Chesterfield Royal Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Chesterfield Royal Hospital NHS Foundation Trust provides acute services from Chesterfield Royal Hospital. The trust provides a full range of acute services plus a 24-hour emergency department service including critical care.

Chesterfield Royal Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries, as well as patients who are ill or seriously ill.

We carried out an unannounced focused inspection of the emergency department (ED) at Chesterfield Royal Hospital on 19 August 2019. Concerning information received by CQC before this inspection suggested that patients may not have been identified quickly when their condition deteriorated, and that safeguarding concerns were not always followed up appropriately.

We did not inspect any other core service or wards at this hospital or any other locations provided by Chesterfield Royal Hospital. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection. However, the ratings for the service overall and the five key questions remain good overall.

Our key findings were as follows;

- We found that staff were unaware of safeguarding risks relating to potential access to medicines and sharps by patients who were being treated for mental health conditions.
- We saw that the environment was visibly unclean with soiling to floors and walls. There were bags of clinical waste in treatment rooms and waiting areas.
- Cubicles were not quickly prepared when patients had left them. Several were left with bloodied and soiled sheets for some time. Trolleys were not always cleaned between uses, however, sheets were changed.
- A patient with a confirmed infection was not cared for in isolation. Staff were observed entering and leaving without appropriate personal protection equipment and without washing their hands. This was not in line with National Institute for Health and Care Excellence (NICE) guidelines for hand decontamination. Some hand gel dispensers were found to be empty.
- Sharps were not always disposed of correctly. Sharps bins were not all correctly dated in line with the trust's policy for managing sharps.

Summary of findings

- We were not assured that the minors area was well supervised. We observed children left unattended in close proximity to adult patients, including a patient in police custody. There were no call bells in these cubicles.
- We found unsecured medical gases on corridor areas. These included oxygen and other medical gas cylinders. This presented a risk of harm to patients and staff as they could cause injury if they fell over. There was also a risk of misuse of a pain relieving gas as it was freely available in public areas.
- We found equipment unsecured and freely available to patients and the public in unlocked treatment rooms. These items included sharps and injectable medicines.
- The main department was severely overcrowded with patients being cared for on trolleys outside rooms which blocked the doorways to cubicles. This led to a risk in the case of a medical emergency, evacuation or fire. Access to emergency resuscitation equipment was not available in the corridor.
- The nearest resuscitation equipment was in the resuscitation room. This meant that in the event of a medical emergency, there was a risk of delay in accessing emergency equipment for patients in cubicles.
- There was poor visibility of some patients across all areas of the department. Due to overcrowding of the corridor we saw that patients in the cubicles were not visible or easily accessible.
- The department had a sepsis pathway which followed national guidelines. It was robust and included clear instructions on flags and actions to take. The pathway was not known well in the department and staff were not aware of the triggers and flags contained in the pathway. We saw examples of this pathway not being followed despite patients meeting the criteria.
- The adult resuscitation room was easily accessible to patients and the public when not in use. The fridge was unlocked and contained many medications including insulin, intravenous (IV) sedation, and anaesthetic drugs. All of these medications if ingested or used incorrectly could result in severe harm or death.
- Staff were not always aware of changes or learning shared from recent incidents, complaints and mortality reviews.

However, we also found areas of good practice;

- There was effective working between the urgent care centre (UCC) streaming nurse and the ED. This ensured safe and efficient transfer of ambulatory patients from the urgent care centre to the ED.
- There was active management of the triage queue by senior nurses and doctors to prioritise patients with high risk conditions.
- There was good compliance with completing initial physiological observations, and in all cases this was within 15 minutes of the patient's arrival.
- Nurse and medical leaders worked well with the active transfer team from outside the ED to move patients on to appropriate areas which freed up space in the ED for other patients. The ED leaders utilised an 'early bed booking' system to prioritise beds for patients who needed them. Risks and issues were shared at regular 'huddles' during the shift.

Following this inspection, we wrote to the trust with details of the most significant concerns and asked them to tell us how they intended to improve these. The trust responded with a detailed plan of actions to address the most significant concerns. They told us they had carried out remedial work within 24 hours of receiving notification of our concerns.

