The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital

Inspection report

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Ratings

Overall rating for this service

Inspected but not rated

Our findings

Overall summary of services at The Princess Alexandra Hospital

Inspected but not rated

We carried out an unannounced focused inspection of the emergency department (ED) at The Princess Alexandra Hospital between 12.30pm and 8.30pm on Sunday 14 February 2021.

We carried out this inspection because we had concerns about the quality of services as indicated by national key performance indicators. The emergency department (ED) had continued poor performance in the trust's ability to meet national targets, which posed concerns about patients' safety. At our last inspection (July 2019) we rated the trust as requires improvement overall and the urgent and emergency service as requires improvement (February 2020).

As this was a focused inspection, we did not inspect all key questions. Our priority was to identify if the service was safe, responsive and well led.

We did not inspect any of the trust's other core services. This was because our inspection was part of the urgent and emergency care focused inspection programme. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

During our inspection we identified a breach of regulation 12; safe care and treatment and regulation 13; safeguarding. After the inspection we told the trust it must make improvements. We took action under our enforcement powers by issuing the provider a Warning Notice served under Section 29A of the Health and Social Care Act 2008. We also identified a breach of regulation 17; governance, and we issued the provider a Requirement Notice. Where we have identified a breach of a regulation and we take action under our enforcement powers, such as issuing a Warning Notice, the rating linked to the area of the breach will normally be 'inadequate'.

Our rating of services went down. We rated them as inadequate because:

- Staff did not follow the trust infection, prevention and control policy or consistently use personal protective equipment and control measures to protect patients, themselves and others from infection.
- We were not assured that the design and use of premises kept people safe because of the lack of suitable facilities for COVID-19 positive patients who may need resuscitation.
- Staff did not consistently complete risk assessments for each patient to remove or minimise risks. For example, risk of falls or pressure ulcers.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. On average 20% of nursing shifts were not filled between November 2020 and January 2021.
- People could not always access the service when they needed it and did not consistently receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards.
- Leaders did not have oversight of the service or use systems and processes consistently to monitor and drive improvement.

Our findings

- Leaders and teams used some systems to manage risk, however leaders had failed to adequately address performance issues performance which impacted on the quality and safety of care.

However:

- There was a stable leadership team in place
- Staff told us they felt respected, supported and valued by service leaders and the trust executive team. 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.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

During our inspection we spoke with 11 registered nurses (RN), seven medical staff, two health care assistants (HCA) and three other staff including a receptionist, site lead and a hospital ambulance liaison officer (HALO). After the inspection we carried out a telephone interview with the urgent and emergency medicine service leaders.

Urgent and emergency services

Inadequate 

Our rating of services went down. We rated it as inadequate.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, but they did not always apply it.

Staff did not assess, monitor or manage risks to safeguard patients presenting with mental ill health. We reviewed two mental health risk assessments for two patients who had presented with a mental health crisis. Staff had not completed either of them appropriately. This meant that staff had not fully assessed the needs of the patient or taken steps to mitigate risks of harm to them.

During this inspection, we saw staff providing care to a patient experiencing a mental health crisis. Staff had not completed appropriate risk assessments or recorded a description of them in the event that they absconded despite senior staff telling us that the patient was suicidal and at risk of absconding.

We were told that security staff had supported a mental health patient with showering. This was particularly concerning because no environmental risk assessments had been completed and there were no assurances that the security staff were trained to support a patient with this activity. We escalated this to the trust. They told us the security staff had received safeguarding training, had disclosure and barring service (DBS) checks and had not entered the shower with the patient. However, we were not assured that this was adequate to keep the patient safe.

A member of staff told us that ambulance staff pre-alerted the ED staff if they were bringing a patient with acute mental health needs by ambulance to the department. However, this did not ensure the patient was prioritised for offload from the ambulance which meant they were delayed in receiving specialist mental health input.

Staff in the ED had 24-hour access to mental health liaison and specialist mental health support if they were concerned about the patient's mental health condition. Staff told us they arranged psychosocial assessments for patients thought to be at risk of self-harm or suicide. However, these had not been completed in the two records we reviewed.

The trust had an up to date safeguarding adults and children policy which staff accessed via the trust intranet.

Data displayed in the staff resource room showed nursing staff were 100% compliant with safeguarding training adults and children level 2. (November 2020).

Staff in the adult ED completed safeguarding checks as part of the first hour assessment.

Urgent and emergency services

We observed one nurse appropriately completing a safeguarding referral regarding an elderly patient who had attended the department.

Three paediatric nurses we spoke with were compliant with safeguarding children level 3.

Paediatric nursing staff completed safeguarding checks on children attending the paediatric emergency department (PED) in line with the trust safeguarding policy.

Reception staff described how they would use an electronic red dot on the electronic patient record to alert staff to any safeguarding concerns they had observed in the waiting area.

Cleanliness, Infection prevention and control

We were not assured that the service-controlled infection risk well. Staff did not consistently use personal protective equipment (PPE) and control measures to protect patients, themselves and others from infection and in line with trust infection prevention and control policy.

In response to the pandemic, the trust had re-configured the ED and implemented 'Red' and 'Amber' areas within the ED to maintain patients and staff safety. Red areas were designated as high risk COVID-19 areas. Amber areas were designated as safe areas for patients not showing symptoms of COVID-19 and those with negative COVID-19 test results.

Staff did not always follow specific guidance designed to control the spread of infection. Staff had displayed a respiratory isolation area poster on the doors entering the amber resus area. This clearly stated that staff in this area should be wearing specific personal protective equipment (PPE). Two medical and two nursing staff in the area did not use the PPE described in the poster. Two nursing staff left the area without changing their PPE. We challenged one nurse who was about to enter the area without the appropriate PPE. They told us the poster was displayed in error but did not remove it. We were concerned that staff would ignore the poster in future, believing it to be displayed in error.

We observed staff moving between red, COVID-19 positive patient areas, and amber, COVID-19 negative patient, areas without changing their PPE. Staff delivering refreshments took the refreshment trolley into the red area and then to the amber area without following the trust process for IPC. This meant we could not be assured that staff were doing everything possible to reduce the risk of the spread of infection.

Staff had access to rapid testing for COVID-19. Staff tested patients who may need to be admitted to the ED using lateral flow device (LFD) testing and simultaneous laboratory testing to establish their COVID-19 status in the waiting room prior to admission to the ED. This ensured patients were directed to the appropriate COVID-19 area in order to minimise the risk of the spread of infection. LFD is a rapid test which provides an initial result within 30 minutes, laboratory testing is more accurate but takes longer to provide a result.

Hand washing stations and sanitisers were available throughout the ED. All staff wore scrubs and had bare arms below the elbow in line with trust policy. We observed staff regularly washed and sanitised their hands.

The trust completed monthly infection prevention and control (IPC) reports. The report supplied by the trust showed 85% compliance with hand hygiene during patient interactions between December 2020 and January 2021. This did not meet the trust target of 95%. The audit stated. "There is improvement required in hand hygiene". The trust had developed an action plan to address poor IPC compliance.

The report on the compliance with PPE showed 88% compliance with PPE at 30 January 2021. The audit stated "there is poor compliance in the doffing of PPE in specific areas of ED as well as ED as a whole. Re-audits have not proven to show any improvement despite the initial findings".

PPE stations were available throughout the department and well stocked with gloves, aprons and masks. Signage on noticeboards and at the entrance to specific areas clearly described what PPE needed to be worn. Donning and doffing stations had aide memoir posters displayed to remind staff what order to put on and take off PPE safely.

The trust IPC team had risk assessed staff rest areas and had assigned a safe occupancy number to each area to ensure social distancing was maintained. Staff told us this was adhered to. The ED report on compliance with staff social distancing, December 2020 to January 2021, showed 100% compliance.

Staff cleaned equipment and trolley spaces between patients. Staff used "I am clean" labels to identify equipment which was clean and ready for use.

Staff described how the infection prevention and control (IPC) team regularly attended the department to help with changing areas from COVID-19 positive to COVID-19 negative to match patient demand.

There were clearly marked areas in the reception area and in throughout the department to remind staff and patients of social distancing regulations. These were being adhered to. All areas were visibly clean.

