medicine (RCEM) issued in January 2020 advising all clinical staff about the risks of patients swallowing 'button cell batteries', and what immediate actions should be taken. However, none of the medical staff we spoke with were aware of this alert.

Of the staff we spoke with – both nursing and medical – only one senior nurse was able to speak with us about a particular safety alert. There was not an effective process to disseminate the actions required following a national patient safety alert to all staff in the department. This meant there was a continued risk that patients may not be receiving care in line with that recommended in these national alerts.

The department encouraged openness and honesty at all levels of the organisation in response to serious incidents. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were open and transparent, and told us they gave patients and families a full explanation if and when things went wrong. One member of staff told us about a conversation which was held after a patient developed a pressure ulcer in the department. The incident was reported via the online incident reporting system and the conversation was recorded in the patient notes.

Safety thermometer

This was a focused inspection and we did not cover this section during this visit.

Is the service effective?

Evidence-based care and treatment

Urgent and emergency services

This was a focused inspection and we did not cover this section during this visit.

Nutrition and hydration

This was a focused inspection and we did not cover this section during this visit.

Pain relief

This was a focused inspection and we did not cover this section during this visit.

Patient outcomes

This was a focused inspection and we did not cover this section during this visit.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Since our last inspection, a practice development nurse had been recruited. They had implemented a training needs analysis spreadsheet and a nursing competency framework using Royal College of Nursing (RCN) guidance. We reviewed both documents and saw they were thorough and covered most core clinical subjects. However, it was unclear how the data was being monitored on an ongoing basis. For example, the competency matrix showed when staff were due for periodic reviews with their mentors but because the spreadsheet contained past and future dates, it was not clear who had received these reviews and who had not. On our previous inspection we found staff had not always been confident to carry out some tasks, and that senior staff had sometimes been dismissive of their concerns. On this inspection we found staff were happy to perform tasks asked of them and training had greatly improved in some areas. Staff also told us they felt supported by senior staff and could go to them for support or unplanned clinical supervision.

The practice development nurse supported the learning and development needs of staff. Since our last inspection the practice development nurse had developed a competency framework for emergency nurses using RCN best practice guidance. We reviewed the document and saw it was thorough. The practice development nurse also held a spreadsheet to show which staff had completed which pages, which was clear. At the time of our inspection, ten out of 37 registered nursing staff had started the document, however all staff we spoke with were aware of it and expected to start theirs soon.

Managers gave all new staff a full induction tailored to their role before they started work. Since our previous inspection, a new starter induction pack had been developed. Staff received a copy of the document upon appointment and were responsible for its upkeep. We reviewed the pack and saw it was comprehensive and detailed expected competencies and milestones. We spoke with the practice development nurse who told us the system was under review as there was currently no central oversight of staff progress against the competencies as staff took the documents home with them. The practice development nurse told us they were planning to bring all the documents into one place on site, so they could monitor staff progress centrally.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed that at the time of our inspection 79.6% of nursing staff had received an appraisal, and this was improving. It was not clear that systems to capture medical staff's compliance with appraisals was accurate or being used effectively. Medical staff must be revalidated every year to keep their medical registration. This process includes a yearly appraisal yet the information we saw suggested this was not the case.

Urgent and emergency services

Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with told us there was not yet a formal system of clinical supervision and staff sought advice and guidance from senior staff as and when they needed it. The new starter induction pack and nursing competency framework showed dates staff were due to have their periodic reviews and supervision sessions, but it was not clear who had received these and who had not.

There was a regional meeting for non-training registrars six times a year and their attendance was facilitated. However, they told us there were no opportunities within the emergency department for regular teaching outside of governance meetings.

We asked about specific training in sepsis identification and management and staff told us there was no mandatory training on sepsis. Staff told us they learnt about sepsis on the job, with support from senior staff. Previously, there had been a trust- wide drive in sepsis management as part of a local initiative, with a dedicated trust lead. Staff told us this role had been removed once the goal had been achieved, and senior staff were now unaware what training junior staff received, if any. Staff told us a sepsis training session had been provided when the emergency department had been closed in June 2020, and 14 staff members had attended. It was not clear which staff, as this data had not been added to the training matrix at the time of our inspection. In addition, specialist neutropenic sepsis training had been delivered by the oncology team to 13 staff, but again, this data had not yet been added to the matrix for oversight.

Managers made sure staff attended team meetings but did not ensure staff had access to full notes when they could not attend. Staff told us there used to be a communication book held in the staff break area. However following a recent deep clean, this had been removed. At the time of the inspection staff were trying to locate the book and were not aware that it had been removed. No alternative method had yet been established to replace the communication book. Senior staff told us the daily handovers and huddles were the only other method of disseminating information to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Most staff we spoke to told us access to training had greatly improved since our last inspection. No staff reported any problems in accessing training when it was relevant to their role. Staff were also encouraged to join junior doctor study days, and staff we spoke to told us a list of these was displayed in the break area. Senior staff told us that this had not yet been taken up by a lot of the nursing staff.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us training was discussed as part of their appraisal but also felt the new competency framework allowed for frank training discussions, although most staff we spoke with were yet to start the document.

Managers made sure staff received any specialist training for their role. The practice development nurse held a detailed training needs analysis spreadsheet which covered all the specialist training subjects staff were expected to undertake. In addition, study days had been arranged for staff to attend in small groups, which were being jointly delivered by the clinical lead for the ED. Staff we spoke with were aware of the days but had not yet attended one. Senior staff explained that the number of staff freed to join depended on staffing levels for the day in question. We did not see any formal record to show which staff had attended study days.

Multidisciplinary working

This was a focused inspection and we did not cover this section during this visit.

Seven-day services

This was a focused inspection and we did not cover this section during this visit.

Urgent and emergency services

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service, although there was a large reliance on the clinical lead in the department. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We spoke with the clinical lead for the emergency department. They had been in the post since November 2019, having previously worked in the department. The clinical lead demonstrated a clear understanding of the challenges faced in the emergency department and had plans to work alongside colleagues to address these. Feedback from staff was positive about the work of the clinical lead. Staff we spoke with told us leaders in the department were visible and approachable and could all identify senior clinical staff within the department.

However, there was a very large reliance on the clinical lead of the emergency department. Whilst we heard of plans to recruit consultants to roles to mitigate this risk, it remained the case that this created a huge vulnerability to all the strands of work currently undertaken solely by the clinical lead and this was a concern.

We were not assured about the support proactively available to the clinical lead from an executive level. There was a clear plan to recruit to roles to support the lead, such as a post to lead on governance and to build some resilience. While the clinical lead had support at a local level from the associate medical director, this did not alter the fact that as clinical lead they appeared to be lacking a clear line of sight to the board. Given the challenges of the emergency department, both historically and currently, we were not assured this risk was being effectively managed.

We met with the senior leadership team in the department, which included the clinical lead, matron and general manager. They reported improved team working and a more cohesive and better educated team in the department, with a stronger consultant body, which had led to improvements in safety in the emergency department.

We also met with senior nurses working within the emergency department. The recruitment into the practice educator role had enabled the service to address both nurse competency concerns highlighted during our last inspection, but had also relieved this pressure from the existing senior nurses. This meant that they felt they had sufficient time to manage the requirements of their role.

Having become part of a new organisation in April 2020, the leadership team were still establishing relationships at a more senior level at the time of our inspection. They told us they felt confident to raise concerns and suggestions, but felt they were still adjusting to being part of a much larger organisation.

Senior staff in the department told us there were still ongoing difficulties with flow through the emergency department and the hospital and felt this was variable depending on the leadership each day. Staff felt there was no ownership of flow in the hospital and there continued to be difficulties between emergency and medical doctors in the acceptance of patients for admission. Staff felt they were beginning to see signs of change in staff attitudes and performance since the merger. Also, band 6 nurses were now charged with overseeing flow though the emergency department, which allowed the band 7 nurses to focus on their specialised areas, which included sepsis and nurse prescribing. We saw a band 7 was always on shift to support and told us using the band 6 in this way was a good way of getting junior staff to own the flow and develop.

Vision and strategy

The service did not have a formal vision for what it wanted to achieve. The emergency department had a short-term vision for the improvements required and getting them to a sustainable state. The long-term vision was not clear, but this reflected the recent merger followed by the disruption caused by the Covid-19 pandemic.

Urgent and emergency services

The Weston division had a new divisional manager who had been in post for three weeks at the time of our inspection. They told us about the plans for a new strategy linking in with local partners.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We heard of a marked improvement in culture in the emergency department since our last inspection. Nursing staff were happy in their work, and told us they felt free to speak up, provide challenge and that leaders would listen to their concerns. The staff we spoke with were happy and willing to talk freely. They reported staff morale was much improved and more staff told us they wanted to stay working in the department. Leaders told us they felt the team had evolved and grown over the past year and this was paying dividends in the wellbeing of front-line staff, as well as being evident in low rates of sickness. They told us told department was now led by its values, and staff would challenge each other's behaviours constructively. Junior doctors were positive about working in the emergency department and told us they felt mostly well supported. It was clear that the cultural improvements had been made by sustained efforts of those working operationally within the department.

However, we were made aware of cultural difficulties between the clinical leadership of the emergency department and that of the acute medical physicians. We were concerned that this reluctance to work collaboratively created a risk to the further development of "front door" services at the hospital. However, we took some assurance from the awareness held by senior leaders of the hospital of this issue and plans to try and address it quickly, as well as from the motivation of the clinical lead in the emergency department to resolve the problems this issue created.

Junior doctors told us consultant presence in the department had improved and told us consultants were more visible and accessible. They told us consultants were mostly approachable, although they told us that a couple of consultants stayed mainly in the 'minors' department and rarely worked in the 'majors' department'. The clinical lead was aware of this issue, and support had been provided from emergency department consultants from Bristol.

Staff we spoke with gave us examples where poor behaviour had been addressed, and this had sent a clear message that underperformance would not be accepted. We saw episodes of respectful challenge that were managed well to ensure work had been done appropriately.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but not had regular opportunities to meet, discuss and learn from the performance of the service.

The governance lead had been in post since May 2019, and during that time had worked hard to improve processes. There had been clear inroads made into the governance concerns identified in our last warning notice. The structure appeared more coherent and effective and the replacement of poorly attended and functioning "front door" meetings with the "Emergency Department Governance Event" (EDGE) meetings was seen as a positive change. In itself, this meeting had given rise to other meetings that fed into the EDGE meeting agenda. For example, the "High Impact User Group" meeting, and this was seen to be working well. Meetings were held two weeks prior to the divisional governance meetings so any issues could be shared with the division's leadership team.

We reviewed the minutes of the last six EDGE meetings. Meetings had a standard agenda, which included: risk management; health and safety; incidents management; mortality and morbidity; safeguarding; patient experience; audits and clinical effectiveness; education and training; and staffing. At each meeting action logs were updated.

Attendance at the EDGE meetings were also greatly improved, with representation on a regular basis from colleagues in the safeguarding team, and pathology and radiology. However, registrars, junior doctors and nursing staff told us that attending these meetings was difficult because of pressures in the department. It was clear from discussions with these staff that information from the governance meetings was not effectively shared with all staff in the department.

Each EDGE meeting included a story about a recent patient which helped to inform discussions and bring perspective to the meetings. Senior managers gave an example of learning from a patient's experience and complaint from a surgical ward.

The number of changes in personnel at the hospital, together with the merger had caused some problems with data management where two different systems were being used but this was a recognised issue that was being worked on at the time of our inspection.

Managing risks, issues and performance

The emergency department had improved systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and the unexpected. The emergency department maintained a risk register, and this was used to maintain oversight and manage risks effectively. The EDGE was the main forum for monitoring and managing risk. Risk management was discussed at these meetings and included a review of the risk register and health and safety concerns. There was an action log maintained to ensure actions were progressed at an appropriate pace. There was evidence of assurance that information about quality and key risks was regularly discussed or consistently escalated to the division's governance forum. The register was up to date and provided insufficient evidence that controls were regularly reviewed.

At our last inspection it was not clear that risks had been reviewed and there was limited assurance provided. There had been 32 risks identified in the department, some of which were duplications. We saw at the inspection that all risks had been reviewed during 2020, and there were 15 departmental risks on the register at the time of the inspection. In June 2020 the emergency department had seven risks that were rated as 'very high'. These included: increased risk of suboptimal levels of medical staff due to heavy reliance on agency and locum staff, risk of delay of specialty review, risk that medical review is not undertaken in a timely manner, risk of inadequate staffing in the transition area, and risk to patients and staff when stacking overnight due to lack of inpatient beds. Risks on the register reflected the conversations we had with staff in the department.

At the time of the inspection the Weston divisional leadership team were reviewing the entire divisional risk register, including re-evaluation of risks.

Whilst staff were confident in reporting incidents, we were not assured that leaders could be confident that learning from them was occurring consistently. A lack of process to establish how this was happening meant that the risk remained that repeated similar incidents could occur. We reviewed the minutes of the last six EDGE meetings and saw incidents were discussed at each governance meeting. This included: how many incidents had occurred in the last month, how many were a near miss, what grade they were, and serious incidents. However, there were no examples of any incident discussed in any detail, any themes, or lessons learned.

During our last inspection in September 2019, we noted over 200 incidents were "open". That meant that the processes surrounding these incidents – investigations, learning, had not been completed and the trust could not be assured these were being managed well. At this inspection, there were 49 open incidents and leaders were able to describe the reasons for this. This represented an improvement in the management of incidents once they had been reported.

Since the merger, the University Hospitals Bristol and Weston NHS Foundation Trust governance team had undertaken a review of the previous Warning Notice, and a paper had been presented to the private board meeting in July 2020 which provided assurance of progress or completion of actions required to improve. We saw clear assurance of progress of actions.

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Managing information

There were not effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.

At the time of our inspection the trust was in transition, merging the systems of the two organisations to produce accurate, valid, reliable, timely and relevant data. However, this had led to challenges which meant that some data, especially in relation to training and equipment, was not reliable. The trust recognised these issues and was working on a solution to improve the quality of data.

The trust acknowledged that there had been challenges with recording accurate mandatory training data in the system and recognised that work was needed to improve the quality of the data. A manual check of data showed that training compliance was much higher than recorded. For example, 81% of nursing staff had completed the life support training (compared to 34% listed above). The trust planned to integrate Weston General Hospital data on to the same systems used in Bristol.

Engagement

This was a focused inspection and we did not cover this section during this visit.

Learning, continuous improvement and innovation

This was a focused inspection and we did not cover this section during this visit.

Areas for improvement

See Guidance note 3 (and delete this text before publication).

Action the provider MUST take to improve:

- Ensure that staff employed in the emergency department are supported to complete regular mandatory training, and compliance is accurately captured.
- Ensure all registered health staff have completed level three safeguarding for children training.
- Ensure there is an effective mechanism where all staff in the department learn from incidents that occur within the department and externally.
- Ensure there is an effective mechanism where all staff are aware of national patient safety alerts to ensure patients receive care in line with that recommended in these national alerts.
- Ensure that all staff receive adequate supervision, mentorship and appraisal, and ensure that this is documented.
- Ensure that governance meetings provide a framework for discussions about serious incidents and include themes and lessons learned.

Action the provider SHOULD take to improve:

- Take further steps to improve the quality and quantity of training for junior doctors.
- Consider a system to alert staff if they had an infectious patient in the department.
- Take further steps to ensure all equipment in the emergency department is maintained and not used past its finite life date. Furthermore, leaders should consider ways to ensure the risk of staff using this equipment unknowingly is mitigated.

Urgent and emergency services

- Consider ways to improve the effectiveness and thoroughness of handovers to ensure they capture all patients as well as learning and teaching.
- Improve compliance with the escalation process to procure and escalate requests for agency and locum staff to make sure all shifts are covered.
- Consider and mitigate the risk created by the high workload of the clinical lead.
- Consider what mechanisms could be introduced to provide a better line of sight between the clinical lead of the emergency department and the executive board of UHBW.
- Consider mechanisms to share information from governance meetings with all staff in the department.
- Consider ways in which the oversight of nursing competencies and training needs analysis can be improved.
- Work to improve the confidence of emergency department staff in caring for seriously ill children.
- Implement training for reception staff in the recognition of seriously ill patients.
- Consider ways to improve data quality available to leaders so they can work proactively to address shortfalls and risks.
- Address the cause of a lack of joined up working between the emergency department and the acute medical physicians.

Our inspection team

The team that inspected the services included and inspection manager, Marie Cox, and two CQC inspectors, and a specialist advisor: a professor and clinical lead in emergency medicine. The inspection team were overseen by Amanda Williams, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance