Cumberland Infirmary

Quality Report

Newtown Rd,
Carlisle
CA2 7HY
Tel: 01228 523444
Website: www.ncic.nhs.uk/locations/cumberland-infirmary

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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

Cumberland Infirmary is operated by North Cumbria Integrated Care NHS Foundation Trust. Trust operates from two district general hospital sites: West Cumberland Hospital (WCH) in Whitehaven; and Cumberland Infirmary in Carlisle (CIC). This report relates solely to Cumberland Infirmary in Carlisle.

CIC operates an emergency assessment unit; a 30-bedded unit for medical admissions.

The admission unit is supported by Acute Care Physicians (ACP). Emergency surgical admissions at CIC are via a 12 bedded and six trolleys surgical unit.

CIC also operates an emergency ambulatory care unit Monday to Friday supported by the acute medical and surgical consultants as well as nurse practitioners.

The CIC unit operates six chairs and two trolleys 9am – 8pm.

The consultant-led emergency department at CIC was open 24 hours a day, seven days a week, to provide an accident and emergency service for children and adults.

There were separate entrances for walk-in patients with a seated waiting area. Reception was used by both walk in patients and ambulance crews booking patients in to the department. There were 19 bays in the department, 10 of which were in the majors' area and could be made available for isolation of patients. There was a separately equipped ophthalmology treatment room, a designated mental health room and a separate area of the department designated for children, with a children's waiting area and a children's treatment room. The resuscitation area comprised three bays, which included one equipped for paediatric patients. The emergency department was a designated trauma unit. The radiology department was adjacent to the department and easily accessible. There was a private relatives' room with comfortable chairs, a telephone and drink making facilities.

During the inspection we visited the emergency department only. We spoke with 17 members of staff, including managers, doctors, nurses, non-clinical, and ambulance staff and volunteers. We reviewed 20 patient records. Inspectors spoke with five patients and relatives, observed the interaction of staff with patients, and observed a team huddle in progress.

We carried out an unannounced inspection of the emergency department at the Cumberland Infirmary on 24 February 2020 due to concerns of crowding and patient care.

Summary of findings

During this inspection we used our focussed inspection methodology. We did not cover all key lines of enquiry, we looked at the safe domain and aspects of both the responsive and well led domains.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

During this inspection we used our focussed inspection methodology. We did not cover all key lines of enquiry, we looked at the safe domain and aspects of both the responsive and well led domains.

We rated it as **Requires improvement** overall.

- Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.
- The design, maintenance and use of facilities, premises and equipment did not keep people safe.
- Staff did not complete risk assessments for each patient. This meant staff could not identify or quickly act upon patients at risk of deterioration.
- The service did not have enough nursing staff or support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Leaders had the skills and abilities to run the service however had not managed the priorities or issues the service faced. Local leaders were both visible and approachable within the service for patients and staff.
- Staff did not feel respected, supported or valued. And were not always 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 but a poor safety culture meant concerns were not always reported.
- The department did not operate an effective governance process, throughout the service or with partner organisations.

Following this inspection, wrote a letter of intent to the trust to gain assurance regarding the concerns we found in particular safe staffing, timely triage and assessment for both adults and children; In addition we told the provider that it must take some actions to comply with the regulations 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 three requirement notice(s) that affected Urgent and Emergency. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	**Requires improvement** 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. 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 found breaches of regulations from previous inspections had not been effectively acted upon. The quality of health care provided by North Cumbria Integrated Care NHS Foundation Trust required significant improvement.

Summary of findings

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Summary of this inspection

Background to Cumberland Infirmary

North Cumbria Integrated Care NHS Foundation Trust provides a comprehensive range of acute hospital for approximately 320,000 people across North and West Cumbria, with a total Cumbria population of approximately 500,000.

The trust is a newly formed legal entity following the acquisition of North Cumbria University Hospital NHS Trust by the Cumbria Partnership NHS Foundation Trust on 1 October 2019.

The trust manages 2 acute hospital sites and eight community hospitals. There is a workforce of over 5400 staff working across the hospitals and in the community.

The trust operates community inpatient hospital services from five community sites:

- Brampton War Memorial Hospital
- Mary Hewetson Cottage Hospital
- Cockermouth Hospital
- Penrith Community Hospital
- Workington Hospital.

Community services for children and young people and also adults including end of life care services are also provided in people's own homes and a range of community clinics across the geography of the trust.

