Mid Essex Hospital Services NHS Trust

Broomfield Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Broomfield Hospital is part of the Mid Essex Hospital Services NHS Trust (MEHT). Broomfield Hospital is an acute district general hospital and it is the only hospital location within Mid Essex Hospital Services NHS Trust to provide accident and emergency (A&E) services. Broomfield Hospital also provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical centre to a population of 3.4 million, and an internationally-recognised burns service in the St Andrew's Centre within Broomfield Hospital that serves a population of 9.8 million.

We inspected the services within the urgent and emergency services (Emergency Department (ED), Emergency Assessment Unit (EAU), Emergency Short Stay wards (ESS and the ambulatory care services) at this hospital on 13 April 2015 in response to concerns of stakeholders and information of concern received into the CQC. Concerns were raised by stakeholders around the flow of patients through the A&E department, whether timely care was being provided and whether patients received sufficient pain relief. Concerns were also raised about ambulance handover delays which resulted in patients waiting for long periods of time prior to being taken into the hospital.

This was our third inspection of the Urgent and Emergency Services due to concerns raised with us. In August 2014 our inspection raised concerns over patient safety, security for patients, especially those with mental illness and paediatric patients, incident reporting and staffing levels and training. At our comprehensive inspection in November 2014 we saw that these issues had failed to be addressed. In February 2015 we returned to the EAU as we were alerted to qualified nurses who were working without registration. Following this issue being raised by us to the trust, action was taken to ensure that only registered nurses were directing patient care in this area. We returned in March 2015 to ensure that actions taken remained in place within the EAU. The service was rated as inadequate following these inspections. We returned in April 2015 due to concerns being raised with us in respect of the care provided within the service. Overall the rating for Urgent and Emergency Services remains as 'Inadequate' following this inspection. The domain ratings remained the same with safety, responsiveness and well-led being rated as 'Inadequate' and caring being rated as 'Good'. However the effectiveness of the service has been downgraded from 'Requires improvement' to 'Inadequate' due in part to a deterioration of the care provided for patients with pressure ulcers.

Prior to the CQC on-site inspection, the CQC considered a range of quality indicators captured through our intelligent monitoring processes. In addition, we sought the views of a range of partners and stakeholders.

This was a focused inspection undertaken by five inspectors from CQC three of whom were qualified nurses, one paramedic and one governance and risk specialist. Only the services within urgent and emergency services (Emergency Department (ED), Emergency Assessment Unit (EAU) and Emergency Short Stay wards (ESS) at Broomfield Hospital were inspected.

Our key findings were:

- The trust has not sufficiently implemented the recommendations and requirements following our five inspections to this service and patients continue to experience a poor level of care and treatment.
- The flow of the emergency department, staff vacancy, skill mix and triage still had an impact on the care patients received which in some cases was poor. Care in the emergency department did not always adhere to NICE guidelines, particularly around head injuries and sepsis.
- The staffing within the EAU and ESS were appropriately trained, qualified and registered for the care they were delivering.
- The care of patients with mental health concerns fell below the expected standard of care in the emergency department.
- Improvements were required in terms of the reporting and learning from incidents.
- There were staffing shortages for nurses throughout the emergency floor and there were notable medical staff shortages within the emergency department.

Summary of findings

- Governance structures at departmental level across the emergency department were not robust and were in significant need of improvement.
- Good governance arrangements were not in place as there was a lack of understanding of the risks and issues within the emergency department by the senior management and executive team.
- Assurances on governance and risk arrangements for the services were provided by the departmental leaders to the trust, with the trust believing the services protected patients from abuse and avoidable harm. however the executive team could not produce the evidence to support the safety of services.
- The multiple changes in leadership locally had impacted on the running and morale of the services.
- The culture within the department was poor, there was fear of the management team blaming staff locally for failure to deliver targets and reports or pressure to undertake work practices that were not safe for patients.

We observed areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure medicines are administered in a timely way, especially for patients receiving intravenous antibiotics and time critical medicines.
- Ensure care documentation including care plans and risk assessments are undertaken in a timely way, accurately, are fully completed and reviewed when required.
- Improve staff training and awareness on mental health so that the provision of care for patients in urgent and emergency services with mental health conditions improves.
- Ensure patients with mental health concerns are risk assessed on arrival at the emergency department and that patients with mental health concerns are appropriately observed and monitored.
- Review staffing levels on the reception desk in the emergency department.
- Ensure that resuscitation trolleys are regularly checked and stocked.
- Improve staff knowledge and understanding of what constitutes a safeguarding referral for adults.
- Ensure that all safeguarding referrals for adults in the emergency department are completed and actioned in a timely way.
- Improve hand washing techniques and infection control practices and techniques in the emergency department.

In addition the trust should:

- Improve the incident reporting culture for staff to increase the number of incidents reported overall.
- Ensure that recruitment plans, to increase the amount of permanent nurses, are agreed and actioned to ensure that the high usage of agency and bank staff is reduced.
- Review mechanisms for using feedback from patients, so that there are opportunities for reviewing and improving service quality.
- Improve patient confidentiality in the ambulance entrance particularly when staff are discussing patient care.
- Ensure that staff are provided with feedback and informed of learning from incidents.
- Ensure the corridor within the emergency department which leads from the ambulance doors and the resuscitation area is kept clear of obstructions at all times.
- Improve shift and nursing handovers in the emergency department to ensure all staff are informed of the required information.
- Safely plan and increase consultant cover in the emergency department from 11 to 16 hours per day as recommended by The Royal College of Emergency Medicine.
- Improve patient care within the emergency department for conditions such as sepsis and head injuries in line with Royal College of Emergency Medicine guidelines.
- Improve implementation of the escalation protocol in the emergency department.
- Improve ambulance handover times within the emergency department.
- Improve local staff engagement within the ED and between the EAU and ED.

Summary of findings

- Improve the working relationship between the ambulance service and the emergency department.

On the basis of the ratings, I have requested for the regulator of non-foundation trusts, the Trust Development Authority (TDA), to review our concerns and implement buddy and support systems for the trust to immediately drive improvement in quality, safety and governance across urgent and emergency services and at trustwide leadership level. We have also served a warning notice to this trust and requested for significant improvements to be made to the quality of healthcare provided to patients. The trust has agreed and continue to voluntarily submit information to the Care Quality Commission to demonstrate the safety of patients, as well as how effective systems and process are within urgent and emergency services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	Urgent and emergency services at Broomfield Hospital were inadequate with regards to being safe, effective responsive and well led. The service did not protect patients from abuse or avoidable harm because staffing levels were not sufficient. Infection control practices in the emergency department were poor and concerns remained regarding the care and treatment for patients with mental health conditions The service was not effective particularly in the Emergency Department. NICE and RCEM guidelines on sepsis, head injury, stroke, chest pain and fracture neck of femur were not always being followed. Within the EAU and on ESS pressure ulcer care for patients was not provided in accordance with NICE guidelines. National audit outcomes of these were poor in the majority. The relationships internally between staff and externally with ambulance and mental health care providers did not work well. Patients were treated by caring staff who were dedicated and passionate about their roles. The majority of patients and relatives spoken with were satisfied with the care and service received. Services were not responsive because patients experienced delays in their care and treatment. The performance for the emergency department had declined and many people had to wait longer than acceptable within the service. The EAU, ESS and Ambulatory care service were not being appropriately used to meet patient needs due to issues with bed capacity and occupancy within the hospital. Leadership locally, at senior management and executive level for urgent and emergency services was inadequate with a notable decline in the understanding of governance arrangements and risks to patients within the service. There was a poor culture within the service associated with blame and fear for failures to deliver targets significantly affecting staff morale.

Requires improvement

Broomfield Hospital

Detailed findings

Services we looked at
Urgent and emergency services

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Detailed findings

Background to Broomfield Hospital

Mid Essex Hospital Services NHS Trust was established as an NHS trust in 1992. The trust provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree.