Environment and equipment

We were not assured that the design and use of premises kept people safe.

The ED comprised of several areas; reception, red resuscitation, amber resuscitation, minors, majors, rapid assessment and triage (RATs) and clinical decision unit (CDU). The paediatric ED was located in a separate building and consisted of reception, six treatment rooms and a high dependency area.

The ED had recently completed a reconfiguration including switching the red, COVID-19 positive areas, to amber, COVID-19 negative areas, in response to the decreasing number of COVID-19 related admissions and the increasing number of non COVID-19 related admissions.

The adult resuscitation area was identified as "amber" which meant staff could treat those patients who were most critically ill without waiting for them to be confirmed as COVID-19 negative or COVID-19 positive. Four trolley spaces were separated by disposable curtains and bays were cluttered with equipment. The trust told us staff deep cleaned bays between patients and changed dividing curtains where they had become soiled or if the patient had identified as COVID-19 positive.

We spoke with a doctor and a nurse about the resuscitation area for COVID-19 positive patients. Both staff told us that positive patients who required resuscitation or aerosol generating procedures (AGPs) would be brought to a cubicle in the majors area. After the inspection, senior service leaders told us that COVID-19 positive patients who required AGPs or resuscitation would be cared for in the high dependency room in the COVID-19 red area. We had reviewed this room and found it was too small to accommodate the numbers of staff involved in the resuscitation procedures, it did not have suitable ventilation and was not properly equipped. We were concerned there was no suitable designated space for the treatment of COVID-19 positive patients who required resuscitation or AGPs. AGPs are treatments where infectious material can become airborne and requires a higher level of PPE for staff.

Urgent and emergency services

We reviewed four pieces of electronic equipment including blood pressure monitors and weighing scales. The equipment had had been safety checked in line with trust policy.

Staff had easy access to resuscitation equipment. We reviewed four resuscitation trolleys and found staff had completed equipment safety checks on three of them in line with trust guidance. Staff had not checked the trolley located in the CDU on five occasions between 1 January 2021 and 14 February 2021. This meant that staff could not be assured that the equipment would be ready to use in an emergency.

Staff completed checklist completion audits to check that checklists had been completed. These were audits of each area of ED to confirm all checks had been completed, for example, monitoring fridge temperatures, resuscitation equipment and difficult airway trolley. Compliance in the CDU was poor. Between August 2020 and October 2020 compliance was less than 50%. In November 2020 the checklist was missing, December 2020 and January 2021, compliance was less than 72%. This meant we could not be assured that staff carried out the required equipment checks in the CDU.

The trust had a designated cubicle in the majors area which was safe for patients attending the department with mental health crisis to use. Staff told us this was a protected space even when the department was busy.

The service had a family room which was available for staff to use when breaking bad news. The room was clean and clutter free in line with trust IPC guidelines.

Assessing and responding to patient risk

Staff did not consistently complete risk assessments for each patient. They did not remove or minimise risks. Staff did not identify and quickly act upon patients at risk of deterioration.

Initial Assessment

We reviewed 12 adult patient nursing records and two paediatric nursing records. These were paper booklets called “My Patient’s Journey Through the Emergency Department”.

All 12 of the adult booklets were incomplete. Staff had missed out dates and times and other relevant information. At our previous inspection in February 2020, we issued the trust with a warning notice that it had not taken enough action to ensure that records of care and treatment were clear, up to date and easily accessible.

In the 12 adult booklets, nursing staff had not completed risk assessments for pressure ulcers and falls in six of them (50%). This meant staff had potentially not identified all patients at increased risk of harm.

Nursing staff were caring for an elderly patient on a hospital trolley. Staff had not completed risk assessments for pressure ulcers or falls despite the patient being admitted as a result of a fall and an assessment by the frailty team stating the patient was very frail. This meant the patient was at increased risk of developing pressure ulcers.

Another patient had been admitted as the result of a fall. Staff had not completed a falls risk assessment and the patient was being nursed behind closed curtains.