We also told the trust that it must take some actions to comply with the regulations that had been breached and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices to help the service improve.

Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Good 	We carried out an unannounced focused inspection of the emergency department to follow up on concerns we had about an increase in complaints and serious events. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection. However the previous overall rating of good remains for the service.

Summary of findings

Contents

Summary of this inspection

Background to Chesterfield Royal Hospital

Chesterfield Royal Hospital NHS Foundation Trust provides acute services from Chesterfield Royal Hospital. The trust provides a full range of acute services plus a 24-hour emergency department services including critical care.

The trust has 547 inpatient beds, employs around 3,900 people and has approximately 100 volunteers.

We carried out an unannounced focused inspection of the emergency department at Chesterfield Royal Hospital on 19 August 2019. Concerning information received by CQC before this inspection suggested that patients may not have been identified quickly when their condition deteriorated, and that safeguarding concerns were not always followed up appropriately.

We did not inspect any other core service or wards at this hospital or any other locations provided by Chesterfield Royal Hospital. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

Chesterfield Royal Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries, as well as patients who are ill or seriously ill.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two CQC inspection managers and an assistant inspector. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Chesterfield Royal Hospital

Chesterfield Royal Hospital NHS Foundation Trust provides acute services from Chesterfield Royal Hospital. The trust provides a full range of acute services plus a 24-hour emergency department services including critical care.

The emergency department accepted patients from the local area and had all the facilities required to treat patients with illness and injury including serious illness and injury.

The department consisted of three main corridor areas which were joined together by a staff base. There was a large newly built area for receiving patients via ambulance, cubicles to treat major injuries and illness, smaller cubicles to treat ambulatory patients, a plaster room, two clean utility rooms, an adult resus room, and a separate paediatric resus room, one nurse-led START cubicle (simple triage and rapid treatment), three triage rooms, one waiting room and a quiet relatives room (which was also used as a mental health assessment room). The department also had two children's cubicles.

During the inspection, we visited the emergency department only. We spoke with nine members of staff including; nursing staff, medical staff, and senior managers. We spoke with five patients and four relatives. During our inspection, we reviewed around 15 sets of electronic patient records and a variety of other information in and around the department. We also observed a meeting between the department lead and the bed coordinator.

Good

Urgent and emergency services

Safe	
Caring	
Well-led	

Are urgent and emergency services safe?

Safeguarding

Staff mostly understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff were unaware of safeguarding risks such as potential access by patients to medicines and children being exposed to inappropriate sights

- Most staff were up to date with training on how to recognise and report abuse and they knew how to apply it.
- We checked to see whether the trust had made changes following an incident relating to missed opportunities in reporting safeguarding concerns. We found that most of the actions had been completed. Staff were clear who the safeguarding champions were and there was an information board outlining safeguarding information for staff, who told us they were confident about making referrals. They had received training, however only 84% of staff were currently compliant with refresher training.
- We saw that children were being treated in an area where there were adults in police custody and with mental health conditions. This meant that children were exposed to sights that might be upsetting for them.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff kept themselves clean, but some equipment and the premises were not clean. They used some control measures to prevent the spread of infection. They did not manage waste well.

- We saw that the environment was visibly unclean with visible soiling to floors and walls. There were bags of clinical waste in treatment rooms and waiting areas which meant clinical waste was not stored securely.
- We saw used swabs and tissues with blood and sputum on floors which were not removed between changes in patients. Trolleys were not always cleaned between uses, however, sheets were changed.
- Cubicles were not quickly prepared when patients had left them. Some were left with bloodied and soiled sheets for some time.
- We noted dried blood on equipment in a clean utility room, the triage room and on a desk.
- A patient who required isolation due to an infection was not isolated. Staff were observed entering and leaving washing their hands. This was not in line with National Institute of Health and Care Excellence (NICE) guidelines for hand decontamination. Some hand gel dispensers were found to be empty.
- Sharps were not always disposed of correctly. Some were left out in treatment rooms and sharps bins were not all correctly dated in line with the trust's policy for managing sharps.
- There was a biohazard bag with a broken glass vial which had not been noted by staff in a clean utility room. This was brought to the attention of staff at the time and was removed.
- Staff adhered to the 'bare below the elbows' policy.