The trust, based in the city of Chelmsford in Essex, employs over 3,800 staff, and provides services from five sites in and around Chelmsford, Maldon and Braintree. The main site is Broomfield Hospital in Chelmsford, which has been redeveloped as part of a private finance initiative (PFI). The trust provides the majority of services at the Broomfield Hospital site including urgent and emergency services.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Fiona Allinson, Care Quality Commission.

Inspection Manager: Leanne Wilson, Care Quality Commission

This was a focused inspection undertaken by five inspectors from CQC. Three of the inspectors were qualified nurses with experience in medicine and emergency services, one paramedic with extensive experience in emergency medicine and one governance and risk specialist.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

This was an unannounced focused inspection which took place during the evening on 13th April.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); the Trust Development Authority; NHS England; and the local Healthwatch.

During the inspection we spoke with a range of staff within the Emergency Department (ED) the Emergency Assessment Unit (EAU) and Emergency Short Stay Ward (ESS) wards including nurses, junior doctors, consultants and administrative and clerical staff. We also spoke with staff individually as requested. We talked with patients and staff who were using the service. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment in ED, EAU and ESS at Broomfield Hospital.

Facts and data about Broomfield Hospital

Broomfield Hospital overview:

Beds: 616

- 527 general and acute
- 56 maternity
- 20 intensive care

- 13 high dependency

Activity Summary:

Activity type 2013-14

Inpatient admissions 85,981

Outpatient attendances 593,103

Accident & emergency (attendances) 81,220

Population Served:

- According to the 2011 census, 96.6% of the population of the borough of Braintree is White, and the highest ethnic minorities are Asian and mixed/multiple ethnic group, both with 1.3%. 93.9% of the borough of Chelmsford is White, and the highest ethnic minority is Asian at 2.9%. The borough of Maldon is 98.1% White and the highest ethnic minorities are Asian and mixed/multiple ethnic group, both with 0.8%

Deprivation:

- Chelmsford ranks 298th out of 326 local authorities for deprivation, Maldon ranks 230th out of 326, and Braintree ranks 210th out of 326 local authorities.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

Notes

Urgent and emergency services

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The emergency department (ED) at Broomfield Hospital is located within the PFI wing of the hospital that was purpose-built and opened in 2010.The ED at Broomfield Hospital provides a 24-hour, seven day a week service to the local area. The department saw around 81,000 patients between April 2013 and March 2014 of which 19,000 were children.

Patients present to the department either by walking in via the reception, or arriving by ambulance. The department has facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's ED service. The emergency department is a member of a regional trauma network.

This unannounced inspection comprised of inspecting the emergency department, emergency assessment unit (EAU) and the emergency short stay ward (ESS). During our inspection, we spoke with three doctors, six members of the nursing team, and three members of admin and clerical staff. We also spoke with ten patients, three relatives and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for 16 patients in the emergency department.

Prior to this inspection concerns were raised by stakeholders around the flow of patients through the ED department, whether timely care was being provided and whether patients receive sufficient pain relief.

Summary of findings

Urgent and emergency services did not protect patients from abuse or avoidable harm because staffing levels were not sufficient to provide safe care to patients within the ED, EAU or ESS. Infection control practices in the emergency department were poor with some staff observed not washing their hands or using hand gels between patients. Concerns remained regarding the care and treatment for patients with mental health conditions in the main emergency department as they were not routinely monitored or risk assessed appropriately. Records were poorly completed with gaps in documentation and patients not being risk assessed despite being in the department for long periods of time.

The service was not effective particularly in the Emergency Department. NICE and RCEM guidelines on sepsis, head injury, stroke, chest pain and fracture neck of femur were not always being followed. Within the EAU and on ESS pressure ulcer care for patients was not provided in accordance with NICE guidelines. Audits on all the national guidelines had been undertaken. However, the patient outcomes of these were poor in the majority. The relationship with the ambulance provider and mental health service did not work effectively. Internal multidisciplinary working did not work effectively due to pressures within the service.

Patients were treated by caring staff who were dedicated and passionate about their roles. The friends

Urgent and emergency services

and family test showed a positive response rate for recommending the service and the majority of patients and relatives spoken with were satisfied with the care and service received.

Services were not responsive because the emergency department was disorganised and patients experienced delays and often significant delays in their care and treatment. The four hour performance for the emergency department had decreased to 78% overall with several people having to wait for more than 12 hours in the department. The EAU, ESS and Ambulatory care service were not being appropriately used to meet patient needs due to issues with bed capacity and occupancy within the hospital.

Leadership locally and at senior management executive level for urgent and emergency services was inadequate with a notable decline in understanding of governance arrangements and risks to patients within the service. There was a poor culture within the service associated with blame and fear for failures to deliver target significantly affecting staff morale.

Are urgent and emergency services safe?

Inadequate

The safety of urgent and emergency services was inadequate. The systems in place to protect patients and maintain their safety were not always used because patient pathways were not followed. Staffing levels were not sufficient to provide safe care to patients within the ED, EAU or ESS and there was an insufficient review on the wards to consider patient acuity as part of safer staffing numbers. Infection control practices observed through the emergency department were poor with staff not washing their hands or using hand gels between patients.

The department was not clean in all places with dust noted and blood stains on a bin and floor. Sharps bins were observed to be full or stored on the floor. Resuscitation trolleys' records showed that they had not always been checked as safe for use in the emergency department.

The department had a waiting area for patients who walked into the department requiring treatment and we noted that patients who were to be admitted to the hospital for treatment were admitted to a chair in the waiting room due to a lack of bed capacity within the hospital. The waiting room was not staffed and these patients were not provided with sufficient observation. The reception staffing levels at night time were not sufficient with one on duty at night and the demand on reception being unmanageable at times.

Concerns remained, from our inspections in August 2014 and November 2014, regarding the care and treatment for patients with mental health conditions in the department as they were not routinely monitored or risk assessed appropriately. It was evident that lessons had not been learned from previous incidences with mental health patients.

Records were poorly completed with gaps in documentation and patients not being risk assessed despite being in the emergency department for more than four hours and in some cases over seven hours. Medicines in the emergency department were not kept securely, allergy statuses were not always recorded on patent records and administrations of records were not always provided.

Urgent and emergency services

Incidents

- The trust reported seven serious incidents (SI), relating specifically to the emergency department, to the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS), between March 2013 and October 2014. They included two incidents relating to delayed diagnosis, one incident reported as suboptimal care of the deteriorating patient, one incident involving the safeguarding of a vulnerable adult, and three following premature discharge.
- Since our inspection the trust has been retrospectively entering incidents on to the system and trust board papers show that the ED is now the highest reporter of incidents.
- We asked three nursing and support staff if they reported incidents and they told us that they try but do not always have time to complete the incident forms.
- We asked two senior nurses about two episodes, we had been informed about, where patients were not observed and whether they were aware if those had been reported as incidents and investigated and they did not believe they had been and this could be down to how busy the service was at the time.
- We spoke with two nurses and a member of medical staff on duty about evidence of learning from incidents since our previous inspections in August and November 2014. These staff members were unable to provide us with an example of a change of practice or what had been learned from an incident they were aware of. It was evident that learning from incidents had not improved since August 2014.
- We pathway tracked two patients with mental health concerns who had been admitted to the hospital to determine whether a serious incident that had been investigated last year relating to a patient with mental health concerns has been learnt from. We found that one patient had been risk assessed however they were was not being monitored and were freely walking through all areas of the department including those that should have had a degree of security in place. The second patient had not been risk assessed and was in a bedded area with other patients, awaiting transfer to a mental health service. Staff were not following procedures to care for, or treat patients with a mental health condition. There have been minimal changes or improvements to care for patients with mental health conditions since our previous inspections.
- Although the room designated a Section 136 place of safety had been adapted since our August 2014 inspection, the concerns identified during the November 2014 inspection in relation to the room had not yet been addressed. The room had ligature points present and the second door was insecure and exited onto a main hospital corridor. We observed that patients in this room were not routinely monitored and we observed a mental health patient freely walking through the department unsupervised. Whilst we note patients are free to leave there was no mechanism for identifying when the patient has left the room and without the risk assessment process being completed correctly this could place the patient or others at risk of harm.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records though this area where medicines were stored was not secured as the door was left open. The checks were carried out by qualified nursing staff.
- We observed throughout the department that medicine cupboards were left open and insecure, and IV fluids were stored in a public area within majors. This was also what we observed in November 2014, evidencing that the safety and security of medicines had not improved. We brought these concerns to the attention of the staff on duty.
- Records showed that fridge temperatures for medicines requiring refrigeration were checked daily to ensure medicines were stored correctly.
- We observed a member of the portering team request for paracetamol from a nurse whilst we were present, when asked why the porter said, “one of the radiographers has a headache.” This request was denied by the nurse.
- In two of the six medicine charts examined, allergy status had not been recorded. In one set of notes prescribed and administered pain relief co-codomal had not been signed for.

Cleanliness, infection control and hygiene

- We witnessed five members of nursing staff and two doctors who did not wash their hands between patients or use hand sanitizer.

- Two members of staff were observed to move between patients wearing the same gloves. They did not remove them or wash their hands between patient contact.
- Hand sanitizer was found at each door entrance, though three out of the ten we checked were noted to be empty and we alerted staff to this who made requests to have them refilled.
- The department was not clean in all areas we looked in. Cubicle eight in majors had a full sharps bin which was at risk of injuring a staff member and there were notable blood marks on the bin and on the floor near the bin.
- In a treatment room we observed dust to have collected into corners which was evidence that the room had not been recently cleaned.
- The resuscitation area of the department was being used for 3 patients, two of whom were well enough to be treated in the major's area but there were insufficient beds. One patient had a potential infection and should have been cared for in a side room. We were told the cubicle would be deep cleaned before the next patient was admitted.

Environment and equipment

- In the suture room we found a large sharps bin placed on the floor, the door was open and parents and children were walking past this room to go to and from x-ray. There was a risk of injury and possible infection should a person come into contact with sharps stored at a low level.
- Of the five sharps bins examined two did not have the sections completed by the person who assembled the clinical waste bin; such as the date when the bin was assembled and the name of the person who assembled the bin.
- The emergency department had a designated children's department, which had a secure access and flow through the department. The children's emergency department had a specific waiting room, which was appropriately decorated and equipped for children waiting to be seen.
- Resuscitation equipment was available in all areas of the department and had been recorded as checked regularly in all areas with the exception of minors and paediatrics which shared a trolley. The resuscitation trolley records there showed that it had not been checked for two days in January, four days in March and three days between 01 and 13 April 2015.
- We observed three patients with cognitive impairment, as a result of living with conditions such as dementia, Alzheimer's or mental health conditions, who were left unattended in the majors cubicles, in the MAZ and in Ambulatory care. These patients were on trolleys which were high in height and we observed the patients grabbing onto them and trying to pull themselves towards them risking falls. There was no assessment in any of the patient notes which addressed the risks of falls and the need to monitor these patients. Due to the layout of the department it was not always possible to observe these patients.
- Although the room designated a S 136 place of safety had been adapted since our August 2014 inspection, the concerns identified during the November 2014 inspection in relation to the room had not yet been addressed. The room had ligature points present and the second door was insecure and exited onto a main hospital corridor. We observed that patients in this room were not routinely monitored and we observed a mental health patient freely walking through the department unsupervised. Whilst we note patients are free to leave there was no mechanism for identifying when the patient has left the room and without the risk assessment process being completed correctly this could place the patient or others at risk of harm.

Records

- Patient records within the department remained unsecured throughout the department. This has been raised with the trust by the CQC during inspections previously in August and November 2014. For example, medical notes were located on work surfaces within the reception area, with other hospital staff and ambulance crews having access.
- We observed notes that were left unattended in minor's assessment and treatment rooms with no patients or staff present and this was a risk to the security of patients' data and demonstrated poor information governance of patient records.
- We examined 16 patients' records the majority of which were poorly completed with gaps in entries. When a patient has been in the department for more than four hours the trust's process is to fully risk assess the patients for risk of falls, nutrition and hydration and pressure ulcers. Six of the records we saw were for patients who had waited over four hours and in one case over seven hours. There were no additional risk

assessments completed for these patients including for pressure area risk assessments despite the patients being unwell and potentially at risk. One patient had a history of falls yet no falls risk assessment had been completed.

Safeguarding

- We examined the proformas for two children in the paediatric area and found that the safeguarding for children form had not been completed in two cases. This was raised with the staff who reviewed the records and completed their assessments.
- The risk of not complying with safeguarding children protocols within the paediatric area is identified on the department risk register where it has been a low graded risk since October 2009. The risks are associated with having limited paediatric cover in the department which is between 07:30am and 12:15pm.
- 98% of staff had received adults and children's safeguarding level 1 in November 2014. All staff we spoke with understood their responsibilities were aware of the trust's safeguarding policies and procedures.

Mandatory training

- Mandatory training compliance has not changed since our inspection in November 2014; however a majority of staff (87%) had received their mandatory training which consists of fire, health and safety and infection control which is above the trust's minimum set standard of 85%.
- Staff have access to training including basic life support - adult training, basic life support – paediatric training, information governance, moving and handling and risk management.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning though staff informed us that it was difficult to release staff for training due to pressures of increased attendances and staff shortages. However we could not corroborate this as the rate of training was above the trusts minimum required.

Management of deteriorating patients

- The department used the National Early Warning Score (NEWS) as a method of identifying deteriorating patients. Most NEWS scores were completed correctly with three of the five records that we observed having been completed correctly. However two patients' NEWS scores had been calculated incorrectly.
- The department operates a triage system of patients presenting to the department, either by themselves or via ambulance, and they are seen in priority, dependent on their condition.
- For patients who walk into the department and present at the reception desk the receptionist would make a decision as to whether the patient was within one of two categories, either injured or illness. Patients were then asked to wait in the waiting room for triage, there was no process in place for escalating patients through the triage process where required.
- We observed a young adult who attended with a parent after falling and losing conscious for a reported 10 minutes. This patient was conscious on arrival and the family did not wait for an ambulance. The patient waited to be seen by a triage nurse for 19 minutes.
- There was no observation of patients in the waiting room and staff did not routinely check on patients who had waited for long periods of time to assess their welfare.
- During the inspection one patient and one relative informed us that on the 8th and 9th April 2015 when they were in the emergency department, patients who had been admitted to the hospital for care and treatment were "admitted" to the waiting room due to no inpatient beds being available. They told us that staff did not come and check on these people who were unwell, were being sick and some were in significant pain. The relative expressed they had to request for assistance for patients whilst they were there. We spoke with two senior nurses, two junior staff and the administration staff and all confirmed that this did happen due to capacity issues within the hospital.
- We asked the nursing staff what nursing support was provided to those admitted patients, did they have observations undertaken were they checked on through care rounding etc. We were informed that this area was not provided with additional staff to care for the admitted patients. These patients were therefore placed at risk of deterioration through no care being provided until they reached an inpatient bed.
- In the majors area there were a number of medical monitors alarming. In one room, we saw a patient lying very close to a monitor that was alarming loud enough to be heard outside the room. When a member of staff entered the room, we witnesses that they did not

silence or reduce the noise of the alarm. We were concerned that this was not comforting or restful for the patient or that the reason for the alarm investigated by this member of staff.

- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area where possible, however due to the capacity and flow issues within the hospital some patients were delayed in getting into majors or resuscitation areas. We observed that it took 24 minutes to transfer a patient with chest pain, and 16 minutes to transfer a patient suffering from a stroke.
- We examined 16 sets of patient records of which 10 patients required a sepsis bundle to be completed due to the risk of sepsis infections. Only one record had a properly completed sepsis bundle assessment. The other sepsis records were not completed or not fully completed. Four patient records we reviewed indicated that the patients either had a medical history of sepsis or were admitted with potential infections which should result in a sepsis assessment being made. This included one patient who had not been responding to antibiotics for a previous infection. One assessment had been commenced and despite the first part indicating a full assessment was required, this was not done.
- There was a GP rapid access service within the EAU which patients were sent to from the community when they were identified to be significantly unwell. One patient we met there had not been reviewed by a doctor despite waiting for more than three hours. They were referred by their GP with a serious infection linked to an end of life condition and were at risk of deterioration. Nursing staff contacted the doctors when they realised the patient had not been medically reviewed.
- The delays to patients waiting to be seen and treated in the ambulance bay led to an increased risk of patients deteriorating. The trust was not auditing or monitoring patients who were excessively delayed for triage, treatment or assessment in the ED prior to our inspection.
- We requested for the trust to review the care of patients subject to delays for the week ending 19th April 2015. The trust identified that of the 18 patients who waited more than 60minutes to be handed over there were three incidents related to suboptimal care. Since the inspection the trust has informed us that those three patients did not come to any harm.
- The first was a patient with sepsis with their medication not being given in 60 minute window. The second was a patient with a NEWS of 7 with sepsis and their medication had not been given within the 60 minute window; it was given 165 minutes after arrival. The third patient had a NEWS of 7 in ambulance bay with no escalation to the senior clinician for reprioritisation.

Nursing staffing

- The number of staff on duty on the EAU and on the ESS matched the number listed as required on the staff rota with gaps in shifts being covered by agency staff members. However there was no measurement of changing acuity changing the staffing levels with the nursing levels being fixed on each shift.
- In the ED there were 12 nurses and seven support staff on duty which was what the rota specified was needed however we observed that the unit was busy and staff nurses were stressed and running to get their work done.
- In one bay there was a registered nurse for 3 patients as another member of staff was attending x-ray with another patient. During this period a patient needed immediate assistance as they were bleeding. The senior nurse happened to be near the bay making a telephone call and was able to assist the other nurse.
- The emergency department had a sufficient number of nurses with specific paediatric qualifications working within the paediatric ED. When they were on shift they would be assigned to the paediatric service within the emergency department, and would be supported with other nurses.
- We saw that actions taken in respect of the use of unregistered nurses in the EAU remained in place and that these nurses were now supervised until they received UK registration.

Medical staffing

- The department currently operates below the England average of whole time equivalent (WTE) consultants employed within a rota. There were four full-time consultants employed at the time of our inspection including one who was not working clinically. The number of clinically working consultants has reduced since our previous inspection in November 2014. The Royal College of Emergency Medicine (RCEM)

requirements list that 10 full-time consultants are required for this hospital's ED. The trust is currently recruiting consultants in emergency medicine though they acknowledge they are finding it very challenging.

- Consultant grade doctors are present in the department for eleven hours each day between the hours of 8am and 7pm. Emergency departments should have consultant cover for sixteen hours each day and the current consultant rota did not support this. We observed the consultant stay on duty long pat the time their shift finished out of good will as the department was busy and acknowledged that they would not leave until the situation was more controlled.
- For the night we were present in the ED there were two junior doctors and one middle grade on duty, the service was one junior doctor down for the evening which could not be covered.
- On the EAU and ESS there were junior medical staff available to attend throughout the night from the medicine and surgery rota, however there were two juniors and a middle grade to cover the services so support was limited.
- The department regularly employed locum middle grade doctors on a long term basis where possible, to provide consistency. When we reviewed the rota, we noted that the same doctors were consistently in use. Doctors had received the trust induction programme, and were familiar with the department and protocols.
- There was no paediatric lead within the children's service provided in the ED, although a clinician within the department did have a sub specialty in paediatric emergency care.

Major incident awareness and training

- The trust's major incident plan was last ratified in 2014. The major incident process had been tested in 2013 and was next due to be tested again later in 2015.
- Security is available within the security and portering service with the security staff who attend incidents being major incident and control and restraint trained.
- There is a HAZMAT area outside of the service which has a store which contains decontamination equipment for use in the event of an emergency. The service is currently training staff in the use of the equipment but due to the vacancy rates the service is having difficulty in getting the required number of staff trained.

Are urgent and emergency services effective?

(for example, treatment is effective)

Inadequate

Following our comprehensive inspection in November 2014 we rated this key question as requiring improvement. However on returning to inspect in April 2015 we found that urgent and emergency services were inadequate in respect of providing an effective service to patients particularly in the Emergency Department. Whilst there were policies procedures and protocols in place the NICE and RCEM guidelines on sepsis, head injury, stroke, chest pain and fractured neck of femur were still not always being followed. At this inspection we found that within the EAU and on ESS pressure ulcer care for patients was not provided in accordance with NICE guidelines because staff were unable to treat pressure ulcers without support of the tissue viability teams and also pressure care was not being adequately monitored or undertaken. This had deteriorated since our comprehensive inspection in November 2014.

Audits on all the national guidelines had been undertaken however the patient outcomes of these were poor in the majority. The service was not meeting seven of eight indicators on the management of urinary retention. The fractured neck of femurs in the ED showed that the hospital was not meeting NICE guidelines on two of the three key guidelines and the emergency department had a poor performance in RCEM Sepsis Shock audit with the hospital being in the lower England quartile for nine of the 13 indicators. These outcomes have been deteriorating since 2011 and showed no signs of improvement.

Throughout urgent and emergency services the nurse staffing is junior in skill mix which means that managing the skill mix through staff rotas is challenging to provide staff with the skills needed on each shift.

There were difficult relationships between multidisciplinary teams both internally and externally. We observed that the medical and nursing teams in the ED were pressured and this caused their communication and working relationship to breakdown at times. The episodes of frustration were often witnessed by patients.

Urgent and emergency services

The relationship with the ambulance provider and mental health service did not work effectively. We observed instances of staff and ambulance crews not working well together which was witnessed by patients. The trust was working on the relationships with both the ambulance service and the mental health trust.

The EAU and ESS worked effectively locally however often felt pressured to take patients and support with the demand in the ED which caused some fracturing in their relationship with the department. The nursing the medical staff did not communicate or handover effectively in the MAZ and EAU with patients having to wait lengthy times to be seen when it could have been avoided.

Pain relief was not being monitored or provided effectively. Patient outcomes through audits on pain relief showed that the ED did not meet two of the four indicators for pain in children. Assessment for pain was not monitored in the ED waiting room and in patient cases reviewed, pain relief was not always offered. Pain relief was routinely provided on ESS and EAU.

The information needed to plan and deliver effective care to people was available but it was disorganised and staff were unclear what they should be looking at or doing to provide effective care. Information about people's care was not appropriately shared through handovers between staff.

Where appropriate, people's mental capacity had not been assessed and recorded and in the ED and in EAU we found that four of six cases where mental capacity assessments were required these had not been completed.

Evidence based care and treatment

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur, and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- We reviewed the policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with NICE and RCEM guidelines. Two doctors and two nurses we spoke with were able to show us these policies on the intranet and could easily access them.
- We saw that NICE and RCEM guidance on sepsis, head injury and fracture neck of femur were not always being followed in the ED. We looked at the notes for a patient with a head injury and observed that neuro observations had not been undertaken routinely, in the records for a patient with a fractured neck of femur pain relief had not been offered in two hours of admission and the admissions of chest pains and strokes were not prioritised or fast tracked through the department.
- We observed that antibiotics had not been prescribed for patients admitted with suspected sepsis, NICE guidelines for conducting neuro observations on patients with head injuries and one patient who was not sent for x-ray or offered pain relief in a timely way with a fractured neck of femur.
- NICE clinical guideline 29 "Pressure ulcers: The management of pressure ulcers in primary and secondary care" was not being adhered to when providing care to patients on MAZ or EAU. Patients who had been on the MAZ for more than four hours in three cases did not have any assessment in place for pressure ulcers.
- On EAU a patient who had been admitted to the hospital on the Friday, three days prior to our inspection, had no clear plan in place for skin management despite having an noted area of broken skin on their body. We asked the staff nurse in charge of their care what the action plan was to care for the wound and they informed us that a referral had been made to the tissue viability team but they needed to wait to know how to treat the wound. The wound had not been treated since admission.
- On EAU a patient who was admitted to the EAU from ED that evening did not have a risk assessment in place despite being in the hospital for 20 hours. The patent was recorded as having an area of redness on their skin and was incontinent however there was no care plan in place to minimise the risk or development of pressure ulcers for this patient.

Pain relief

- The audit on the Royal College of Emergency Medicine Pain in Children showed that the service was meeting two of the four key indicators. The standard to provide pain relief if required at triage is 100% and the service met this on 36% of cases. Moderate pain should be re-evaluated in 75% of cases and trust met this on 0% of cases. Severe pain should be re-evaluated in 90% of cases and the service did this in 8% of cases.
- We had to bring the care of two patients to the attention of staff because they were so distressed through pain in

the waiting room and required support. We observed two nurses enter the waiting area prior to our escalation but they failed to recognise the distress and pain of patients waiting.

- One patient had a fracture which was causing them severe pain but was not offered pain relief at triage or prior to x-ray which caused severe discomfort, they were also not provided pain relief on return despite requests. We escalated the care of this patient to the triage nurse who went to review and offered pain relief.
- A relative came out of a bay in majors to seek pain relief for the patient they were with, the pain relief had not been provided despite being in the department for more than one hour, they observed the nurses and doctors at the desk arguing and chose not to request the pain relief and returned to their room. We tried to encourage them to speak to the staff but they said they "did not want to get involved in that".
- Of the 16 sets of notes examined pain relief was not offered in six cases.
- Pain relief was routinely offered to patients during medicine rounds on the EAU and ESS.

Nutrition and hydration

- On the EAU and ESS, we saw that people had been offered food and drink. Drinks were place at people's bedsides. Where a patient required support with eating their meals were placed on a red tray which indicated that they required support with eating and drinking.
- Out of hours there were no advertised options for food or drink for patient and relatives except for the vending machines available. We were informed by the trust that hot food and drinks are available 24 hours per day through the domestic team leader. There was a breakfast bar provided at the weekends for people in the ED.

Patient outcomes

- The trust took part in RCEM management of urinary retention audit in 2013 but performed poorly not meeting seven of the eight key indicators. It was noted that 18% of patients were prescribed pain relief within one hour of arrival and 36% of patients were catheterised within one hour against a standard of 90%.
- The audit of NICE guidelines around fractured neck of femurs in the ED showed that the hospital was not meeting NICE guidelines. Specifically the results showed that 36% of patients were x-rayed within one hour against the guideline of 90%, 21% of patients were referred to orthopaedics within two hours against a standard of 75% however 84% of patients were admitted to an appropriate ward within four hours.
- The department did undertake an internal audit between September and December 2013 reviewing 4 of the parameters, not including pain management. This showed that the trust was in line with the median nationally for the percentage of cases X-rayed within 60 minutes was 36% and of cases admitted within 4 hours the result was 89%.
- The result of the audit on RCEM guidelines for fever in children under 5 years with the service meeting three of the six key indicators. The service for example did not have the traffic light system available in the notes for 89% of cases audited.
- The emergency department performance in the 2011 RCEM Sepsis Shock audit placed the hospital in the lower England quartile for nine of the 13 indicators. The 2013 audit has shown that the management of severe sepsis and septic shock in Emergency Departments (ED) has improved since 2011 with three of the 13 indicators in the lower quartile.
- During the inspection we found that sepsis six bundles were poorly completed and sepsis monitoring was not being undertaken in nine out of 10 cases. The management and care of patients with sepsis in the department has shown no signs of improvement since the undertaking of the audit and deterioration since our inspection in November 2014.

Competent staff

- The skill mix for adult trained nurses in the department was poor with many staff being junior and with limited experience in emergency medicine. Within the EAU there was a sufficient number of Band 6 nurses employed, shifts were occasionally led by Band 5 nurses but it was a band 6 where possible.
- The Chief Nurse, Head Nurse and Lead Nurse recognised that the skill mix of nursing in the ED did not always meant that it was effective as the workforce was very junior in experience but they did try to balance this with experienced staff leading teams.
- A skill mix review was being undertaken by the trust however the senior nurses reported that the priority was nursing numbers because there were many vacancies.
- 88% of nurses had received an appraisal across the services. An appraisal is a personal development review

of staff's performance objectives, and a process for determining staff development needs. This rate is lower than the trust expected rate of 90% but there were plans to further improve appraisal compliance.
- We were not provided with details of the appraisals of medical grade staff which were undertaken though the consultant on duty informed us that they had received an appraisal.
- Staff we spoke with felt that options for professional and educational development were available throughout the emergency services.

Multidisciplinary working

- Within the EAU and ESS the nursing, medical and support teams worked together to deliver care effectively. However their relationship with the ED was not always effective. Two nurses we spoke with spoke of the pressures of the ED and that site management could increase pressure on them with the ED to take patients due to increased demand and if junior staff were in charge this was difficult to manage at times.
- There was an ambulance service representative in the department to assist with the delayed ambulance handover process, which was consistently not being met by the trust.
- Within the GP rapid Access service based between MAZ and EAU the nurses and doctors did not work well together to communicate patient needs or escalate patients where required. Patients admitted for treatment or tests there were subjected to long waits on the day of our inspection through poor communication between the teams.
- Medical and nursing staff did not work well together in the ED due to the pressures the service was under, whilst the service was not seeing a high number of patients the management of the flow of these patients and priorities was very disorganised and led to fractured working between teams.
- We observed on two occasions Medical staff speaking rudely to the nursing teams about the patient priorities, we also observed medical staff raising their voice to the site management team regarding patient priorities, we also observed both nurses and medical staff speaking rudely to the paramedics and ambulance staff arriving with patients.
- One member of the ambulance crew told us that nurses usually "ignore" them but it was better today as CQC were in so they were trying. All three ambulance crew members reported experiencing significant delays at the hospital and that the relationship with the department was strained because they felt ignored on arrival.
- Mental Health liaison support was available to access twenty four hours per day, however there was a shortage of beds in the community which meant that patients were admitted to Broomfield until one became available. Nursing staff raised that they felt the teams responded quickly to their calls however once they had attended they felt that there was little input or support. The Chief Executive of the trust reported that they are working with all agencies including the mental health trust, with the aim to improve care provided to patients with mental health conditions.
- The pressures of the shift were evident and it was noted how strained people were, CQC staff were spoken to harshly by a member of senior nursing staff for inspecting when it was busy and disrupting the service when this was not the case.
- We found that nursing handovers were not always comprehensive and thorough, we observed three nurse handovers and found elements of general safety as well as patient-specific information missing from the handover. For example, a patient's history of falls was not handed over, a patients existing pressure ulcer was not handed over and patients who had been in the department over 4 hours it was not handed over if they had been risk assessed or not.
- The shift handover was carried out around a board in the major's department. This area is a busy thoroughfare and staff interrupted the handover process to ask questions. Not all staff were involved in the handover process, and individual patients were not involved in the handover of their care.
- The handover at night in the clinical operations room was basic and referenced the protocol had been followed to get the on call manager to stay because there were more than 50 people in the department. However it was not clear what the role of the on call manager was doing to help the situation within the ED. There was no reference to the disorganisation of the ED or that there were significant delays as this had become an accepted practice for the trust.
- There was a consultant out-of-hours' service provided through an on-call system and the services had access to junior and middle grade medical staff on site twenty four hours per day.

Urgent and emergency services

- The emergency department offered all services where required seven days a week.
- Seven day services in the community are not provided which staff reported had an impact on the delivery of ED services at the weekend because activity often increased and they had difficulty discharging patients at the weekends.

Seven-day services

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Access to information

- The documentation was difficult to navigate through because notes were not defined between clinical observations and nursing and medical notes; therefore doctors and nurses were looking for the same notes at the same time.
- Information on patient flow and throughput for the department was available including outcomes, delays and arrivals but this was not monitored, acted upon or organised in a way which supported the effective delivery of the service.
- Radiology, pathology and pharmacy systems were electronic and staff could access these at all terminals in the departments using their access cards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 98% of staff had received training in mental capacity however two staff nurses and a HCA we spoke with were unclear about when they would need to assess a patient's capacity.
- Four of six mental capacity assessments required in the ED were not completed. One assessment that was completed indicated that the patient had no capacity concerns though several entries in their medical records showed a diagnosis of dementia.
- Patients in the EAU and ESS did have capacity assessment in place where required.

Are urgent and emergency services caring?

Good

Urgent and emergency services provided care to patients which was mostly good however the impact of the pressures in the service and working relationships between the teams did impact on the quality and compassion of care provided.

We spoke with 10 patients and three relatives about the care they received. Five patients spoke highly of the care they received and said that staff had been attentive and friendly and treated them with dignity and respect. Three patients were happy with the care they were received but reported that staff were very busy and were not always quick to get to them. Two patients were not happy with the care they had received with one saying it took a long time to get response from the staff and another who reported that the doctor was not caring in how they spoke to them.

Friends and Family Test questionnaires were available in reception areas, and we found two posters in the waiting room displaying different information to the public about Friends and Family Test results. The Friends and Family Test showed that 71% of people would recommend the service to their friends or family.

Support was available to patients and relatives through specialist support services as well as through the chaplaincy service and specialist nurses should support be required.

Compassionate care

- The ED scored 71% on the friends and family test for patients who recommend this hospital to others from 1279 responses.
- The NHS inpatient survey for 2014 was sent to 850 patients who received care at this trust and received 399 responses. The results for the ED scored 8 out of 10 for ED services which is the same score as the previous year and was about the same when compared to similar sized trusts.
- The ED scored worse than average on patients being given enough information on their condition and treatment in the ED with a score of 7.5 out of 10.

Urgent and emergency services

- The trust scored 8.2 out of 10 for patients that felt as though they were well cared for by staff in this hospital which is worse than the England average.
- When staff were observed to interact with patients they did so in a respectful way and were kind to patients.
- In a room immediately opposite the nurse's station a patient was vomiting. This was clearly audible to staff in the department and went on for some minutes. Nobody entered the room to see if the patient was all right or needed any assistance.

Understanding and involvement of patients and those close to them

- We spoke with 10 patients and three relatives about the care they received. Five patients spoke highly of the care they received and that staff had been attentive and friendly and treated them with dignity and respect. Three patients were happy with the care they were received but reported that staff were very busy and were not always quick to get to them. Two patients were not happy with the care they had received with one saying it took a long time to get response from the staff and another who reported that the doctor was not caring in how they spoke to them.
- Of the three relatives we spoke with, two were not happy with the delays in the care that was being received and did not want to disturb the staff that were busy. The third relative was complimentary about their care their relative received on ESS.

Emotional support

- Staff tried to support patients and their relatives as much as they could in the time they had; however they were very busy during our inspection and were unable to spend time with people.
- Patients and relatives thought that the staff were helpful however two people we spoke with did not want to approach them as they were busy.
- Staff had 24 hour access to the chaplaincy service to provide emotional support to families of trauma and bereavement if required.
- Clinical nurse specialists for stroke and fractured neck of femur, those patients living with dementia and falls were available for patients and relatives Monday to Friday but with limited access out of hours and at weekends. Feedback through NHS choices and patient surveys speak highly of these specialist nurses.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Following our comprehensive inspection in November 2014 we rated this key question as inadequate as the department had been taking a reactive approach to the managing high surge activity and busy periods, rather than a proactive approach, delays in treatment were frequent and the escalation policy was not enacted in a timely manner. At this inspection in April 2015 we found that things had not changed significantly. Urgent and emergency services at Broomfield Hospital continued to be not planned or delivered in a way that met people's needs and we have rated the responsiveness of this service as inadequate. The emergency department was disorganised and patients experienced delays and often delays in their care and treatment through the Emergency Department. Whilst the service has an escalation policy in place this was still not used in a timely way that met people's needs.

The four hour performance for the emergency department had decreased to 78% overall with several people having to wait for more than 12 hours in the department. The delays caused significant challenges to ambulance handovers into the hospital which was not responsive to patient needs or the needs of others who required ambulance services. Broomfield Hospital has been reported as one of the hospitals with the poorest performance on ambulance handovers in the East of England.

The EAU and ESS whilst short stay wards were providing people with care longer than the ward was designed to do due to capacity and flow issues within the hospital, due to bed occupancy being consistently above 95%. The Ambulatory care unit was not able to deliver a full service to meet patient needs as the area was being used to provide inpatient bed space, this meant that the ambulatory care patients were being referred through the emergency department route for their treatment rather than directly to this area.

We found on-going and continuing concerns regarding the treatment and provision of care for patients with mental

health conditions in the emergency department and on the wards with limited provision or understanding of mental health needs. This has shown very little improvement since August 2014.

Meeting the needs of all people

- The emergency department has an escalation policy, which was developed by the management team. This policy was be followed when the department was experiencing long delays in ambulance handovers, or when patients were being transferred to a ward, and when there was a lack of available beds within the hospital to admit patients.
- During the inspection the department was busy and the teams were unable to manage the flow and capacity demands between minors, majors and resus which led to delays in patient care and despite departments becoming busy there were notable delays in the implementation of the escalation protocol.
- The ED has consistently not met the national target of four hours to treatment since our previous inspection in November 2015. During the week prior to our inspection the service achieved seeing 78% of patients within four hours. This was worse than when we inspected in November 2015 when the department was achieving 87% of patients seen within four hours.
- The number of patients who were seen within four hours each day varied; on 8th April 2015 the service saw 68% of patients within four hours, which was the lowest, and at its highest saw 89% on 12th April 2015.
- There was limited space within the department to cope with the number of patients arriving. The service informed us that they were currently undertaking building works to open an additional 10 cubicles in the majors department however the provision for staffing this area, when the unit was already short of the required number of nurses and doctors, had not yet been agreed or determined.
- The paediatric area, since its redesign in August 2014, has functioned well as a separate area of the department with children and parents waiting in a separate area to the main ED to be seen.
- Leaflets on a variety of conditions including back pain and flu as well as choosing the right pathways of care and when to choose emergency care were available to patients in the reception area.
- The ED, EAU and ESS were able to access a range of nurse specialists who were available Monday to Friday to provide support and guidance on specialist conditions including Dementia, Falls, Learning disability and stroke. This service was not available at the weekends or out of hours.
- It was identified during our inspection in November 2014 that the recognised assessment tool for people with mental health issues was not being used. We reviewed the notes of two patients with mental health concerns in the department during our inspection and found that these assessments were still not being done. We could not see what specific outcome measures were being used in for people with mental health concerns and this was therefore not responsive to people in crisis or who long terms mental health concerns.
- Due to the designated ambulance handover area being crowded during times of high attendances patients were offloaded into the corridor entrance and their dignity or privacy could not be maintained.
- The environment where patients were handed over by ambulances in the ED meant that there was no way to hand over this information with due regard to patient confidentially due to the number of people waiting to go into the department. The ambulance handover area needed significant improvement in these aspects whereby members of the public and other patients could be in this area and hear confidential information.
- Patients were treated on trolleys in the MAZ area though they had been in the department longer than four hours. For one patient this was in excess of 7 hours. We saw one patient was transferred onto a bed after being in the department for 6 hours.

Access and flow

- The service sees approximately 1400-1600 patients per week which equates to approximately 200-250 patients per day on average. During the week prior to our inspection the service saw 1629 patients of which 226 were in the department for more than six hours, 126 for more than eight hours and 34 waited more than 12 hours.
- There was a designated ambulance handover area, which was often used to cohort ambulances waiting to handover above a 15 minute waiting time. This area was crowded and meant that during times of high attendances patients were placed into the corridor.

Urgent and emergency services

- The ED was not effective at providing treatment in line with RCEM guidelines to triage patients within 15 minutes. In the week prior to our inspection the average time to triage was between seven to 23 minutes.
- The RCEM guidelines for treatment to start within 60 minutes was consistently not being met. The week of our inspection the media time for treatment on each day ranged between 54 and 95 minutes with the 60minute timeframe being met once in seven days.
- During the week prior to our inspection the service had 484 ambulances arrive at the ED with patients. Of those 76% of patients were off loaded within 30 minutes. 14% were offloaded within 30-60minutes, 7% were offloaded within 1-2 hours and 3% were offloaded in over two hours. The longest wait that week to offload ambulances was over four hours. This was not responsive and had a negative impact on the performance delivery of the ambulance service.
- The Ambulatory Care Unit was open but was taking a limited number of patients, 79 for the week, due to the bed spaces being used for inpatients. There was insufficient capacity in the department to meet the needs of people who required ambulatory care with these patients having going through the ED route for their treatment rather than directly to the Ambulatory Care Unit. This impacted upon the care that could be provided to all patients.
- The hospital operates on a bed base of 527 beds and during the week prior to our inspection the capacity of the hospital had reached 'black alert' status with the bed occupancy for week reaching 98%, 92% at its lowest and 104% at its highest. Four of the seven days the previous week had occupancy rates above 98% which meant that capacity and flow through the ED, EAU and ESS was severely restricted.
- The conversion rate for admission through attendances to the ED were 26% which was slightly higher than the England average of 24%. One consultant informed us that they believed the conversion rates were higher when locum or junior grade staff were on duty and the consultant was on call rather than on site.
- EAU and ESS nursing staff informed us of the trust policy to avoid where possible moving patients during the night to wards however this was not being adhered to due to capacity pressures within the hospital. No figures were available for night time transfers from these services to wards at the time of our inspection.
- For the week of our inspection the trust was only able to discharge 20% of patients before 1pm and 38% of patient discharged after 5pm. The week prior to our inspection it was 23% discharged before 1pm with 41% discharged after 5pm which was not responsive to flow through the emergency floor and not responsive to the people being sent home late.

Complaints handling (for this service) and learning from feedback

- The ED, EAU and ESS advertise the Patient Advice and Liaison Service (PALS), which is available throughout the hospital. However there was little information displayed for patients or relatives on how to make a complaint and how to access the Patient Advice and Liaison Service.
- The services also encourage patient feedback with posters displayed in all departments however there were no comment cards available for people to use.
- All concerns raised were investigated through the trusts complaints process. The service receives the highest number of reported complaints compared to all other services in the trust. The top three reported complaints concerned 'all aspects of clinical treatment', 'communication' and 'attitude of staff'.
- Of the three doctors, six members of the nursing team, and three members of admin and clerical staff we spoke with we asked five whether they received feedback about the complaints received and learning from complaints. All were not aware of the complaints that had been reported and all five informed us that they had not received any feedback or learning from complaints.

Are urgent and emergency services well-led?

Inadequate

Following our comprehensive inspection in November 2014 and our focused inspection in February 2015 we rated this key question as inadequate. At that time we found that changes were not embedded to improve the care given to patients. We also found that staff were not engaged with the wider hospital and that concerns of staff were not being listened to. At this inspection in April 2015 we found that the inadequacies were linked to failures by the local teams

as well as by the trust executive and senior management teams. It was evident that the delivery of care was not assured by the leadership, governance or culture in place and we noted a noticeable decline in the performance of the leadership team since our last inspection. We found that there had been little change in the culture of leadership of this department despite our inspections and subsequent recommendations or requirements made of the trust.

The leadership team throughout the service had been subject to numerous changes over the previous 12 to18 months, it had changed since our inspection in November 2014 and again since our inspection in February 2015 and the continual changes had led to a feeling of instability in the service which affected the running of the department as well as staff morale.

The service was not engaged in the wider trust and staff did not feel listened to. Staff reported a poor culture where openness was not encouraged and concerns were not listened to. In various roles, staff reported fear about being confronted by senior management regarding failures to deliver performance targets and how this affected their work.

The senior management and executive team did not have an understanding of the severity of the concerns within the emergency department nor did they have robust governance frameworks in place to reflect changes made to resolve issues previously highlighted. We met with the service leaders and the senior management team prior to the inspection and were provided with full assurances that governance processes were in place, audits, assessments and checks were being undertaken. However during the inspection this was not the case in that patients were not protected from avoidable harm but were at risk of harm.

The governance arrangements around the provision of assurances internally to the senior management team, executive team and external stakeholders were poor with a lack of understanding about governance needs and requirements throughout urgent and emergency services in the hospital. The management team were unaware that they would need to review patients who had waited for excessive lengths of time for treatment to determine if they had sustained any harm.

Vision and strategy for this service

- The trust has a vision for the trust however staff within the services were not knowledgeable about the vision for the service and it was told to us by two members of staff that the trust was “firefighting” due to pressures with beds and capacity in the hospital which they believed affected the emergency floor the most.
- On the EAU and ESS staff were more aware of the vision and journey for the services though equally felt negatively impacted by the bed and capacity pressures within the hospital.
- The trust executive and senior management team had a lack of vision in how best to operate the emergency floor and improve the capacity and flow concerns. It was evident prior to, during and after the inspection that the teams did not have a clear understanding of the issues or how to resolve them.
- The executive team’s plans revolved around the capacity and flow throughout the hospital and the recruitment of key staff to roles within the service however they had failed to address or identify the reasons for the failures throughout the services prior to making changes. This meant that the cultures within the service were not being addressed and the vision for the service by the senior management and executive team wasn’t effectively managing either the short or longer term issues.

Public and staff involvement and engagement

- Staff throughout the emergency floor did not feel engaged with other services within the trust and did not have any knowledge of what initiatives were being undertaken to improve the service.
- We were told by three staff in services across the emergency floor that they felt isolated and blamed for the failures and delays within the services.
- Out of the three staff on EAU we spoke with all felt like changes within the department were being implemented as a result of the inspection in February however they did not all have confidence that change would be sustained.
- There was no information available for the public to engage in the service displayed anywhere throughout the emergency floor. Information was available on the website though at the time there was no internet access so people were unable to access this information remotely.

Urgent and emergency services

Governance, risk management and quality measurement

- Monthly departmental meetings are held within the management teams. We were provided with minutes of the previous meetings at our last inspection. However these meetings were not producing actions in order to rectify the issues highlighted at our previous inspection in August 2014 and November 2014. Neither did governance systems highlight the issues in respect of nursing staff that we found at our inspection of February 2015, When the service was alerted to these issues teams did take action to address the situation to ensure that patients were safe on EAU. However at this inspection we were not assured that risks were well managed within the service.
- The ED dashboard identified significant delays in patient care, access and delays to treatment however the service was not assessing the risks to patients who were subject to significant delays until it was identified to the executive team that there was a concern. Upon reviewing the patients subject to delays the week of our inspection there were three patients who experienced suboptimal care.
- We were informed, during a meeting with the executive team a week prior to the inspection, that there was a robust process for governance and risk management and audit of patients' records to ensure that risk assessments were undertaken and patients were safe despite delays. During our inspection we found many examples that this was not the case which demonstrated that the governance and risk management systems for the service was poor and that risks were not understood or managed by the senior management or executive team.
- The service had a risk register in place which had a variety of risks on it, some of which have been on the register since 2009 and despite being graded as low risks remain on the risk register. However not all of the risks we identified during our five inspections were on the local risk register.
- The corporate risk register examined only contained two risks relating to the ED; these concerned meeting the four hour target, and the availability of junior and middle grade doctors. Significant risks to deteriorating patients, pressure, capacity and flow and ambulance handovers should have been raised as corporate risk register matters due to their severity and impact on patient safety but were only recorded on the local risk register.

Leadership of service

- The leadership team for the ED, EAU and ESS has been subjected to multiple changes within the previous 18 months. The EAU leadership had been changed since our November inspection and was due to change again in the near future which was causing uncertainty to staff.
- The ED team had changes to both medical and nursing leadership within the last 12 months and the nurse leadership at both lead nurse and head nurse level was in the process of change again. Continual changes and instability in leadership has impacted on the team working abilities and morale of the teams throughout the emergency floor.
- Clinical leadership was limited, with the low number of substantiated consultants available. The permanent consultants were passionate about their roles and often stayed to support the service and provide support beyond their working hours.
- The executive management and senior management team were unaware of the risks to patients within the emergency department. We met with the teams prior to our inspection and they provided full assurances that the service was safe, that audits were undertaken, that resuscitation trolleys had been checked and that whilst the department was pressured it was within control.
- During our inspection we found that the assurances provided were inaccurate because records showed that resuscitation trolleys were not checked, audits and risk assessment had not been undertaken and patients were not protected from avoidable harm within the service. This demonstrated to us that the management and executive team did not understand what was happening in the department or what risks there were to the service or to the patients.

Innovation, learning and improvement

- We did not see evidence of staff innovation, either on an individual or team basis, which was put into practice and owned by the department.
- We spoke with a senior manager within the trust about how lessons learned from incidents were disseminated across the trust. They told us that they would expect senior staff to pass this information to the rest of the

team, but they said there was no formal mechanism in place to check that this was happening. This meant that the culture did not centre on the needs and experience of the people who use the services.

Culture within the department

- We were informed that the senior management team and executive team often responded very negatively towards staff members when the service had not performed well to discharge patients or meet the four hour target. Two members of staff said they feared meetings with some managers because they were concerned about what would be said.
- During the inspection we were approached by a senior member of staff who spoke with us very abruptly about our inspection disrupting the flow of the service. Following the conversation a member of staff made a comment that indicated that this was not an unusual occurrence. This did not demonstrate a good leadership style to a team already under immense pressure.
- We were unanimously told that the department did not feel supported by the senior management or executive management team. When the ED is under pressure staff shared their experiences with us that the department did not always receive the support it needed.
- On EAU staff shared that they were forced to move patients in the middle of the night regularly despite the trust policy due to pressures and take patients when they may be short of nursing staff. They were concerned about patient care and safety when this happened. We were unable to corroborate that staff were pressured into moving patients during the night.
- In Ambulatory care concerns were raised by staff that ambulatory care could not be provided due to the area being used for inpatient beds, they had tried to raise this with management but had received no response. The ambulatory care area has been used for inpatients since prior to our inspection in November 2014.
- Five members of staff raised to us that the executive team only arrived in the department when there were significant pressures and they were not present regularly. These staff members reported that they had been subjected to or observed people being questioned publicly about why the four hour target was not being met. This, they told us affected their morale.
- Staff were willing to go above and beyond the call of duty, and were dedicated and passionate about their work however they were not supported and felt blamed for target performance issues and failures which affected their morale.
- Staff on the EAU informed us that the inspection in February 2015 had meant that staff were now more willing to speak openly about their concerns and the senior staff were asking for the culture to be more open, this we were told was led predominantly by the lead nurse.
- We spoke with staff of various grades within the departments in clinical and non-clinical roles during the inspection and the majority felt that in the ED there was a “blame culture” and people were put in situations of “pressure” and two reported that they felt “bullied” to doing things they did not agree with for patient safety reasons.
- During our inspection we saw that the staff were dedicated, passionate and caring towards their patients; however, they were not supported, and in some instances felt blamed for target performance issues, which affected their morale. The effect on their morale came out negatively towards other staff members and towards patients which was observed during the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure medicines are administered in a timely way, especially for patients receiving intravenous antibiotics and time critical medicines.
- Ensure care documentation including care plans and risk assessments are undertaken in a timely way, accurately, are fully completed and reviewed when required.
- Improve staff training and awareness on mental health so that the provision of care for patients in urgent and emergency services with mental health conditions improves
- Ensure patients with mental health concerns are risk assessed on arrival at the emergency department and that patients with mental health concerns are appropriately observed and monitored.
- Review staffing levels on the reception desk in the emergency department.
- Ensure that resuscitation trolleys are regularly checked and stocked.
- Improve staff knowledge and understanding of what constitutes a safeguarding referral for adults.
- Ensure that all safeguarding referrals for adults in the emergency department are completed and actioned in a timely way.
- Improve hand washing techniques and infection control practices and techniques in the emergency department.

Action the hospital SHOULD take to improve

- Improve the incident reporting culture for staff to increase the number of incidents reported overall.
- Ensure that recruitment plans, to increase the amount of permanent nurses, are agreed and actioned to ensure that the high usage of agency and bank staff is reduced.
- Review mechanisms for using feedback from patients, so that there are opportunities for reviewing and improving service quality.
- Improve patient confidentiality in the ambulance entrance particularly when staff are discussing patient care.
- Ensure that staff are provided with feedback and informed of learning from incidents.
- Ensure the corridor within the emergency department which leads from the ambulance doors and the resuscitation area is kept clear of obstructions at all times.
- Improve shift and nursing handovers in the emergency department to ensure all staff are informed of the required information.
- Safely plan and increase consultant cover in the emergency department from 11 to 16 hours per day as recommended by The Royal College of Emergency Medicine.
- Improve patient care within the emergency department for conditions such as sepsis and head injuries in line with Royal College of Emergency Medicine guidelines.
- Improve implementation of the escalation protocol in the emergency department.
- Improve ambulance handover times within the emergency department.
- Improve local staff engagement within the ED and between the EAU and ED.
- Improve the working relationship between the ambulance service and the emergency department.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. The trust had not ensured that patients were provided with care that was in line with their required treatment plan. Resuscitation trolleys' records showed they had not been routinely checked. The emergency department was not clean and staff did not adopt good infection control techniques when providing care to patients. Medicines were not securely stored. Relationships with other care providers of patients were poor and impacted on patient care. Regulation 12 (1) and (2) (a), (b), (e), (g), (h) and (i) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. The trust had poor processes for the audit, risk management, risk assessment and provision of safe care to patients within the emergency department.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.** There were an insufficient numbers of suitably qualified, skilled and experienced trained nurses and midwives. Regulation 18 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

The trust is inadequately analysing the quality of information provided as assurances thathe services are safely providing care to patients.

Regulation 17 (1) and (2) (a) and (b) Health and Social Care Act 2008 (Regulated Activities) 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	Section 29A HSCA Warning notice: quality of health care The trust is failing to provide quality healthcare to service users because they are failing to carry out assessment of needs for service users to ensure the care delivered minimises the risk to their health or safety from pressure ulcers, falls or sepsis due to delays in their care and treatment pathway. The trust is failing to ensure that the equipment used for the provision of healthcare services is safely stored, checked and appropriate for use. The trust is failing to ensure that you have assessed the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

The enforcement action we took:

We have issued the trust with a warning notice. This warning notice requires Mid Essex Hospital Services NHS Trust to make a significant improvement to the quality of the health care provided to service users.