The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Inspection report

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Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Russells Hall Hospital

Not inspected

Russells Hall Hospital provides urgent care, medical care, surgery, children and young people services, maternity services, outpatients, diagnostics, end of life and critical care services.

We carried out an unannounced focused inspection of the emergency department (ED) at Russells Hall Hospital following our 'Resilience 5 Plus' process. The 'Resilience 5 Plus' process is used to support focused inspections of urgent and emergency care services which may be under pressure due to winter demands or concerns in relation to patient flow and COVID-19.

The inspection framework focused on key lines of enquiry under safe, responsive, and well-led and covered aspects of care that included care of the critically ill patient, infection prevention and control, patient flow, workforce, leadership, and culture.

We did not inspect any other services as this was a focused inspection in relation to urgent and emergency care. We did not enter any areas designated as high risk due to COVID-19.

During our inspection we spoke with eight members of nursing staff, two doctors, two hospital ambulance liaison officers, a physiotherapist, the ED matron, the clinical director for urgent and acute care, the chief of medicine, the chief operating officer, the director of nursing and the chief executive. We also spoke with two patients and three patient's relatives about their care and treatment.

We reviewed the records of 11 patients, staff rotas, safeguarding training records and governance records, such as audits and relevant policies and procedures.

The previous rating of requires improvement remains. As a result of this inspection the rating limiter which restricted the rating in safe to inadequate has been removed. This key question is now rated requires improvement.

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https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

Urgent and emergency services

Requires Improvement

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff were up to date with their safeguarding training. However, a recovery plan was in place to address this. This inspection took place during the Covid 19 pandemic.

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

The design, maintenance and use of facilities, premises and equipment kept people safe.

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

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

People could not always access the services they needed in a timely manner. Waiting times from referral to treatment were in line with national standards. However, arrangements to admit, treat and discharge patients were not always in line with national standards.

Leaders had the skills and abilities to run the service and were visible and approachable in the service for patients and staff. They understood and managed the priorities and issues the service faced. However, some issues were not always effectively responded to in a prompt manner.

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders and teams used systems to manage performance. They identified and escalated relevant risks. However, sometimes there was a need for a more proactive and integrated approach to risk mitigation. The service had plans in place to cope with unexpected events.

Is the service safe?

Requires Improvement

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff were up to date with their safeguarding training. However, a recovery plan was in place to address this.

Urgent and emergency services

All the staff we spoke with were able to inform us how they would recognise and report potential abuse in line with local and national safeguarding procedures. Safeguarding posters were on display and staff also knew where to find the trust's safeguarding policies and procedures which were located on the intranet.

The electronic records system used by staff contained safeguarding prompt boxes that staff had to complete. Records showed that safeguarding concerns were assessed and escalated in line with national guidance. Staff in the children's ED showed us a recent example of how an appropriate safeguarding concern was identified, escalated, and reported.

There was 67% compliance with adult safeguarding training within the ED. The trust had an outstanding requirement notice in this respect from our previous inspection. The trust told us that training compliance had reduced during the pandemic as this had resulted in additional work pressures and staff absences. However, the trust had a recovery plan in place to address the compliance gaps with the target date set for full compliance by 29 March 2021.

There was 72% compliance with children's safeguarding within the whole ED. However, 80% of children's ED staff had completed level three safeguarding training in line with national guidance. Of the remaining 20% of staff, two staff member's safeguarding training was in progress and the third staff member was not currently working in the department. This meant most children's ED staff had completed or were in the process of completing this training.

Cleanliness, infection control and hygiene

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

Staff followed safe infection control principles including the use of personal protective equipment (PPE) in all patient areas. Hand washing facilities and PPE were readily available throughout the ED. Patients and their carers were also able to access face masks on entry to the ED.

The ED had dedicated areas for staff to put on and remove PPE and those areas contained signage to guide staff on what PPE to wear and how to put this on. However, we noted designated 'red areas' (areas where patients were either COVID-19 positive or suspected to be positive for COVID-19) were not clearly signed to remind staff on the PPE required to safely enter these areas. Despite this, all staff we spoke with and staff we observed were wearing appropriate PPE.

Patients who presented with COVID-19 symptoms or other potentially infectious conditions were appropriately moved to 'red areas' to ensure the risk of infection transmitting to other patients was reduced.

All areas within the ED were visibly clean and had suitable furnishings which appeared clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

A policy was in place for terminal cleaning (a procedure required to ensure than an area has been cleaned/ decontaminated after a patient with a transmissible infection has been cared for in, to make it safe for the next patient) and we saw this was followed promptly when isolation/cohort areas were vacated to create capacity.