Our inspection team

The team that inspected the service comprised of two CQC inspectors,a CQC inspection planner, and two specialist advisors with expertise in emergency department care. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Cumberland Infirmary

The Cumberland Infirmary emergency department is a consultant led service that operates 24 hours a day 7 days a week to manage critically ill patients including children. From 1 January 2019 to 31 December 2019 approximately 57,521 patients attended the department, 10,632 of which were children.

We carried out an unannounced focused inspection of the emergency department at Cumberland Infirmary on the 24 February 2020. The inspection took place in response to concerning information we had received in relation to patient care.

We did not inspect any other core service at this hospital, however we did discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry.

During our inspection we spoke to 15 members of staff, we spoke to patients, relatives and reviewed 20 sets of patient records.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated it as **Inadequate** because:

Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

Staff did not complete risk assessments for each patient. This meant staff could not identify or quickly act upon patients at risk of deterioration.

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

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

Are services responsive?

Requires improvement

We rated it as **Requires improvement** because:

People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Are services well-led?

Requires improvement

We rated it as **Requires improvement** because:

Leaders had the skills and abilities to run the service however had not managed the priorities or issues the service faced. Local leaders were both visible and approachable within the service for patients and staff.

Staff did not feel respected, supported or valued. And were not always 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 but a poor safety culture meant concerns were not always reported.

The department did not operate an effective governance process, throughout the service or with partner organisations.

Requires improvement

Urgent and emergency services

Safe	Inadequate
Responsive	Requires improvement
Well-led	Requires improvement

Are urgent and emergency services safe?

Inadequate

We rated safe as **inadequate**.

Safeguarding

Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.

Information provided to us following the inspection demonstrated that not all staff had undertaken the necessary safeguarding training. For example, 50% of the registered nurses deemed eligible by the trust had undertaken level two safeguarding training and 58% level three.

Only 41% of medical staff had completed level three safeguarding training. This was a concern and meant that staff may not recognise possible safeguarding concerns. On reviewing patient records during our inspection, we found information demonstrating that a safeguarding concern had not been reported by the department. This concern was reported retrospectively once highlighted to managers.

Staff explained that attending 'face to face' sessions was extremely difficult due to low staffing numbers and challenges in accessing the course. This meant the majority of training was completed online as electronic learning and that important discussions, examples of scenarios and professional curiosity did not take place. The Royal College of Paediatric and Child Health Safeguarding Children and Young People: roles and competences for health care staff intercollegiate document specifies that, all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should undertake level three training.

The service used a nationally recognised electronic child protection information sharing system embedded within the department. Any information received into the department was checked at the point of arrival and shared by way of a flagging system on the electronic record and by documenting on the triage paperwork. However, we found a case where an opportunity for a safeguarding referral was missed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

Patients presenting to the emergency department could not easily book in. During our inspection we saw this particularly after 6pm. There was only one space at the reception desk for patients booking into the department. And after this time, one of the two available desks were used by the out of hours general practice provider. A third desk had been created, however, this was unsuitable because it was at the back of the office and the staff member booking the patient in had to repeatedly walk back and forth to ask the patient information and type it into the system.

We observed that patients using the other two desks had to continually repeat their personal details as the microphone speakers did not work properly. patients in the waiting room could easily overhear private information resulting in a lack of confidentiality, privacy and dignity for all patients. Staff told us that this had regularly resulted in abuse.

Staff told us there was no connecting telephones between the emergency department and the reception area. If a patient became unwell the receptionist had to leave the area to summon help. This was also the case

when information from the child information sharing service highlighted a concern. This posed a risk that important information may not be transferred due to pressures placed on one individual, the front desk was left unmanned and caused delays in booking patient in. However, following our inspection we were informed there were two connecting telephones.

There were four computers in the doctor's office which meant that staff often had to wait to access a computer to input important patient details and request diagnostic tests. During our inspection we saw there were four computer terminals for 10 junior doctors. Staff told us this impacted upon patient care on a daily basis and was not in line with The Royal College of Emergency Medicine Emergency Department Care. Following our inspection the trust informed us there were ten additional computers on wheels (COWS) available within the department. However, at the time of our inspection they were not commonly used by junior doctors, the trust is addressing this issue.

Clinical waste was managed well in the department and in line with national guidance.

There was a separate children's emergency department and waiting room however, this consisted of one small room, with one trolley for both the treatment and triage of children, and a small waiting room with five seats. As the department saw on average 18,000 children per year, this was not in line with The Royal College of Paediatric and Child Health Standards for Children in Emergency Care Settings.

Due to the environment, key issues such as managing a deteriorating child, confidentiality, privacy and infection prevention and control could not be undertaken properly. During our inspection we saw there was no isolation area for children. One patient was left in the waiting room with other children whilst another was moved to a cubicle in the adult area without supervision from staff in the children's department. This was not in line with national guidance set out in the Department of Health Building Note 15-01: Accident and Emergency Department planning and design document.

There was no resuscitation trolley containing emergency equipment and defibrillator within the paediatric area, however, oxygen and suction and other basic equipment was available meaning initial resuscitation could be given. Senior staff told us they would transfer the child to a trolley and move to the resuscitation room in the emergency department. This was not in line with national standards and meant that if a child needed emergency resuscitation, they would need to be first moved to the resuscitation area, if a cubicle was available, causing a delay in time critical treatment.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. This meant staff could not identify or quickly act upon patients at risk of deterioration.

Comprehensive risk assessments were not undertaken in line with national guidance which meant the department could not respond appropriately to the changing risks of people using the services, such as those with deteriorating health or wellbeing.

On reviewing the triage times of 31 patients on the day of our inspection we found that 21 had waited beyond 15 minutes to be triaged, two of these patients had waited over an hour. This was not in line with The Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients document, which sets the standard for the time to undertake triage as within 15 minutes of arrival. No dedicated registered nurse was allocated to the triage area overnight and during our inspection we saw the triage area was frequently left unmanned.

Patients were not streamed to other services or areas of the hospital unless they had first been assessed by a clinician. In this instance patients could be sent to the Same Day Emergency Care unit and to the co-located primary health care service.

The department did not have a robust system for identifying seriously ill patients such as those suffering from neutropenic sepsis or for them to bypass the waiting area as set out in the cancer assessment framework, National Institute for Health and Care Excellence CG151 Neutropenic sepsis: prevention and management in people with cancer. This meant that not only did patients have to wait for extended periods of time before a time critical illness was identified, they also had to sit in a waiting room where the risk of infection could cause further harm or suffering to them.

The rapid assessment treatment area where patients arrived by ambulance consisted of four cubicles. This

area was staffed between 10am and 10pm by an employed paramedic and a band five nurse, where possible. During our inspection we saw there were two paramedics manning the area. There was no medical staffing within this area due to a shortage of medical staff. There was no provision for any cases arriving after 10pm. Staff we spoke with told us that all patients arriving directly to the resuscitation area were reviewed quickly by a senior doctor.

During our inspection, we saw that important risk assessments, such as early warning scoring, and safety checklists, were not completed in line with trust policy. This included missing checks, incomplete checks and unlabelled documentation. We reviewed 20 sets of patient records and found that eight did not have the relevant checks.

Department leaders had identified this was a problem through their audit processes and had written to staff in an attempt to rectify it. However, staff we spoke to told us that when the department was busy comfort checks which formed part of the patient safety checklist such as nutrition and hydration, pressure area care and pain relief were rarely done giving an example of one registered nurse caring for between 10 and 16 patients.

Information provided to us by the trust following the inspection demonstrated that the department, over a six-month period between August 2019 and February 2020, had achieved between 79% and 100% compliance in the early warning score audit, scoring 100% on two occasions and on three of the six occasions the documentation was found to be incomplete. This was a concern because early warning tools are used to identify deteriorating patients early, the system employed by the department to identify such patients could not be effective and meant the department was not operating in line with the Royal College of Emergency Medicine Emergency Department Care best practice guidelines, the National Institute for Health and Care Excellence (NG51) Sepsis: recognition, diagnosis and early management or The Royal College of Paediatric and Child Health Facing the Future: Standards for Children in Emergency Care Settings (2018).

Patients and relatives that we spoke with during our inspection told us they considered staff to be caring and empathetic however, some told us that privacy and dignity was a significant issue, as conversations could be heard in the corridors and cubicles with only curtains between the patients. Patients also told us that a lack of food and drink provision for both patients and relatives was upsetting, as there was no routine food or drink rounds.

The doctor in charge of the department was aware of all patients and knew what was happening with each of them. Staff we spoke to during the inspection told us that referral to specialty teams worked well and that the teams could often be found reviewing patients within the department. A medical ward round took place in the form of a board round of patients however was done from the medical assessment unit.

Turnaround data for pathology testing that we reviewed during our inspection demonstrated that 90% of basic test results were available within one hour. This demonstrated good practice and was in line with the recommended standard.

All policies and guidelines were available for staff on the trust intranet. We found these to be easily accessible. During our inspection we spoke to three doctors who were all able to identify how to access these guidelines.

Nurse staffing

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

Staffing within the department had been set by the trust using a recognised staffing tool. Leaders within the department told us they had not had input into this. At the time of our inspection we saw there were three registered nurses on bank shifts within the department. Information provided to us by the trust following the inspection demonstrated that in January 2020 there were 211 whole time equivalent (full time) vacancies across the site. The information provided did not demonstrate the vacancy or turnover rate within the department. However, unanimously, staff of all disciplines spoken with told us their biggest safety issue was the lack of registered nursing staff.

Staff told us they regularly cared for between 10 and 16 patients and rarely had breaks or finished on time. This was echoed within incident reports from the department

which highlighted occasions since September 2019, where three registered nurses had been caring for the entire department of patients. Feedback form incidents that reported low staffing levels and compromised patient care, was that senior managers were looking to staffing establishment levels.

There was three registered sick children's nurses within the department, which meant that children were not always triaged or looked after by a nurse with specialist training in caring for children. However, we did not find evidence of harm in relation to this.

Registered adult nurses within the department had not undertaken any specific additional training to provide the knowledge, skills or competencies necessary to care for infants, children and young people. This was not in line with the Royal College of Paediatric and Child Health, Facing the Future: Standards for children in emergency care settings (2018) and meant the department could not be assured that children were provided with the most appropriate and timely treatment.

An electronic rostering system was used to allocate staff duties however, key skills such as advanced adult and paediatric life support were not taking into account at the point of allocation.

Bank and agency staff received an induction to the department, had access to policies and procedures on the trust intranet and were able to generate incident report forms.

On the first shift, they worked closely with another member of registered nursing staff. Bank staff were not allowed to work within the triage area of the department.

Medical staffing

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

The emergency department had 8.4 whole time equivalent consultants within the department. Each year the department had approximately 57,500 attendances each year, this meant there was an approximate ratio of one consultant to every 6,800 patients. This was not in line with The Royal College of Emergency Medicine Consultant Workforce Recommendations (2018), of one whole time equivalent consultant to every 4000 new attendances.

Consultants achieved the standard of being on site for 16 hours and then provided an on call rota for the remainder of the time however, the department was often covered overnight by a doctor of ST3 level – this was a qualified doctor who had three years of specialty training in emergency medicine. This was not in line with the Royal College of Emergency Medicine Consultant Workforce recommendations, that overnight the department should be staffed by an ST4 (specialist emergency department doctor) or above.

This was a concern because the minimum standard set is designed to protect patients and practitioners and those who have not yet achieved the correct level of training may not always have advanced training such as advanced paediatric life support.

The department had one dual trained emergency consultant however, we saw that this medic covered both adults and children.

General practitioners and advanced clinical practitioners worked within the department. The GP's did not specifically see primary care patients, staff told us they saw a large amount of the children attending the department in the evenings as they felt they added most value and were less risk averse in paediatric management than junior doctors.

Junior doctors and trainee clinical practitioners spoke highly of the mentoring and teaching within the department and felt their rota commitments were satisfactory.

Incidents

Staff did not always recognise and report incidents and near misses. Although when incidents were reported managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

We saw that over a six month period between September 2019 and February 2020 there had been 179 incidents

reported within the department. The main themes of these incidents were safeguarding concern reporting, pressure area damage, staffing issues and delays in treatment and care.

Staff we spoke to during our inspection told us they did not always report issues such as difficulty in providing care for patients due to lack of staffing because they felt little was done in response to the issues and often, they were too busy to take the time to report incidents.

Staff and managers understood duty of candour and knew how to apply it appropriately.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated responsive as **requires improvement.**

Access and flow

People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

During our inspection we found that patients struggled to access the services due to demand and lack of bed space within the hospital. At one point, 16 patients in the department required inpatient beds but none were available. These patients had waited in the department up to 13 hours from the decision being made to admit them.

This was mirrored by national data which had been taken over a two-week period from the 19th February 2020. Data demonstrated the four-hour performance for the department was at 76% and 52% of people were treated in less than 60 minutes. The standard set by the Department of Health for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department and that all patients treated within 60 minutes of arrival.

Bed occupancy levels for the hospital were at 95% with 100 escalation beds open during February 2020 and 22% of patients had been in the hospital for longer than 21 days. Senior trust leaders told us that acute admission patient went to the emergency department instead of the acute medical unit because of the backlog. This meant there was an increased flow of patients through the department.

Several patients we spoke to during the inspection were distressed by the long waits. Two patients in particular had been told at lunchtime that a bed was unlikely to be available before midnight

Of the 31 patients we reviewed up on the electronic system during the inspection, we saw that the time patients were waiting for initial assessment ranged between 16 minutes to two hours 22 minutes.

The department were included in the trust escalation, patient flow and full capacity protocol. This listed actions such as ensuring patients were referred to sub-specialties immediately following decision to admit and ensuring the site coordinator were aware of any three to four-trolley waits.

The expectation of the departmental nurse in charge, who was not supernumerary, was to ensure that capacity issues, waits for assessment and assessing ambulance turnaround issues were dealt with. There was no further explanation as to how this could be achieved. This meant that staff had no option but to react individually based on their own interpretation of the protocol.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership

Leaders had the skills and abilities to run the service however had not managed the priorities or issues the service faced. Local leaders were both visible and approachable within the service for patients and staff.

Requires improvement

Urgent and emergency services

Local leaders were able to understand and also experienced on a daily basis the challenges to quality and sustainability which the department faced. This included concerns relating to paediatric care, triaging patients, patient flow and staffing issues. However, were not able to identify actions to address them.

Senior leaders were not highly visible within the department. Staff within the department told us improvement works had 'stalled', partly because "the plans were too ambitious". However, the trust informed us refurbishment works had been delivered, and plans had been agreed by senior members of the trust.

There appeared to be little collaboration between the department and executive teams to improve safety and quality within the department.

Culture

Staff did not feel respected, supported or valued. And were not always 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 but a poor safety culture meant concerns were not always reported.

Staff we spoke with did not feel engaged, often did not have breaks and worked beyond finish times.

First line clinical managers within the department were included within the staffing numbers and were not supernumerary. This meant managing issues such as levels of staffing to was extremely difficult whilst still undertaking patient care

Staff appeared to have accepted issues within the department as normal practice and failed to incident report key issues regularly such as lack of ability to provide basic care needs or to complete core tasks or department delays.

Governance, risk management and quality measurement

The department did not operate an effective governance process, throughout the service or with partner organisations.

In terms of governance structure, staff had the opportunity to regularly meet and discuss performance of the service. This was in the form of a monthly staff meeting and registered nursing sisters' meetings which were minuted and well attended. Minutes were made available for those who could not attend.

We were told there was a monthly consultant meeting, however, minutes were not recorded.

At the time of our inspection, departmental leaders told us that regular weekly and monthly governance meetings (Agenda for change) were held in the sisters office. However, leaders recognised due to staff absences and operational pressures the meetings were not happening as regularly as they were planned. This highlighted a disconnect between the department and the board for the sharing of important information from board to ward.

At the time of inspection there was no mortality and morbidity review held within the department. Despite challenges faced with the department, there was no evidence of any audit or governance review in relation to operational process.

There were no long-term strategic mitigating actions around the lack of paediatric nurses within the department in terms of recruitment. Nurse staffing for children and adult numbers were not recorded on the department risk register. The department undertook demand analysis to understand the peak times or case presentations of patients. This analysis has helped the department to determined peak times for ambulance traffic and paediatric presentations in inform the RSCN rota. However, we spoke with leaders in the department who were unaware this work has been undertaken.

Outstanding practice and areas for improvement

Outstanding practice

The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the provider MUST take to improve

- The service must ensure the timely triage of patients arriving to the department and ensure patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals. **Regulation 12(2)(a)(**b)
- The service must ensure that care is provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed. **Regulation 12(2)(a)(b)**
- The service must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. **Regulation 12(2)(b)**
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding identification and reporting. **Regulation 13 (1)(2)**
- The service must ensure that there is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines. **Regulation 17(2)(a)(b)**
- The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care. **Regulation 18(1)**

Action the provider SHOULD take to improve

- The service should ensure that appropriate governance structures are in place and operating within the department.
- The provider should improve environment facilities including reception and paediatric areas to ensure they are both suitable and inline with national standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients were not being triaged in line with the national standard. We did not see that there was a dedicated triage nurse in the department. The department did not provide care in line with national standards and risks to protect adults and children. The flow of patients through the department was poor and patients were not assessed, treated, admitted and discharged in a safe and timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment We found evidence where best practice safeguarding processes were not always followed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

We found not all mental health patients had appropriate and timely risk assessments completed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found there were not sufficient numbers of appropriately qualified nursing and medical staff.