Following our inspection the provider told us about immediate remedial actions they had taken to improve control of infection, management of sharps and waste and improve cleanliness and hygiene. They had;

- conducted a deep clean of the department.
- allocated an additional member of cleaning staff to provide a 'rapid response' service when patients were being transferred from the department.
- removed all loose bags of clinical waste from clinical areas and provided additional waste bins to hold clinical waste.

- arranged for the domestic supervisor to monitor the cleanliness of the department twice daily.

Environment and equipment

The premises were not entirely suitable and some equipment was not looked after well.

- The main department was severely overcrowded with patients being cared for on trolleys outside rooms which blocked the doorways to cubicles. This led to a risk in the case of a medical emergency, evacuation or fire. Access to emergency resuscitation equipment was not available on the corridor. There was no space for accompanying relatives to wait or sit in the corridors which meant they needed to stand in the corridor. This contributed to overcrowding.
- We saw two patients living with dementia on trolleys in this area who appeared distressed and unaccompanied.
- We observed some patients on trolleys receiving treatment and consultations on the corridor, which could be overseen and overheard by other patients and relatives.
- There was poor visibility of patients throughout the department due to the layout and narrow corridors.
- There were no call bells in the cubicles within the minors area.
- Staff told us that the minors area would only be used for minor patients who were ambulatory. However we found that there were patients in this area with high risk conditions including mental health conditions, cardiac problems and children.
- The adolescent and children's room was unsecure. Staff told us, and we observed that this area was also used to accommodate adult mental health patients. The room had ligature risks, moveable furniture and did not have anti barricade doors. We saw that one adult patient with obvious self harm was placed in this room. This was not compliant with Royal College of Emergency medicine (RCEM) guidance which states that rooms used to conduct mental health assessments should be safe for both patients and staff. For example; free from ligature points and have two doors which open both ways to avoid barricading.
- There were two children's cubicles which were unsecured and easily accessible from the main waiting area. The children in this area were exposed to inappropriate behaviours such as aggressive patients in police custody who were shouting and swearing. They were also exposed to adult patients in distress and with obvious wounds. We saw that some children were left unattended. This included a young male who was partly dressed with the door open and fully visible to patients and visitors passing.
- We found unsecured medical gases on corridor areas which were not kept in cylinder carriers. These included oxygen and pain relieving gas cylinders. This presented a risk of harm to patients and staff as they could cause injury if they fell over. There was also a risk of misuse of medical gases as it was freely available in public areas.
- There was an unlocked store room which was out of sight of most staff but located where patients could easily access it. We entered unseen and unchallenged and were able to stay in the room for 10 minutes. The door was lockable from the inside.There were ligature risks present in this room and equipment was unsecured. This equipment included items which presented a risk of harm to patients and could be used as weapons including sharp instruments in cut down packs, needles, scissors and razors. This meant that patients could be exposed to the risk of harm.
- The clean utility rooms were in a public area freely open to patients and members of the public. We saw patients and relatives standing near the entrances. The clean utility had an unsecured and unlocked fridge containing injectable medicines. There was an intravenous (IV) fluid cupboard which was broken and held together by tape. This was open, and we were able to access and remove fluids including potassium. A second clean utility room was visibly unclean and cluttered with boxes. This posed a risk of injury and fire, as well as a risk of infection to patients as intravenous preparations were completed there.
- Bags of fluids were stacked on top of the cupboard and accessible to patients and the public and these included potassium containing fluids and fluids which were no longer sealed. This posed a risk of tampering and misuse.

- In the nearby corridor area and cubicles area we saw that patients with intentional self harm and mental health conditions, patients living with dementia and some children and adolescents were unsupervised. This posed a risk that these groups could access accidentally or intentionally items and fluids that could be life threatening.
- There was cleaning equipment unsecured and left in open areas of the department. These products were liquids that were harmful if ingested.

Following our inspection the provider told us about immediate remedial actions they had taken. They had;

- Secured equipment by installing locks on store rooms and treatment rooms.
- Secured medical gases by providing appropriate storage carriers.
- Provided privacy curtains in children's examination cubicles.
- Fitted anti-barricade doors for the room used for children and adolescents and removed ligature points.
- Reviewed their Corridor Care Standing Operating Procedure with a view to identifying additional actions to minimise risk.
- Installed call bells in the cubicles in the minors area.

Assessing and responding to patient risk

Staff completed risk assessments for each patient but did not always update them in a timely way. Staff identified patients at risk of deterioration but did not always act upon this.

- Nursing staff used the National Early Warning Score (NEWS) and the Paediatric Early warning Score (PEWS) systems to record routine physiological observations such as blood pressure, temperature, respiratory rate and heart rate. Observations were recorded electronically and included a 'track and trigger' system whereby scores were displayed visually within the department.
- There was good compliance with completing initial physiological observations, and in all cases this was within 15 minutes of the patient's arrival. The department was not meeting the Royal College of Emergency Medicine (RCEM) standard for repeat observations within 60 minutes of an abnormal observation and not following or meeting the NEWS2 guidelines. For example, there was a patient with a NEWS of seven for a sustained period which rose to eight. This should have prompted continuous observation and instead their observations were recorded two hourly.
- Staff were not clear on how often observations should be taken and could not articulate their local policy.
- The department had a sepsis pathway which followed national guidelines. It was robust and included clear instructions on flags and actions to take. However, this pathway was not known well in the department and staff were not aware of the triggers and flags contained in the pathway. Some staff told us that they did not use the national early warning score (NEWS) to escalate a concern and other staff told us they relied more on their own clinical judgement. This meant there was a risk that sepsis would not always be identified in a timely manner.
- We found that in the records we reviewed, there was no documentation to indicate that the patients had been commenced on a sepsis pathway and four patients had not commenced on antibiotics within 60 minutes. We found that staff did not consistently record sepsis screening when this was clinically indicated. We raised this documentation issue with staff during the inspection. Following our inspection, the trust provided information to show they had reviewed patient records and found that all 23 patients who were in the department with an infection at the time of our inspection had been screened for sepsis.
- There was effective working between the urgent care centre (UCC) streaming nurse and ED. This ensured safe and efficient transfer of ambulatory patients from the urgent care centre to ED.

  We observed that the triage process was fast and comprehensive and that the most unwell patients were identified quickly and safely. There was active management of the triage queue by senior nurses and doctors to prioritise patients with high risk conditions.

Nurse staffing

Good

Urgent and emergency services

We did not have enough information to assess whether the service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment

- The nurse staffing levels and skill mix had met the rota requirements and were sufficient to meet the needs of patients during the period of our inspection.

Medical Staffing

We did not have enough information to assess whether the service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment

- The staffing levels and skill mix were sufficient to meet the needs of patients during the period of our inspection, however staff were aware that there was a recruitment gap for a consultant and we were told that agency consultants were frequently utilised to fill gaps in rota. Managers told us that regular agency consultants were used to ensure consistency.
- Two consultants were present in the department for the entirety of our inspection visit.

Medicines

The service did not store medicines safely. Staff did not lock medicines cupboards in line with national guidelines.

- We were not assured that controlled drugs (CD's) were recorded and managed in accordance with the law and relevant legislation. We found that the record book was incorrectly completed for Morphine with missing signatures and dates from the records. Having only one member staff signing for receipt of these medications meant that medicines could be misused, or mislaid. However the CD count was correct.
- In the adult resuscitation area there was easy access to the room when no patients were being treated there. We found the fridge to be unlocked and contained many medications including insulin, intravenous sedation, and anaesthetic drugs. All of these medications if ingested or used incorrectly could result in severe harm or death.
- In addition, there was unsecured oral liquid paracetamol and ibuprofen on a shelf, both of which were over labelled from 'take home' stock and neither had an 'opened' date. This posed a risk of intentional overdose and they may have passed the date when they would be required to be discarded.
- There was a used, open sharp in the fridge in a clean utility room.
- Fridge temperatures had not been recorded apart from one date in August.

Following our inspection the provider told us about immediate remedial actions they had taken to improve storage and security of medicines and recording of CDs.

Are urgent and emergency services caring?

Compassionate care

Although staff did not always manage to treat patients with dignity and privacy, feedback from patients confirmed that staff treated them well and with kindness.

- We found there was significant overcrowding in the department which impacted on patients privacy and dignity
- We found that patients privacy and dignity needs were not always respected. Throughout our inspection, we found patients being cared for on trolleys in the central area of the main department, outside cubicles where other patients were being cared for. This meant patients privacy and dignity needs were not always respected. We observed some patients still received interventions and examinations in this area and were sometimes left in stages of undress and exposing themselves.
- We observed a member of the medical team consulting with a patient from the doorway of a small cubicle where family members were in the room. The consultation could be clearly heard by other nearby patients.
- We also observed patients in gowns and states of undress cared for on the corridors highly visible to other patients and visitors.

- Computers were open and unlocked displaying highly detailed and sensitive information. These were easily accessible by the inspection team who were not challenged at any point.
  - We saw patient labels and results left unattended and available. This posed a risk that patients did not have their confidential information dealt with sensitively and securely and their privacy was compromised.
  - Staff appeared kind and caring with patients and relatives.
  - Food and drink was generally provided for patients who had waited in the department for a long time. However, we spoke with one patient who had waited in the department for many hours without being offered a drink.

Following our inspection the provider told us about immediate remedial actions they had taken to improve overcrowding in the main corridor by monitoring the situation more closely. Any trolleys not in use were to be removed from the area.

Are urgent and emergency services well-led?

Leadership

Managers did not always ensure the department was providing high-quality sustainable care.

- From our observations of the department, we were not assured that high quality care was consistently provided. However, leaders appeared to work well together and described processes and procedures which would enable the provision of good care.
- The leaders on the night shift were visible and offered advice and support to staff. And nursing and medical staff leaders worked well together.
- Nurse and medical leaders worked well with the active transfer team from outside the emergency department to move patients onto appropriate wards or areas to free up space in the ED for other patients and to maintain patient flow.
- There was a hospital senior manager present in the ED. Risks and issues were shared at regular 'huddles' during the shift.

Governance

The department did not use a systematic approach to continually improve the quality of its services or safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

- Staff were not always aware of changes or learning shared from recent incidents, complaints and mortality reviews.
- Nurse leaders described a governance structure in place where monthly meetings were held. The monthly sisters meetings and nurse meetings were chaired by the matron.
- Staff were aware of current risks and issues which were displayed on a wallboard for all staff to see.
- There was a Governance wall board which displayed the current governance dashboard and other performance data and risks.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to security and storage of medicines.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to security and storage of medical gases.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to security of equipment and store rooms.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to infection prevention and control, cleanliness and hygiene.
- The provider must ensure there is a clear plan for mitigating risks associated with overcrowding, including the location of patients.
- The provider must ensure that all patients are treated with dignity and respect, including ensuring discussions about care, treatment and support take place where they cannot be overheard.
- The provider must ensure that staff are able to adhere to the trust's policy and procedures for identifying and managing sepsis.
- The provider must ensure that staff meet the local or national NEWS2 guidance for repeat observations.

Action the provider SHOULD take to improve

- The provider should ensure that staff follow the trust's policy for monitoring fridge temperatures where medicines are stored.

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 Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for patients. • Systems in place to protect patients from the risk of harm and clinical deterioration were not consistently followed. • Equipment was not always stored safely. • Management of medicines, including secure storage was not conducted in a safe way. • Infection prevention and control measures were not consistently in place with regards to cleanliness. Regulation 12 (2) (a) (d) (g) (h)

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and privacy • Privacy was not always assured for people receiving treatment. • Discussions about care, treatment and support could be overheard by other patients and relatives.

This section is primarily information for the provider

Requirement notices

Regulation 10 (2) (a)