The trust evidenced that they monitored the effectiveness of their infection and prevention control (IPC) policies and procedures through audits. These were completed by the trust's IPC teams and IPC link staff within the ED. Where concerns had been raised through audits, action plans were in place to ensure the concerns were addressed in a timely manner. For example, we saw that ripped chairs which posed an IPC risk had been removed from the ED and replaced with new chairs.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

ED COVID-19 pathways were based on national guidance. The trust had implemented 'Red' and 'Green' areas within the ED to mitigate the risk of infection transmission. Red areas were designated as high risk COVID-19 areas which enabled staff to provide care and support in line with the trust's COVID-19 risk assessments. Green areas were designated as safe areas for patients not suspected of having COVID-19.

There was an 'emergency department social distancing escalation plan' in place that guided staff on how to monitor, manage and escalate times of increased capacity in each area of the ED. This ensured that staff had access to the information required to recognise and escalate occasions when the ED was at risk of becoming less COVID-19 secure.

There was evidence in the main ED waiting room to show thought had been given to promote social distancing by using social distancing signage and making some seats out of use. However, there was limited evidence to show the same thought had been applied to the children's ED waiting area. We escalated this to staff during inspection who said they would address this by placing new out of action signage on chairs that had previously been removed by children attending the ED. We received information following the inspection the trust had actioned this.

Staff carried out daily safety checks of specialist equipment. Logbooks evidenced that equipment such as resuscitation trolleys and associated equipment were checked daily to ensure they were safe and ready for use.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, data showed that this was not the case in times of increased demand.

Patients arrived at the ED as walk in patients or by ambulance. We saw systems were in place to ensure all patient's received timely initial assessment on arrival to the ED. We observed patients being triaged routinely within 15 minutes of arrival where they were then streamed to the appropriate area within the ED. The trust reports triage times to the Care Quality Commission (CQC) in accordance with a condition on their registration. Data from 17 December 2020 to 27 January 2021 showed that 98.07% of all patients attending the ED were triaged within 15 minutes of their arrival. This exceeded the trust's target of 95% and was a significant improvement from our last inspection.

Patient records showed that staff completed risk assessments for each patient on admission, using recognised tools. This included risks such as sepsis, falls and risks to patient's skin. We saw that where a risk was identified appropriate action was taken to mitigate these risks.

Patient records showed that patients who had been assessed and identified as presenting with suspected sepsis received care that was in line with national guidance. This meant they were treated appropriately for suspected sepsis within the hour. The electronic patient records raised visual alerts to highlight each patient's sepsis screen status and the nurse in charge monitored these records to ensure patients received appropriate care. This is an improvement from our previous inspection.

The nurse in charge completed daily sepsis audits for all patients to monitor compliance with sepsis assessment and treatment. This meant staff were provided with timely feedback if any concerns were identified, to ensure appropriate

sepsis assessment and treatment was maintained. Senior staff told us how these audits were then monitored for themes to ensure sepsis care was safe and appropriate. For example, recent audits had shown a decrease in compliance with administering intravenous fluids to suspected sepsis patients. This had triggered staff to explore why this was occurring. Results from this exploration confirmed that the omission of intravenous fluids was deemed clinically appropriate for these patients and their patient records reflected this clinical decision.

Patient records showed and staff told us they used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The trust used the national early warning score system (NEWS2) for adults and paediatric early warning scores (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs of respiratory rate, oxygen saturation, temperature, blood pressure, pulse and heart rate. Records showed that when these scores increased, appropriate escalation took place to assess and respond to clinical deterioration.

At times of increased demand patients brought by ambulance waited in the backs of ambulances. Whilst this did not happen during our inspection, data in the three weeks prior to inspection showed the trust had been worse than the national average for ambulance hand over delays. These patients were cared for by ambulance personnel during their wait to be admitted to the ED. Whilst the hospital staff had triaged these patients, they relied on ambulance personnel to escalate any concerns or deterioration in the patient's condition.

Regular safety huddles were carried out throughout the day to ensure safety risks were continually assessed, monitored and acted upon. A safety huddle is a short multidisciplinary briefing that focuses on the patients most at risk.

Staff shared key information to keep patients safe when handing over their care to others. Handovers were completed on each shift change where patient and departmental risks were discussed.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Staffing rotas from 3 January 2021 to 30 January 2021 showed minimal unfilled shifts. There were 30 unfilled twilight shifts. However, in response to these shifts being unfilled, the numbers of nurses working the day and night shifts was increased to fill this gap. Staff told us that unfilled shifts were escalated to senior leaders who filled these shifts with bank, agency staff or staff from other areas of the hospital. There was regular review of patient acuity which meant that more staff could be requested in times of increased capacity and surge to promote patient safety.