Urgent and emergency services

Following the inspection, we asked the trust to provide care records for three additional patients. In one record, staff had not completed risk assessments for venous thromboembolism (VTE) for a patient who had been admitted with a broken leg. In the second record, which was for a patient who had been admitted post fall, staff had not completed risk assessments for falls. The third record showed staff had completed the risk assessments four and a half hours after the patient had arrived in the department.

Minutes of the morbidity and mortality (M&M) meeting, July 2020, cited poor documentation as a factor in the poor patient outcomes. M&M meeting minutes, September 2020, also recorded poor quality of documentation. We were concerned the trust were not learning from incidents.

At our previous inspection in February 2020, we issued the trust with a warning notice as the trust had not taken enough action to mitigate the risks associated with the lack of an endoscopy service out of hours. We were not assured that staff knew what process to follow in the event of an out of hours upper gastrointestinal (GI) bleed. The trust had developed a policy, Acute upper gastrointestinal bleeding policy which detailed the process for staff to follow. The policy was approved and issued on 16 February 2021 although a draft version of the policy had been in place since May 2020. Two senior clinical staff could not articulate the process and one told us it was work in progress.

Staff, working with a GP from the local clinical commissioning group (CCG), used patient symptoms and clinical observations to stream patients immediately when they self-presented at ED. Staff could refer patients to opticians, GPs or minor injuries unit or admit to the main ED. Patients identified as requiring further treatment in the department were then directed to the rapid access and triage area (RATs) for further investigations.

RATs nursing staff triaged patients in the ambulance when there were delays to unloading. This was to try to ensure patients who were the sickest were prioritised for unload.

During rapid assessment and triage, an advanced nurse practitioner (ANP) completed initial observations using the national early warning scores (NEWS2), symptoms and professional judgement for all patients who were considered to need admission to ED. The trust did not use a nationally recognised triage tool, for example the Manchester triage tool, and had not audited the effectiveness of their process. This meant we could not be assured that the triage system was identifying the sickest patients first.

We reviewed the rapid assessment and treatment within the ED policy, version 1, issued November 2018. The policy did not have any references. This meant we were unable to identify what guidance the trust had based their triage procedure on.

Minutes of the M&M meetings July 2020 and September 2020 were detailed and showed clear sharing of learning from incidents. Staff discussed two patients at the M&M review meetings, July and September 2020, who had both re-presented at the department within 48 hours of discharge. Both patients had sadly died. The minutes of the M&M meeting September 2020 identified that the patient should have had a better assessment on initial presentation. We were concerned the acuity of patients was not always realised at initial presentation.

Staff completed sepsis screening during the first hour of admission assessments. We reviewed 12 adult records and saw staff had completed sepsis screening in six.

Staff we spoke with were aware of clinical pathways for ST-segment-elevation myocardial infarction (STEMI), stroke and fractured neck of femur among others. Pathways were easily accessible throughout the ED and on the trust intranet. ST-segment-elevation myocardial infarction (STEMI) is a type of heart condition known as an acute coronary syndrome.

Forty-seven registered nurses (RNs) (100%) had completed basic life support (BLS) training and 10 RNs (21%) had completed advanced life support (ALS) training.

All doctors completed basic life support (BLS) training as part of their trust induction and forty-eight doctors had completed advanced life support (ALS) training.

Critically ill patients in ED

Ambulance staff pre alerted the ED staff to seriously ill patients who were on their way to the department and who were potentially in need of resuscitation. ED staff made arrangements to receive them which included donning the appropriate PPE.

The trust had a hospital ambulance liaison officer (HALO) who was employed by the local ambulance trust. The HALO liaised with ambulance crews and the nurse in charge (NIC) to ensure patients were prioritised appropriately and help to provide efficient ambulance offload and turnaround.

During the inspection we noted two patients waited in excess of four hours for speciality medical review. Data supplied by the trust following our inspection showed that from 1 December 2020 to14 February 2021, the average time to specialty review was between 60 and 100 minutes. On five occasions the average wait was greater than 120 minutes. This meant patients did not always receive specialty medical input in a timely way.

Staff told us that staff "Stopped the clock" for those patients who had been referred for speciality review before the review had taken place. Two incident reports shared by the trust showed the trust was aware of the "Stop the clock" concerns. This meant that we could not be assured that data relating to time to speciality review data in the ED was accurate. After the inspection the trust told us that they had completed a piece of work to assure themselves that these were one off incidents and that learning had been shared.

Deteriorating patients in ED

In the adult ED staff monitored patients using the national early warning scores (NEWS2). Paediatric staff used the paediatric early warning scores (PEWS).

Staff recorded observations hourly on a handheld electronic device. There was space in the "My Patient's Journey Through the Emergency Department" booklets for staff to record what time these observations had been completed and what was the outcome, staff had completed this section in five of the 12 adults booklets we reviewed (42%). Due to lack of documentation, we could not be assured that staff had completed the observations for the remaining seven patients.

Staff carried out monthly audits of the completion of NEWS2 and PEWS. After the inspection we reviewed the audit data for NEWS2. For the three months prior to our inspection, compliance was 88% (December 2020), 83% (January 2021) and 89% (February 2021). PEWS audit compliance for the same period was consistently greater than 93%.

Patients who were deemed likely to go home were transferred to the clinical decisions unit (CDU) where they could await the results of additional tests, for example blood test results. Nurse staffing from this area were shared between ED and the trusts frailty service. We were not assured that there was clear ownership/oversight of patients in this area. For example, an elderly patient who had been transferred from ED had not had any risk assessments for pressure ulcers completed. When we escalated this to the nurse in the CDU they told us that the patient was an ED patient and they were part of the frailty team.

Urgent and emergency services

We reviewed the policy for the transfer of patients to the CDU, the policy had a clear set of patient inclusion and exclusion criteria. One of the exclusions said that patients who had decisions to admit (DTA) in place were not suitable to move to CDU. Two staff told us they were often told to transfer patients to CDU inappropriately. Another criteria was that patients should be discharged within six hours, we noted one patient was in the CDU more than eight hours.

The nurse handover took place at the time of each shift change led by the nurse in charge (NIC). We attended the night shift nurse hand over. The NIC described any patients of concern in the department and any ongoing concerns from the day shift.

Nurse staffing

Workforce

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff consistently told us that there were not enough staff to keep patients safe. Service leads told us the ED had a vacancy rate of 19%, 23 registered nurses (RNs).

The nursing rota provided by the trust showed between November 2020 and January 2021, the department relied heavily on bank and agency staff. Approximately 50% of all registered nurses (RN) and health care assistants (HCA) on each night shift were bank or agency staff and approximately 25% on each day shift. The trust told us they were experiencing increased staff absence due to high levels of staff sickness and staff shielding and shifts were covered by ED substantive staff undertaking additional shifts and regular agency staff who were familiar with the department.

Data supplied by the trust showed actual monthly RN hours did not meet monthly planned hours. For November 2020, December 2020 and January 2021 the trust filled 80% of day shifts on average.

Department leaders told us they had undertaken a staffing review in October 2020 in response to COVID-19 and had increased RN establishment from 16 RN to 19 RN as a direct result.

On the day of our inspection, the actual nurse staffing did not meet planned nurse staffing level. Planned RN was 19 and HCA was 11 but the actual number was 16 RN and six HCA. Staffing levels impacted on patient safety and we observed an ambulance unload delayed by 30 minutes because no staff were available in the rapid assessment and triage area (RATs) to receive the patient.

Nurse handover took place at the time of each shift change led by the nurse in charge (NIC). We attended the night shift nurse hand over. The incoming NIC allocated staff to ED areas. On the day of inspection night nurse staffing was not as planned and the site team had found cover for the clinical decisions unit (CDU) from another area in the hospital.

Staffing for the department was based on the baseline emergency staffing tool (BEST) which allowed managers to calculate the workforce and skill mix which would be required to provide the nursing care needed in the department.

Senior hospital staff discussed nurse staffing levels as part of their regular patient placement meetings held throughout the day. We attended the 4.30pm patient placement meeting. The meeting was multidisciplinary with input from ED, maternity, discharge team and the local commissioning group. However, at this meeting there was no representation from medicine service or surgery service.

Urgent and emergency services

All the nursing staff working in the paediatric emergency department were registered children's nurses.

Staff told us that preceptorship training was being delivered virtually rather than face-to-face.

Medical staffing

Workforce

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Consultant cover was not in line with Royal College of Emergency Medicine (RCEM) which recommend consultants provide 16 hours of cover as opposed to the 14 hours provided in the department.

The service was operating with eight consultants, service leads told us they were in the process of increasing this number to 16 to meet RCEM guidelines. Seven of the consultants were on the General Medical Council (GMC) specialist register. The trust has four specialist paediatric emergency consultants.

Consultant led care was provided with two consultants working overlapping shifts in the department from 8am to 10pm and on call from home from 10pm seven days each week.

Consultants were supported by a team of junior doctors. Middle grade doctors worked on overlapping shifts as did the foundation year doctors in the department.

At the time of inspection, we observed four middle grade and three junior doctors in the ED. Planned medical cover overnight was three middle grade and three junior doctors. However, staff told us that they often worked with two middle grade and two junior doctors.

We reviewed the medical rota and in February. There were eight out of 28 night shifts where the department was operating with one middle grade less than planned staffing. On the day of inspection, the night shift was one middle grade doctor less than planned. We were not assured there was any mitigation for the shortage of medical cover overnight. This meant patients could potentially be delayed in receiving medical input overnight. After the inspection the trust told us that they would approach middle grade doctors to start their shifts earlier or finish later to provide additional medical cover.

Middle grades told us it was difficult to get senior medical review and medical speciality input when the department was busy and to handover patients at the end of a shift.

Data supplied by the trust showed actual monthly medical staff hours did not meet planned monthly medical hours. During November 2020, December 2020 and January 2021, approximately 20% of all medical shifts were covered by locum doctors. This meant the trust filled 92% of all medical shifts.

Paediatric medical cover was via a paediatric registrar from mid-day until 9pm and a paediatric senior house officer outside of these times. Paediatric consultant cover was available via the paediatric ward seven days per week.

Four middle grade and three junior doctors we spoke with told us they were happy working in the department and had regular teaching.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

Access and flow

People could not always access the service when they needed it and did not received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards.

NHS Digital - A&E quality indicators show during January 2021 the trust received approximately 6,000 attendances at the emergency department (ED). This was lower than the previous month, December 2020, were the ED saw 7,400 attendances.

NHS Digital - A&E quality indicators shows that during December 2020, the percentage of patients who left the department before being seen was 3%. This was higher than the England average of 1.5%.

Data supplied by the trust showed that from November 2020, there was an increasing trend of patients spending longer than the four-hour target in the Emergency department (ED).

NHS Digital - A&E quality indicators show that for January 2021, 70% of patients were admitted, transferred or discharged within four hours. This was lower than the England average of 76%. The operational standard is that at least 95% of patients attending ED should be admitted, transferred or discharged within four hours.

Between, August 2020 and December 2020, the median total time spent in ED was consistently higher (190 minutes) than the England average (160 minutes).

Ambulance hand over data for the week ending 14 February 2021 showed that 62 patients waited over 60 minutes for handover and 59% of patients waited 30 minutes or more with the average time to handover being 45 minutes. This was not meeting the national target of 15 minutes to handover.

The trust looked at the number of patients re-attending the ED within seven days of their first attendance. In December 2020, 9% of patients re-presented this was higher than the regional average, 7%, and the England average 8%.

Information was available to staff on the status of patients and on the performance of the department through the electronic display screen in the ED. The inspection team requested information relating to patient numbers throughout the day and staff were able to make use of the system to quickly report on the situation at any time.

Flow

Staff told us that patients who had decisions to admit to a ward were often transferred to wait in the clinical decisions unit (CDU) despite this being against the trust CDU exclusion criteria.

Once patients were in the CDU these patients were no longer considered to be in the ED and so "stopped the clock". This meant that the total time the patient spent in the ED was recorded from admission to the ED until the patient was transferred to the CDU even though the patient was still under the care of the ED.

Two incident reports shared by the trust showed the trust was aware of the "stop the clock" concerns. This meant that we could not be assured that data relating to total time in the ED was accurate.

At the time of inspection staff were not providing care for any patients in the corridor. However, staff told us that in times of extreme pressure this did happen, and we observed numbers on the corridor walls to indicate trolley spaces where patients would be held on trolleys which confirmed this practice was in place.

12 Hour waits

Staff told us there were often delays in finding beds once the decision to admit (DTA) had been made.

NHS England – published A&E Situational Report (SitReps) show that since November 2020, there had been a notable increase in the number of patients waiting more than four hours from the decision to admit (DTA) to admission. There was a notable spike in 12 hours waits during December, with 31 patients waiting over 12 hours from the decision to admit to admission. In January 2021, 34.6% of patients waited more than four hours this was worse than the England average of 25%.

At the time of our inspection one patient who was waiting to be admitted to mental health services had been in the department more than 17 hours. At the time of our inspection there were an additional six patients in the department who had waited over six hours for admission.

Bed and flow meetings

Senior hospital staff discussed bed occupancy, capacity and discharges as well as patients awaiting admission as part of their regular patient placement meetings held throughout the day.

We attended the 4.30pm patient placement meeting. The meeting was multidisciplinary with input from ED, maternity, discharge team and the local commissioning group. The meeting was well chaired and covered all areas of the hospital. However, at this meeting there was no representation from medicine service or surgery service which meant we could not be sure that service leads had clear oversite of issues in the ED at that time.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

Leadership

The service leaders did not demonstrate the skills and abilities to run a service providing high-quality sustainable care.

Urgent and emergency services

The emergency department (ED) was led by a team of managers including the clinical lead for ED, the nursing lead for ED and the operations lead for ED.

We were not assured that service leads had oversight of the day-to-day service. For example, senior leaders told us that there was a process implemented for the provision of out of hours endoscopy but staff in the department were not aware of it.

Managers did not always use nurse staffing resources effectively. For example, during the inspection we observed that at 14.58 the rapid assessment and triage (RAT) area was closed to patients for 30 minutes due to lack of staffing but we were aware of nursing staff in the paediatric department who were not caring for any patients at that time. After the inspection the trust told us they were able to increase or decrease the number of RATs staffing teams depending on demand.

Senior leaders told us that there was monitoring of the outcome of triage and referred to it as the R audit. When we asked the trust for a copy of the R audit the trust told us it was not complete.

In the minutes of the Urgent and Emergency Care safety and quality (PS&Q) meeting 11 November 2020 and 9 December 2020, there was no evidence of discussion around infection prevention and control (IPC). This meant that we could not be assured that service leaders were aware of any concerns in IPC. The minutes also highlighted poor attendance from clinicians and leads and lacked detail.

Most nursing staff told us the executive team were visible and supportive in the department.

Culture

Staff felt respected, supported and valued by local managers. They were focused on the needs of patients receiving care.

Senior staff described a close, supportive and positive working relationship with the infection prevention and control (IPC) team who regularly attended the department to support staff.

Four nursing staff described the culture in the ED as like family and a strong and supportive team.

All the staff we spoke with told us how proud they were of each other and of the service they provided.

Staff interacted with each other respectfully and professionally.

Governance

Leaders did not operate robust governance processes or effectively manage the performance of the service

We were not assured that the trust's governance processes were effective to identify and manage the risks to the service. For example, senior leaders told us trust audits showed an improving compliance with documentation audits, however we found compliance was deteriorating.

Urgent and emergency services

We were not assured about the oversight of the clinical decisions unit (CDU). Service leaders told us it was the ED leads responsibility, the ED nurse in charge told us it was a shared space with the frailty nurses. However, no one had taken responsibility for ensuring appropriate checks had been carried out in line with trust policy.

We were not assured that service leaders had clear oversight of day to day activities in the department. For example, two staff told us COVID-19 positive patients would be cared for in the majors cubicle if they required resuscitation but senior service leaders told us these patients would be treated in the high dependency room in the COVID-19 positive area.

We reviewed the meeting minutes for the Urgent and Emergency Care PS&Q meeting 11 November 2020 and 9 December 2020. The minutes highlighted poor attendance from clinicians and service leads and lacked detail, for example, there was no evidence of discussion or challenge around the reports presented by the subcommittee. There was no evidence of discussion of infection prevention and control (IPC) in either set of minutes despite the audit data reported by the IPC team showing poor staff compliance. We were not assured the urgent and emergency care PS&Q committee had good oversight of issues and concerns in the ED.

The trust used a governance framework to support the delivery of governance. The framework consisted of a number of subgroups reporting into the quality and safety committee which then reported to the trust board.

Managing risks issues and performance

Leaders and teams did not use systems effectively to manage performance. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

There was insufficient oversight of the quality of records and the managers had failed to address the issue, this was brought to the trust's attention at our previous comprehensive inspection in 2019.

The trust did not always ensure that prompt action was taken, and learning was implemented in response to serious incidents. Despite being aware of risks related to a lack of provision of out of hours endoscopy service since 2017, leaders had not taken timely action to mitigate those risks to prevent potential future incidents, the policy for staff to follow in the event of an out of hours gastro intestinal (GI) bleed was issued to staff on 16 February 2021. This was after our inspection.

The use of escalation areas and the clinical decisions unit was not in line with the trust's operational policy. On occasions, the ED utilised the clinical decision unit as an escalation area. This meant patients stayed there for longer than allowed by the service operational protocol. During our inspection we observed one patient in the CDU for longer than six hours. This is not in line with trust policy.

The trust was not able to provide assurances of the effectiveness of the triage tool they used and there was a lack of audit of the process despite a higher than regional number of re attendance within seven days.

The trust used ward monthly audits to monitor compliance with medicine management. In August 2020 ED was 100%, this was an improvement on July where compliance was 96%. There was no audit completed for October or December due to the trust revising their audit priorities and January showed 91% compliance. We were not assured the trust audit process was robust.

Urgent and emergency services

The trust had a policy called Emergency Department Escalation plan v1. October 2020. The policy detailed what steps staff should take if the department reached capacity. These steps were designed to ease pressures and improve access and flow within the department and throughout the hospital.

Two staff we spoke with could describe the process for escalating concerns around capacity.

We reviewed the trust ED risk register. The register held the details and mitigating actions for ten risks rated six and higher. Each risk was red, amber or green rated and had an owner and a date of review clearly recorded.

Areas for improvement

MUSTS

We took enforcement action against the trust in the form of a section 29A Warning Notice because the quality of healthcare required significant improvement. In summary the reasons we issued this notice were:

- The trust must ensure all appropriate risk assessments for patients attending the department are completed in a timely way to ensure appropriate mitigating actions can be taken. (Regulation 12).
- The trust must ensure all risk assessments for patients presenting with a mental health crisis are completed in a timely way in order to identify and mitigate any risks to patient and staff safety. (Regulation 13).
- The trust must ensure all staff comply with all trust infection prevention and control (IPC) guidance in order to minimise the risk of the spread of infection. (Regulation 12).
- The trust must ensure the out of hours endoscopy process is embedded and understood by all appropriate staff in the department. (Regulation 12).

We took enforcement action against the trust in the form of a requirement notice because there was a breach of the legal requirements. In summary the reasons we issued this notice were:

- The trust must ensure that staffing resources are used efficiently throughout the ED to reduce delays to patients. (Regulation 17).
- The trust must ensure that there is robust oversight of the clinical decisions unit (CDU) including that patients cared for there meet the inclusion criteria. (Regulation 17).
- The trust must ensure the triage process is robust and accurately identifies those patients who are the most sick. (Regulation 17).
- The trust must ensure the monitoring of the time to specialist review and total time spent in the department is accurate. (Regulation 17).

SHOULDS

- The trust should ensure that urgent and emergency services meet the national standard patient waiting times for treatment and arrangements to admit, treat and discharge patients (Regulation 12).
- The trust should ensure resuscitation equipment in the CDU is checked in line with trust guidelines. (Regulation 12).

Urgent and emergency services

- The trust should continue to recruit registered nursing and health care staff in order to meet establishment. (Regulation 18).
- The trust should continue to recruit consultants in order to meet Royal College of Emergency Medicine (RCEM) guidelines. (Regulation 18).
- The trust should ensure the minutes of the Urgent and Emergency Care meetings are detailed. (Regulation 17).

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors. The inspection team was overseen by Bernadette Hanney, 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 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment