Risk Assessment of Unscheduled Care Pressure

BACKGROUND

In response to this sustained period of unscheduled care pressures experience at Morriston Hospital is reflected on the Unit Risk Register which demonstrates high score in relation to the Emergency Department's ability on a daily basis to provide timely assessment and treatment to emergency patients resulting in avoidable patient harm (ID54).

Additional factors impacting on this score:

- Requirement to instigate Business Continuity Processes on 1 occasion
- Requirement to instigate Major Incidents Protocols on 1 occasion
- Delayed Ambulance offloads on both acute sites (predominantly Morriston & occasionally Singleton)
- WAST notified risk in relation to avoidable harm in the community as a result of ambulance delays – 13 on going WAST SI incidents
- Correlation in volume of reported incident to locations supporting emergency and ambulatory care pathways – specifically in medicine and the recognised deficit in medical bed capacity with over capacity outlying in specialty and general surgery
- Sustained levels of medically fit patients leading to delayed admissions and overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and within the wider hospital decreasing patient experience and increased clinical risk for patients being cared for in inappropriate areas. This also puts significant strain on nursing, medical and AHP resources both through increased patient numbers and stress on staff
- The management of "Majors" category emergency patients in "Minors" location within the ED which stagnates flow of minor's patients and is not designed to accommodate these patients safely in terms of facilities or space.
- The necessity to pre-empt and place additional patients on wards as 'plus -1' and on Occasion 'plus 2'. These are in corridor areas in the bays and do not have oxygen or suction, power or curtains to provide privacy for toileting or examination or treatment.
- Breach of Powys Ward bed pool
- Breach and closure of Children's ward leading to regional burns and plastics centre status vulnerability as well as poor experience for children and young people as increased distance to travel for care or being cared for by inappropriately experienced children's nurses.
- Cancellation of planned care admissions on occasion this has included clinically urgent and cancers.
- Breach of Cardiac Short Stay and consequential reduction in elective flow to this area and pressure on STEMI capacity

Other recognised acknowledged risks within unscheduled care:

- ID1345: ED Medical workforce capacity

<u>Mitigations in place</u>:

- Silver daytime roster in place with senior MSDU directors and managers to support escalation and flow
- Use of decontamination room as decant area for ambulance offload support

- Use of REACT to off load and provide pressure damage preventive care and personal care.
- Use of agency to support surge capacity across the site
- Continued opening of surge capacity across medicine and surgery.
- Daily review of elective cases based on clinical priority by one of the 3 directors
- ITU 'go or no go' surgical cases huddle at 08.45 each day.
- Altered minors triage priorities to be more sensitive to acuity
- Firm stance on maintaining paediatric protected ED capacity 24/7
- Strengthened leadership by merging ECHO and Medicine service groups
- Strengthened Nursing leadership in ED by increasing ED matron to 2 wte.
- Consultant posts out for recruitment – continuing
- ACP model of acute medicine
- Ambulatory care model continuing to grow and coming on line in new location and expanding
- Maximizing SDMU and SSSU flow.
- Hospital 2 Home project showing some initial results but ramp up numbers as yet to reach maximal anticipated impact.
- Signal project to provide coordination centre with whole hospital view in near future

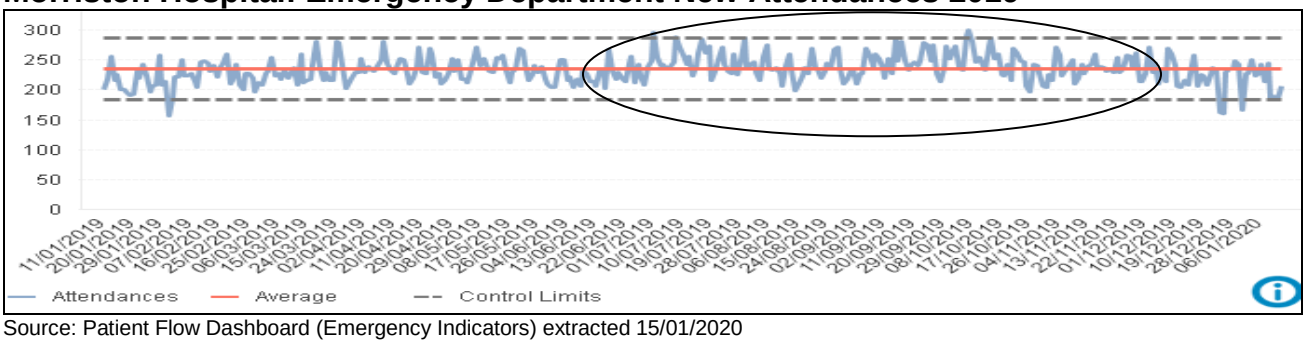
Unit Unscheduled Care Performance Data

The number of patients attending as new patients to the Emergency Department at Morriston in the 3 months Oct to Dec 2019 was **21,768**, compared to **20,732** in 2018 (5% increase or an additional 9 patient per day).

For the Qtr3 period in 2019, median daily attendances are now in excess of **230** (at 236) with a range of **301** (07/10/2019) to **160** (25/12/2019).

The graph below illustrates attendance numbers for a 12 month period 11/01/2019 to 06/01/2020. There has already been recognition that the summer period (July and August was challenging however it is clear on this graphic that the pressure continued into mid-December and resulted in the increases highlighted above.

Morriston Hospital: Emergency Department New Attendances 2019



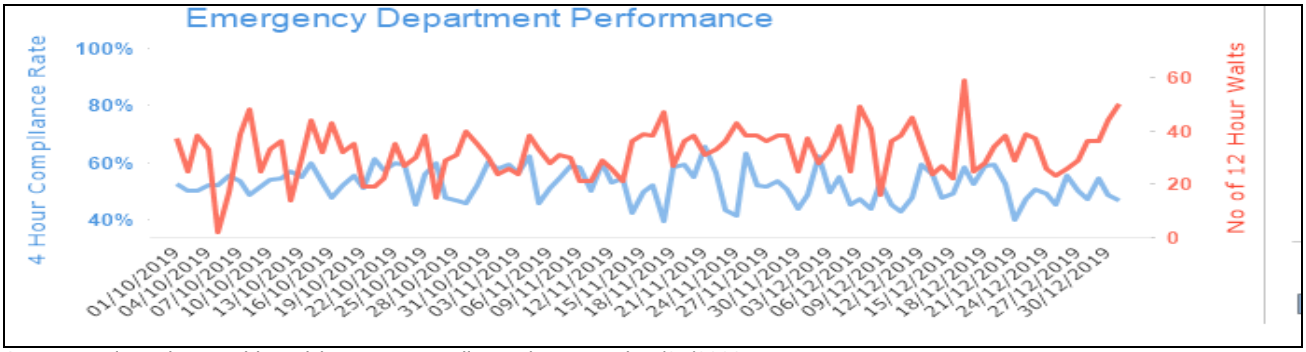
Source: Patient Flow Dashboard (Emergency Indicators) extracted 15/01/2020

4 hour performance; reducing. 4hr unscheduled care performance is between **47-71%** since the 18th December. Weekend performance remains challenging with performance at the lowest at 47.37% over a weekend. Despite efforts to address the weekend Consultant middle shift gap, the fill rate has been poor. In addition, the core number of doctors rostered to work weekends is less than on weekdays owing to limiting weekend frequency and

sustaining compliant rota patterns for training doctors. The issue with outflow in ED also contributes to the performance as the department operates above 100% occupancy and space constraints can delay or postpone patient assessment.

The daily breach analysis process continues and key reasons for breach remain unchanged are ED assessment delay and wait for medical bed

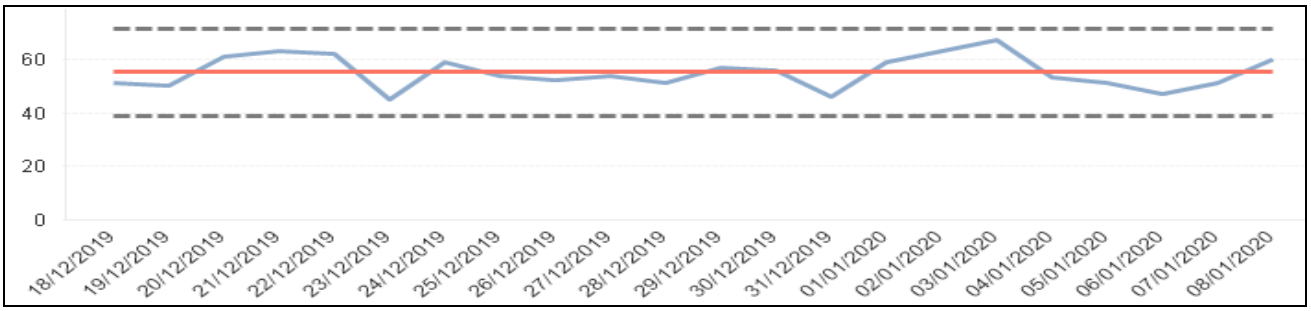
12 hour performance; unstable. 12 hour performance for the reporting period is between **74–88%.** Compliance for the same period last year was between 87– 100%. This can be attributed to: High number of medically fit patients in Morriston and across the wider Swansea Bay Health Board hospitals, high emergency bed day utilisation on site, internal and external process delays in relation to the discharge pathway and time of day of discharge linked to Board and Ward rounds



Source: Patient Flow Dashboard (Emergency Indicators) extracted 15/01/2020

Ambulance Activity & Performance

There was an increase in ambulance demand on Friday 3rd January 2020, however the average remains within normal parameters.



The ambulance handover delays remain a challenge and correlate with the poor and deteriorating 12 hour performance. Hospital flow in general is compromised. More latterly there has been cancellation of planned care patients, including on occasions those patients on cancer pathways or waiting for clinically urgent surgical procedures.

WAST Serious Incidents

A joint piece of work with WAST is underway to review serious incidents reported by WAST to Welsh Government in relation to deaths in the community whilst patients waited for WAST emergency vehicle resource to be allocated.

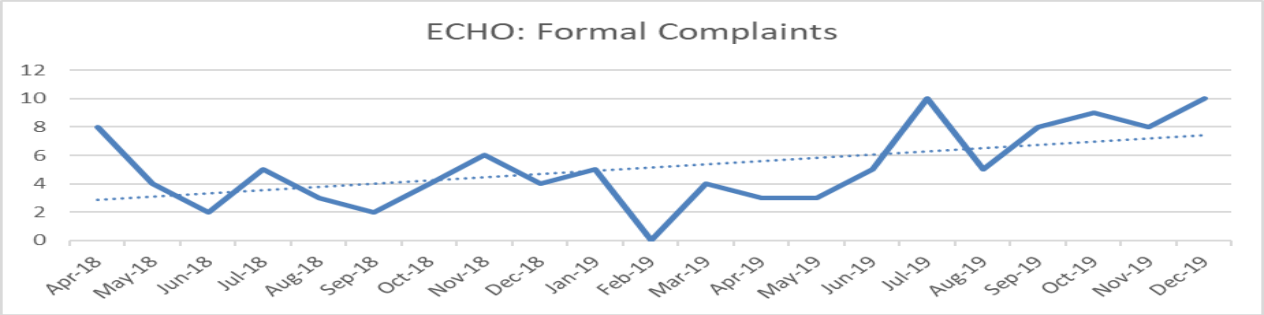
To date 9 incidents have been reviewed with 4 further incidents noted whilst it is clear the offload delays at Morriston Hospital are contributing to WAST's ability to allocate clinical resource to the community to date there has been no case where a direct causal link to a death has been identified although it is recognised potentially as a contributing factor.

Outcome from these reviews have been shared with the Health board Serious Incident Team and via the Emergency Department Quality & Safety meeting.

Mitigation Service Action:

- ECHO workforce plan developed in parallel to the review undertaken by Kendall Bluck and the RCEM peer review report triangulated with professional judgement model
- Operational implementation of Clinical Site Manager/Matron (8a) role and support from "silver" daytime senior decision-making
- Joint standard operating protocols in place with WAST regarding ambulance hand-over delays and immediate release of vehicles 'red release' and monitoring of this compliance which is currently 100%.
- WAST Patient Flow coordinator working daily within the department and are working in partnership with our ED and Site Team. An evaluation of this will be completed by the Operations Manager for WAST alongside the ECHO team.
- Operationally compliant with the All Wales repatriation database (fully electronic) with well-established escalation of delays in place via Executive Director to other HB's
- Joint working with Paediatrics to develop a single point of access supported by Executive Directors
- Extended adult mental health assessment provision in ED with dedicated assessment facility
- Specific case management of CAHMS patients including commissioners, providers and Executive Directors
- Separate out the ENP minors stream with fast track access from ED reception – reducing triage demand
- Ongoing recruitment work efforts within the department for all groups of staff in both training and non-training posts
- WAST Serious Incident Review Workshop planned for January 2020
- Weekly review of medical workforce with Clinical Lead to mitigate risks associated with workforce gaps
- Shift by shift monitoring exercise to demonstrate the fill rate of workforce gaps and to enable financial forecasting.
- Use of on and off contract medical agencies to reduce service gaps and enable safe delivery of care
- Tailoring posts to available resource – creating bespoke job roles to attract and accommodate specific skills and areas of interest
- Personal contact made with all EM Registrars due to complete training within next 2 years by Clinical Lead to attract into available posts

PATIENT EXPERIENCE
Formal Complaints: Emergency Care Direct Impact



July 2019 reached a peak in the number of formal complaints raised in relation to patient experience and clinical treatment in the ED. This level of feedback has continued to be sustained over the following 5 months with Dec 2019 equalling July's peak.

Emerging themes from ED complaints:

- Treatment within clinically appropriate timescales (redress identified in some cases)
- Delay in communication due to pressure in the department
- Significant inquest (external expert commissioned by HMC – delay in treatment)
- Health Board Serious Incident (investigation outcomes pending – delay in treatment)
- Incorrect medication/allergy (penicillin near miss)
- Delay in medication administration analgesia and treatment medications
- Mis-fractures (redress investigation pending)
- Poor patient experience as a result of staff frustration (inappropriate attendance)
- Poor patient experience due to environment they are being treated within

Family & Friends Feedback: Emergency Department
The significant reduction in the volume of feedback provided on services was identified in August this has continued with recommendation rates reflecting negative experience.

Month 2019	Highly Recommend	No of Surveys
Sept	78%	104
Oct	79%	84
Nov	79%	68
Dec	62%	42

Key Feedback Messages

- Long waiting/access times

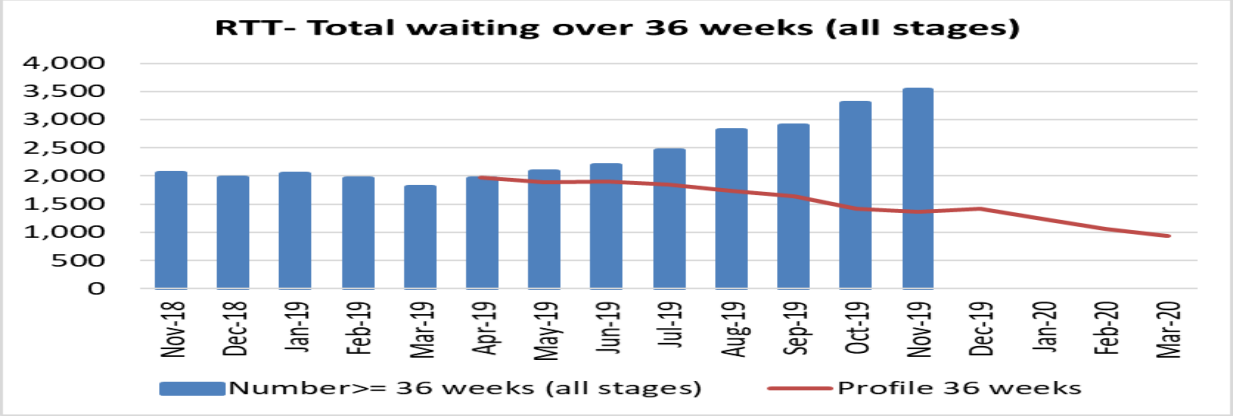
- Frustration with delays in communication involving results and from staff to patients
- Frustration with environment due to long waits
- Consistently positive feedback in relation to staff

Actions: Emergency Department at Morriston involved in All Wales project to implement "Happy or Not" technology within the environment. Project from end of January 2020.

PATIENT ACCESS – Unit Wide Access
RISK

- ID796: Inability to meet RTT access targets Orthopaedics - stage 5 (treatment)
- ID809: Inability to operate on spinal patients requiring a clean ward environment due to unscheduled care pressures
- ID1508: Treatment of Lap Chole Patients at Morriston Hospital impacting on Stage 5 waiting times
- ID1449: Unable to provide pancreatic surgery to patients due to the lack of capacity available for operating for both cancer and non-cancer patients
- ID1091: Long waiting adult patients of the Cleft Service

Planned Care



As indicated earlier unscheduled care has a direct impact on the Unit's ability to deliver planned care. In the case of Morriston this specifically impacts on patient's requiring regional services and who due to existing co-morbidity cannot receive their treatment at an alternative healthcare provider.

The degree of avoidable harm related to this cohort of patients is currently not quantified.

Mitigation Actions

- Local escalation framework for at risk planned care patients on a cancer pathway
- Daily planned care safety huddle to review total elective demand versus capacity on a daily basis – Unit Director involvement on decision-making
- Local escalation framework for planned care patients requiring ITU facilities
- Clear communication on planned care demand included in week end planning

Medically Fit Patients
Risk

- ID1832: Unable to discharge medically fit patients

The wider health system within ABMU offers opportunities to reduce the number of medically fit across the Morriston site with 117 patients as at Tuesday 7th January 2020.

Operationally, this has directly resulted in an increased exit block in the Emergency Department for medical patients requiring emergency admission and thus reduces space to deliver the level of emergency care demand presenting at the front door.

Mitigation Actions

- Weekly MDT meeting to review all patients (no longer requiring an acute hospital bed at Morriston) medically fit within Morriston.
- Weekly report generated breaking down reason underpinning medically fit delays. Report shared (including patient information) with Local Authority Director, Swansea Bay Executive Director and other key stakeholders
- Engagement in monthly DTOC validation exercise – senior manager sign-off of all reported DTOC prior to submission to Welsh Government
- Daily escalation of "red" days I line with Safer flow principles adopted by the HB

SAFE, PATIENT FOCUSED CARE
RISK

- ID1021: Limited service for timely mental health assessment for children and young people within ED
- ID1020: Limited service for timely mental health assessment (adult) within ED
- ID1902: Service Sustainability – AMAU East & West

Emergency Department: Incident Reporting
Oct to Dec 2018 – **206** incidents reported
Oct to Dec 2019 – **700** incidents reported

Underlying Incident reporting trends & themes:

- Overcrowding in ED – resulting from wait for beds in Medicine
- Access & Admission: Prolonged delays for assessment
- Resource Availability: Staff
- Overspill of Majors into Minors – inappropriate environment for patients and inadequate staffing to support acuity
- Offloading of patients into REACT
- Prolonged periods with no resuscitation capacity
- Use of Plaster Room/Theatre to offload patients
- Prolonged ambulance offload delays
- Patient's in inappropriate clinical setting leading to patient falls and health acquired pressure ulcer

Serious Incidents

Red inquest pending following death of 42year old female, concerns in relation to the failure to diagnose and treat. *Independent clinical reports commissioned by HMC and inquest date set.*

Serious incident raised in relation to the delay in treating a patient who passed away in the emergency department suffering from an abdominal aneurysm. *Current position – SI team investigating outcomes pending*

Unit Wide Incident Reporting
Oct to Dec 2018 – 1603 incidents reported
Oct to Dec 2019 – 2569 incidents reported

Top 5 Unit Locations for Incident Reporting: October to December 2019

Accident & Emergency Department	700
General Intensive Therapy Unit	125
AMAU (West)	123
AMAU (East)	104
Ward F(Morriston)	96

Top 10 themes for Incident Reporting: October to December 2019

	Oct-Dec 2018	***Oct-Dec 2019***	**V*ar.***
Injury of unknown origin (moisture lesion)	226	417	
Patient Accidents/Falls	287	340	
Admission & Access (Administrative)	140	507	
Behaviour (Including Violence and Aggression)	120	171	
Service Disruptions (environment, infrastructure, human resources)	106	234	
Infection Control Incident (Healthcare Associated Infection)	117	111	
Medication/Biologics/Fluids	114	130	
Pressure Ulcers (including non HCA)	43	78	
Medical Devices, Equipment, Supplies	85	116	
Communication	71	86	

In all aspects the number of reported incidents has increased. In 2018 period the percentage of harm reports was **29%**. This level has been sustained in 2019 at **28%**.

Mitigation Action:

- Locally established escalation processes in place to support flow and reduce ED crowding
- Proposal to centralize patient flow management within Unit
- Robust incident review and investigation via Datix – clear understanding of trends and themes and links to Unit annual planning process via the risk register
- Focused workstream for Infection Control Improvement, Inpatient Falls Improvement, Medicine Management (including Controlled Drug) and Pressure Ulcer Improvement – linked to Datix reporting

- Monitoring of patient incidents related to medically fit/delayed patients to support quantification of harm
- Unit Environmental and Support Services Group fully established and linked to Health Board Health & Safety agenda support environmental safety for staff and patients