The children's ED was staffed in line with national guidance with planned staffing exceeding this guidance at times, meaning that three children's nurses were planned to be on shift rather than the recommended number of two. Rota's from 3 January 2021 to 30 January 2021 showed that two shifts had just one children's nurse on shift, rather than the recommended two. However, the risks associated with this were mitigated by ensuring support was available from staff on the children's ward and/or staff from the adults ED who had children's competencies.

Due to Covid related sickness, bank, and agency staff (temporary staff) were being used in the ED. We saw most of the sickness was covered by bank staff. When agency staff were used these staff were familiar with the ED and were block booked where possible to ensure consistency for the service.

Urgent and emergency services

New staff told us they had completed a throughout induction and had spent time observing clinical care in a supernumerary capacity before working independently.

There was a named nurse in charge on each shift. Staff knew where this nurse was in the department and on the day of our inspection, this nurse was observed to have a good oversight of the ED.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Staffing rotas from 3 January 2021 to 30 January 2021 showed no unfilled shifts. There was consultant presence in the ED 16 hours a day, appropriate on call cover and two paediatric emergency medicine consultants in post which met national guidance.

There was a shortage of middle grade ED doctors. However, regular locums were utilised to address these shortages and recruitment to these posts was ongoing.

Medical staff told us that they were appropriately supported with the training and induction needs.

There was a named emergency physician in charge (EPIC) on each shift. Staff knew where this doctor was in the department and on the day of our inspection, the EPIC was observed to have a good oversight of the ED.

Is the service responsive?

Requires Improvement 

Access and flow

People could not always access the services they needed in a timely manner. However, arrangements to admit, treat and discharge patients were not always in line with national standards.

Data showed that patients arriving to the hospital from ambulances experienced delays in being admitted to the emergency department (ED). From June 2020 to December 2020 the National Ambulance Information Group data shows there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Russells Hall. Between August 2020 and December 2020 there were consistently high numbers of turnaround times that exceeded 60 minutes. Increased ambulance turnover times means there is a risk that people in the community who dial 999 may experience delays in receiving ambulance care.

ED and trust leaders told us they had responded to concerns raised by the ambulance service about delays in offloading ambulances and had made changes to ED systems. This included, deploying a doctor to the ambulance entrance area to

work alongside a triage nurse, ensuring early clinical assessment was completed and if appropriate patients could be treated and discharged directly from the ambulance. This was in addition to the standard practice of triaging ambulance arrivals and working with hospital ambulance liaison officers (HALOs) who were employed by the local ambulance trust to help manage the hospital – ambulance interface and release ambulances quicker to respond to the next emergency.

Although it was too early to confirm the trust's response to the ambulance offloading concerns had been effective or was sustainable, data reviewed from the time following our inspection showed improvement with ambulance turnaround times. NHS England – published A&E Situational Report (SitReps) show that for the week ending 21 February 2021, 92 ambulances exceeded the 30-minute time, which was an improvement from the six-week average of 224 reported on 2 February 2021.

Staff from the ED participated in regular bed flow meetings. However, national targets around patient flow in the ED were not always met. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department. NHS England - A&E Waiting times data from January 2020 to December 2020 showed the trust did not meet the standard but did perform better than the England average.

There were significant delays in moving patients from the ED to speciality wards in the hospital. This meant patients stayed in the ED for longer than expected and meant ambulance offloading was challenging. NHS England - published A&E SitReps data from January 2020 to December 2020 showed the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. Peaks in four-hour waits occurred in January 2020 and September and October 2020.

NHS England - A&E Waiting times data from January 2020 to December 2020 showed that 152 patients waited more than 12 hours from the decision to admit until being admitted. January 2020 saw the highest number of 12 hour waits with 108 patient's waiting more than 12 hours. December 2020 was the second highest month for 12 hour waits with 20 patients waiting more than 12 hours for admission.

Overall, the average amount of time spent in the ED for all patients was lower than the England average. NHS Digital - A&E quality indicators shows that the median total time in the ED per patient between April 2020 and November 2020 was lower than the England average.

The number of patients leaving the service before being seen for treatments was lower than the England average. From December 2019 to November 2020 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was better than the England average.

Is the service well-led?

Requires Improvement ● ➔➔

Requires improvement

Leadership

Urgent and emergency services

Leaders had the skills and abilities to run the service and were visible and approachable in the service for patients and staff. They understood and managed the priorities and issues the service faced. However, some issues were not always effectively responded to in a prompt manner.

Emergency department (ED) senior leaders displayed the qualities required for effective leadership. This included being approachable and accessible. Staff told us and we saw that senior leaders were visible in all areas of the ED. All the staff we spoke with told us they felt supported and valued by their ED leaders.

Leaders within the ED had successfully driven significant improvements within the department, including improving patient triage times and sepsis management.

Staff told us that ED leaders recognised and understood the priorities facing the department. However, we saw that these priorities were not always managed in a prompt manner. Concerns around ambulance wait times had been an ongoing concern for a considerable time. We did identify that recent changes had been made to the processes in place to reduce ambulance waits, this included a doctor being based at the ambulance entrance during times of increased demand who completed early clinical assessments of patients waiting on ambulances alongside the existing nurse who triages patients on ambulances. The chief executive had also recently installed a screen in her office which enabled her to monitor and act upon ambulance waits throughout the day. Early data for the week post our inspection suggested an improvement to ambulance delay numbers. However, it was too soon to identify if this improvement will be sustainable.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that despite the increased pressures from the pandemic, they felt respected, supported and valued by ED and trust leaders.

We observed mutually respectful interactions between staff and patients. Patients and their relatives whom we spoke with were complimentary about their care and they told us they felt able to raise concerns should they wish to do so.

Staff told us they were able to raise and escalate concerns and staff gave us examples of recent occasions there they had been supported to do this.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks. However, sometimes there was a need for a more proactive and holistic approach to risk mitigation. The service had plans in place to cope with unexpected events.

ED and trust leaders had access to technology that enabled them to have consistent oversight of oversight of ED performance. Staff and leaders had access to real-time performance data for the ED. The electronic records system provided a live display of patient acuity, waiting times and specific performance areas such as sepsis management. We saw senior staff and leaders monitor this data throughout our inspection to ensure the care provided was safe and appropriate.

Urgent and emergency services

Organisation and patient safety risks were recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and review dates were set and met. Minutes of committees, governance and board meetings showed that the risk register was discussed on a regular basis which showed there was senior management and board level oversight and management of risk.

We identified that on occasions there was a lack of a proactive and integrated approach to risk. We found that the concerns reported on under access and flow were on the ED risk register. However, the risks that long ambulance waits posed to the wider system and public were not reflected in the risk detail. The risk register record for this entry did not reflect the risks placed on ambulance staff/services for waiting with patients for lengthy periods of time. Neither did it record the potential impact this risk posed to members of the public who were at risk of not receiving timely ambulances. The chief operating officer and her team had daily meetings with other stakeholders to review the delayed discharges from the hospital to manage the flow through the hospital. However, there was little evidence of proactive management of system working to affect a timely discharge. The need for proactive, multi-agency working on this issue was also not reflected in risk mitigation plan.

ED leaders told us how they attended regular leadership huddles. These huddles included leaders from other acute specialities within the trust with the aim of discussing and problem-solving operational issues, including issues with ED access and flow.

Escalation plans for times of increased demand were in place and staff told us these were enacted when required. The ED surge and escalation plan was under review and we saw that standard operating procedures around ambulance offload delays and COVID-19 had been updated in response to changing risks.

ED leaders had used the CQC's Patient FIRST model in response to the pandemic. Patient FIRST is a support tool designed by clinicians, for clinicians. It includes practical solutions that all emergency departments could consider. Implementing these solutions supports good, efficient, and safe patient care - for both adult and children's care. We saw that using this model had resulted in some positive changes for patients. This included working with another service provider on the introduction of timed appointment slots for patients to attend the ED via the 111 service (111 services are phone and web-based services that help people get the right health care advice and treatment when they urgently need it). We spoke with a patient and their relative who had accessed the ED using this system and they were very complimentary about how it had worked positively for them. The trust led the Black Country for the emergency ambulance standard. Currently the trust is ranked 13 out of 32 trusts in the West Midlands.

Areas for improvement

We told the trust that it should take action to prevent it failing to comply with legal requirements in future or to improve services.

- The trust should continue to work towards achieving improvements in staff compliance with safeguarding training.
- The trust should consider implementing a system that includes visual prompts at red area access points to remind staff of the PPE requirements before entering these areas.
- The trust should consider how to make children, young people, and their relatives aware of social distancing requirements within the children's ED.
- The trust should continue to work with the wider health and social care system to improve flow from the ED to speciality wards.

Urgent and emergency services

- The trust should consider taking a more proactive and integrated approach with regards to the assessment and management of the risks associated with ambulance offload delays.

Our inspection team

The team that inspected the service comprised a CQC Head of Hospital Inspection, a lead inspector and a specialist adviser, who was an emergency department physician.