Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Quality Report

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Date of inspection visit: 6 November 2018
Date of publication: 14/01/2019

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Norfolk and Norwich University Hospital is an established 1237 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 1,016,000 people. The trust provides a full range of acute clinical services and operates from a large purpose built site on the edge of Norwich and from a smaller satellite at Cromer in North Norfolk. The emergency department at the Norfolk and Norwich University Hospital is a type one major injuries unit, which had 133,073 attendances between July 2017 and June 2018.

We last inspected the urgent and emergency service in October 2017. The service was rated inadequate overall; safe and well-led were rated inadequate, effective and responsive were rated requires improvement, and caring was rated good. During the 2017 inspection, we identified significant concerns regarding staff understanding and application of the Mental Capacity Act (2005), the systems and processes for preventing and controlling the spread of infections, the healthcare records of service users, and the emergency department premises. Concerns regarding the premises included the layout and size of the department, the size of the children's emergency department and the lack of safe environments for those living with mental health concerns. As a result, we issued a Section 29A warning notice to the trust in October 2017. The warning notice informed the trust that significant improvements were required by 1 January 2018, and we requested an action plan from the trust, outlining steps that had been taken to address the concerns raised in the warning notice.

We carried out a focussed inspection on 6 November 2018 to follow up on the concerns raised in the Section 29A warning notice.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We carried out a focused inspection which did not include all key lines of enquiry (KLOEs). We did not rate the service as a result of this inspection.

During this inspection we visited the emergency department (ED), children's ED, older people's emergency department (OPED), clinical decisions unit (CDU) and the urgent care centre (UCC). During the inspection visit, the inspection team spoke to 24 members of staff, including nurses, doctors, support workers and senior managers. We reviewed 10 paper healthcare records and seven electronic healthcare records.

Before and after the inspection visit, we reviewed information that we held about these services and information requested from the trust.

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

We found the following issues that the service provider needs to improve:

- Patients at high risk of deliberate self-harm continued to be cared for in the CDU, which remained an unsafe and inappropriate environment for these patients.
- Risk assessments for patients with mental health concerns had not always been completed appropriately. Mental capacity assessments had not always been completed when required, despite concerns raised at the time of our last inspection.
- We were not assured that staff understanding of isolation procedures was consistent or that implementation and monitoring of compliance was fully effective. Results from cannula insertion, commode and bed pan audits showed mixed compliance.
- There was a lack of evidence that progress against concerns raised at our last inspection were being regularly monitored at a local level. There was a lack of progress in developing and implementing effective governance systems within the department.

Summary of findings

- The level of scrutiny and oversight that the mental health board was providing could be improved.
- Information was not always collected, analysed, managed and used well to support all the service's activities.
- The emergency department strategy had not been reviewed or developed since our inspection in 2017.

However, we also found the following areas where improvement had been made:

- Environmental changes had positively impacted on infection prevention and control. We observed staff using personal protective equipment appropriately and adhering to bare below the elbows standards. Area specific cleaning records had been implemented.
- The emergency department premises had been re-configured to increase the number of patients that could be accommodated at any one time. The service had increased the environments which were safe, and secure where necessary, for those living with mental health concerns.
- There had been a reduction in the number of areas that were inappropriately being used as an extension to the majors area due to a lack of capacity. Whilst patients were still being cared for in the corridor at times of peak pressure, the trust had improved their processes to ensure that all patients were clinically assessed before a decision was made about whether their condition was appropriate for them to be cared for in the corridor.
- Staff had become more aware of the need to carry out a risk assessment to review whether patients could pose a risk of harm to themselves or others. Staff understanding of the Mental Capacity Act (MCA) and compliance rates for MCA and Deprivation of Liberty Safeguards (DoLS) training had significantly improved.
- Significant progress had been made in the development of the urgent and emergency service and senior staff were able to describe plans to further develop the service.
- The establishment of the mental health board had improved the focus on mental health care within the organisation.

Following this inspection, 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 two requirement notices that affected urgent and emergency services. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals

Norfolk and Norwich University Hospital

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Detailed findings

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Background to Norfolk and Norwich University Hospital

The Norfolk and Norwich University Hospital is an established 1237 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 1,016,000 people. The majority of patients live in Norfolk, North Suffolk and Waveney; the trust has the largest catchment population of any acute hospital in the East of England. The trust provides a full range of acute clinical services including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery. The status of foundation trust was achieved in May 2008. The trust is one of the largest teaching hospitals in the country. The Norfolk and Norwich University Hospital opened in late 2001, having been built under the private finance initiative (PFI). Cromer and District Hospital was rebuilt by the trust in 2013. It has a Minor Injuries Unit and provides a range of outpatient and day-case services.

Our inspection team

The team that inspected the service comprised of an inspection manager, a lead inspector,two mental health inspectors, and an inspection planner. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

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Safe	
Effective	
Well-led	
Overall	

Information about the service

The emergency department at the Norfolk and Norwich University Hospital is a type one major injuries unit, which had 133,073 attendances between July 2017 and June 2018.

Since our previous inspection in October 2017 there had been some major development work completed. This included an older people's emergency department (OPED) and a new children's emergency department, opened in December 2017. Part of the majors area had been reconfigured to provide four rapid access and treatment (RATS) cubicles and one cubicle had been modified to provide a safe environment for the care of patients with mental health concern. The service had also created three dedicated quiet rooms, safe for the treatment of patients with mental health concerns, but these were not yet operational at the time of our inspection.

The emergency department included six resuscitation spaces and 16 majors cubicles, with space for three trolleys for patients awaiting ward transfer. The department also included six minors cubicles and a plaster room, co-located with an urgent care centre with five rooms. The children's emergency department consisted of four trolleys, a triage area, an isolation cubicle, a quiet room, and an extended care bay. The older people's emergency department had four cubicles and two side rooms. There was also a clinical decisions unit (CDU) with 12 spaces and an ambulatory emergency care (AEC) unit with nine trolley spaces.

Summary of findings

Are services safe?

We found the following issues that the service provider needs to improve:

- Patients at high risk of deliberate self-harm continued to be cared for in the clinical decision unit (CDU), which remained an unsafe and inappropriate environment for these patients.
- Risk assessments for patients with mental health concerns had not always been completed appropriately.
- We were not assured that staff understanding of isolation procedures was consistent or that implementation and monitoring of compliance was fully effective. Results from cannula insertion, commode and bed pan audits showed mixed compliance.
- The trust's deliberate self-harm policy was six months overdue for review and this meant that staff did not have an up-to-date policy to refer to when caring for patients at risk of deliberate self-harm.
- Three new treatment rooms, which were safe for patients with mental health concerns, had been created but were not operational at the time of our inspection due to staffing shortages.

However, we also found the following areas where improvement had been made:

- Environmental changes had positively impacted on infection prevention and control. We observed staff using personal protective equipment appropriately and adhering to bare below the elbows standards. Area specific cleaning records had been implemented.
- The emergency department premises had been re-configured to increase the number of patients that

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could be accommodated at any one time. The service had increased the environments which were safe, and secure where necessary, for those living with mental health concerns.

- There had been a reduction in the number of areas within urgent and emergency services that were inappropriately being used as an extension to the majors area due to a lack of capacity.Whilst patients were still cared for in the corridor at times of peak pressure, the trust had improved their processes to ensure that the all patients were clinically assessed before a decision was made about whether their condition was appropriate for them to be cared for in the corridor.
- Staff had become more aware of the need to carry out a risk assessment to review whether patients could pose a risk of harm to themselves or others.

Are services effective?

We found the following areas where improvement had been made:

- Staff understanding of the Mental Capacity Act had significantly improved.
- Compliance rates for Mental Capacity Act and Deprivation of Liberty Safeguards training had significantly improved and staff said that their confidence in assessing patients' capacity had improved as a result.

However, we also found the following issues that the service provider needs to improve:

- Mental capacity assessments had not been completed when required in six out of 10 patient records reviewed, despite concerns raised at the time of our last inspection.
- The trust's consent policy was overdue for review at the time of our inspection and this meant that staff did not have an up-to-date policy to refer to when assessing capacity and gaining consent.

Are services well-led?

We found the following issues that the service provider needs to improve:

- There was a lack of evidence that progress against concerns raised at our last inspection were being regularly monitored at a local level.
- There was a lack of progress in developing and implementing effective governance systems within the department.
- There had been a lack of review and development of the emergency department strategy at a local level since our inspection in 2017.
- The level of scrutiny and oversight that the mental health board was providing could be improved.
- Information was not always collected, analysed, managed and used well to support all the service's activities.
- Staffing shortages were impacting on service development. For example, three new treatment rooms, which were safe for patients
- with mental health concerns, had been created but were not operational at the time of our inspection due to staffing shortages.

However, we also found the following areas where improvement had been made:

- Significant progress had been made in the development of the urgent and emergency service and senior staff were able to describe plans to further develop the service.
- The establishment of the mental health board had improved the focus on mental health care within the organisation.

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Are urgent and emergency services safe?

Cleanliness, infection control and hygiene

- **There had been some improvements in the systems and processes to prevent and control the spread of infections. However, the processes still required further embedding with all staff members.**
- At our inspection in October 2017 we found that systems and processes were neither properly established nor operating effectively to prevent and control the spread of infections. Our concerns related to isolation procedures in the emergency department, the design and quantity of sinks, the lack of a sluice in the children's emergency department, the lack of cleaning records, and staff use of personal protective equipment.
- The trust developed an action plan which included six actions to address these concerns, all of which were due to be completed in November and December 2017.
- The children's emergency department was re-located in December 2017 and we confirmed during our inspection in November 2018 that the new children's emergency department had a designated sluice and a sufficient quantity of sinks.
- During our inspection in November 2018 we confirmed that cleaning logs were in place and were being regularly completed. We also found that the use of "I am clean" stickers had improved. However, the trust's action plan stated that cleaning log audits would be introduced and we were not provided with any evidence of these audits. In addition, there was no evidence that any results from cleaning log audits had been monitored at the clinical governance meetings in the six months prior to our inspection.
- Taps in the emergency department had been converted to allow elbow operation to be compliant with national standards. The cubicles in the majors area of the department had been re-arranged, back to single spaces, to ensure that there was one sink per cubicle.
- We found that staff, including clinical staff and security guards, were using personal protective equipment appropriately and were adhering to bare below the elbows standards. Information provided by the trust after our inspection showed that dress code compliance was an average of 99.8% between April and September 2018. Hand hygiene audit results showed an average compliance rate of 97.6% between April and September 2018. This therefore indicated that the concerns raised at the time of our last inspection had been addressed.
- A new system had been introduced for patients who were being isolated, where a card was attached to the outside of a patient cubicle to make staff aware of an infection risk. We were not able to observe this system in use in the main emergency department during our inspection as there were no patients being isolated. The majority of staff spoken to on inspection were aware of the new system. However, we found that the application of isolation procedures remained inconsistent. For example, in the children's emergency department, a child was being cared for in the isolation cubicle during our inspection as a precaution, due to a potential infection risk. There was no precaution notice on the cubicle door to inform staff that there was a potential infection risk. In addition, staff in the observational area of the emergency department identified a room that had been used as an isolation cubicle shortly prior to our inspection but they were not aware that a sign should have been placed on the cubicle door to inform staff that there was an infection risk. This meant we were not assured that staff understanding of isolation procedures was consistent or that implementation and monitoring of compliance was fully effective.
- Results from cannula insertion, commode and bed pan audits showed mixed compliance. Results from peripheral cannula insertion audits showed that, in October 2018, compliance was 17% in the emergency department and 80% in the older people's emergency department. Compliance in the children's emergency department had been 67% in September 2018 but this had improved to 100% in October 2018. The areas of non-compliance in this audit, for the main emergency department and the children's emergency department, had both been relating to documentation, as staff had not ensured that the date, reason for insertion, size of cannula, person undertaking cannulation and risk level was recorded. The area of non-compliance in the older people's emergency department related to staff not wearing personal protective equipment. Whilst an action plan was available, this only stated the area of non-compliance and had not been completed to specify the actions that would be taken to address the concerns or the person responsible for completing the action.

- The older people's emergency department had scored 100% on a urinary catheter insertion audit in October 2018. Commode and bed pan audits carried out in the main emergency department and the children's emergency department from August to October 2018 had shown 100% compliance. September 2018 audit results for the older people's emergency department had shown 0% compliance in the commode audit and 50% compliance in the bed pan audit. However, this had improved to 100% compliance when this was re-audited a week later and in October 2018.
- Results from cleaning audits showed a high level of compliance; compliance had averaged at over 95% between August and October 2018 in the urgent care centre, the older person's emergency department, and the resus area. Compliance in the trolley bay had averaged at 94.8%, compliance in outer emergency department areas averaged 93.8% and compliance in ED x-ray averaged at 93.4%.
- We found that chairs, whilst appearing to be of a fabric material, were cleaned regularly and that the intervene fabric was waterproof, washable and anti-microbial. The chairs were cleaned with a chlorine releasing solution. The external company responsible for cleaning kept a log that indicated a regular cleaning schedule had been adhered to. This information therefore addressed the concerns raised in October 2017.

Environment and equipment

- **There had been significant building alterations in order to ensure that the environment and equipment met the safety needs of the patient. However, sytems and processes required embedding and further work was required in respect of the safety of patients with mental health concerns.**
- During our inspection in October 2017 we found that the emergency department premises were not fit for purpose; the layout was widely spread, the area was not large enough to accommodate the potential number of service users using the department at any one time, and multiple areas within the department were not being used as intended, which was a risk to patient safety.
- During our inspection in November 2018, we found that the emergency department premises had been re-configured to increase capacity and enable the department to accommodate the increase in the number of patients that the department was experiencing.
- An older people's emergency department had been opened in December 2017 with six treatment areas, including two side rooms. At the time of our inspection the older people's emergency department was available between 7am and 7pm, Monday to Friday, and saw an average of 18 to 20 patients a day. The area was still available for use outside of these hours, although not specifically designated for patients over the age of 80. There were plans to extend the availability of the older person's emergency department to seven days a week in 2019, depending on the availability of medical staff in the older people's medicine (OPM) specialty.
- We found that the corridor was still used to care for patients when the majors was full to capacity. However, to mitigate the risk to patients, there had been a change to processes to ensure that all patients in the corridor had been clinically assessed as appropriate to be in the corridor. Four cubicles within the majors' area had been allocated as rapid assessment and treatment (RATS) cubicles. Patients arriving by ambulance were initially assessed in one of these four RATS cubicles, before a decision was made about whether the patient's condition was appropriate for them to be cared for in the corridor. Staff were allocated to care for patients in the corridor. During our inspection, we observed that the patients being cared for in the corridor were appropriate and that the area was appropriately staffed.
- Staff said that the observational area of the department was no longer used as an extension to the majors area, that they were able to obtain a majors cubicle for any patients requiring more urgent assessment and treatment, and that the staffing levels in the observational area had improved. The patients being cared for in this area during our inspection were appropriate to be there and portable suction and oxygen cylinders were in place.
- At our previous inspection we found that the "review clinic" (room 132), which was not intended to be used for majors patients, was also being used as an extension to the majors area. At our inspection in November 2018, staff said that they tried to minimise the use of the review clinic room, but that there was no formal way of recording when it was used. Portable oxygen cylinders

were available in the room but there was no suction available and we escalated this with staff during our inspection. The patients being cared for in this room during our inspection were appropriate.

- The service had created a standard operating procedure for ambulant patients in the emergency department in November 2017 which set out the type of patients who could be cared for in the review clinic room and the observational area, and the process for escalating patients who required a majors cubicle. An action plan indicated that compliance with the SOP would be monitored at monthly clinical governance meetings. However, we reviewed minutes from the last six months of meetings as part of our inspection and saw no evidence that compliance was being monitored. As there was no way of formally recording the use of the review clinic room we were also not assured that the trust had sight of accurate information to enable this to be fully monitored.
- At our previous inspection we had found that patients who required admission frequently had to wait in the urgent care centre until a bed became available. During our inspection in November 2018, the department's electronic system confirmed that there were no patients in the urgent care centre who required admission and were waiting for a bed to become available. The service had created a standard operating procedure in December 2017 for patients in the urgent care centre with a decision to admit. This stated that if there was a delay in bed availability, most patients would remain in the urgent care centre, receiving regular observations. However, the standard operating procedure also stated that if a patient's clinical need exceeded the care available in the urgent care centre, then contact would be made with an emergency department consultant to discuss the appropriateness of transferring the patient to the main department.
- In December 2017, the children's emergency department was re-located and expanded. The children's emergency department had expanded to four trolleys, a triage area, an isolation cubicle, a quiet room which could be used for the assessment and treatment of children and young people with mental health concerns, and an extended care bay. There was space to potentially increase the size of the department by a further eight trolley spaces, if staffing levels could be increased accordingly. The size of the waiting area had increased to 21 seats.
- At our inspection we found that there was sufficient seating to accommodate the number of children and young people, as well as their relatives and carers, attending the department. However, the location of the waiting area within the children's emergency department meant that there was a lack of ongoing clinical oversight, as the nurses station was located down the corridor from the waiting area. Staff confirmed that there was no CCTV in the waiting area and said that they had to ensure that they regularly checked the waiting area as a result. This raised concerns that there may be a delay in clinical staff becoming aware of and responding to patient deterioration in the waiting area. Health Building Note 15 Planning and designing accident and emergency departments (2013) states that for dedicated children's facilities, "The waiting area should be provided to maintain observation by staff". When concerns were raised with senior staff during our inspection, they stated that regular clinical oversight of the waiting area was ensured via the triage process; the triage cubicle was near the waiting area and this meant the triage nurse regularly reviewed the waiting area when they called patients in for triage. If a patient was deemed at risk of deterioration during triage, they would not be returned to the waiting area but would be moved into a treatment area. In addition, children were accompanied by a parent, relative or carer who could raise concerns with staff if the child deteriorated. This therefore reduced the risk that there would be a delay in clinical staff becoming aware of and responding to patient deterioration in the waiting area.
- Staff stated that children were no longer seen outside of the children's emergency department due to a lack of space. The department's electronic system confirmed that no children were being treated outside of the children's emergency department due to a lack of space on the day of our inspection. Data provided by the trust stated that "During the period 1st May 2018 to 31st October 2018 inclusive there were 127 occasions where children were treated outside the Children's ED however each of these times this was not due to lack of capacity but due to clinical/family need."
- Staff showed us a treatment area within the children's emergency department which was described as being a HDU area. However, information provided by the trust following our inspection stated that "Children requiring High Dependency Unit (HDU) level care are nursed in the adult Emergency Department resuscitation area, and

not CHED (children's emergency department)...The Extended Care bay on CHED is not a designated HDU, and only used for acutely unwell children in the Children's Emergency Department" This was confirmed in the Standard Operating Procedure for the Children's Emergency Department, dated October 2018. This meant that the concern identified at our last inspection about the lack of a HDU for children and young people in urgent and emergency services, outside of resuscitation, had not been fully addressed. However, the trust was not commissioned to provide HDU care for children and young people in urgent and emergency services outside of resuscitation and the introduction of the extended care bay meant that acutely unwell children could now be cared for in the children's emergency department.

- We confirmed that appropriate alterations had been made to the environment for those living with serious mental health concerns, including those patients that were detained under the Mental Health Act (1983). The trust had invited representatives of a mental health trust to visit in October 2017 to provide advice on infrastructure and processes, to assist with the development of the available space and the redesign of the service. A trolley bay in the majors' area had been modified to provide a safe environment for the care of patients with mental health concerns, including a shutter system which meant that wall furniture could be covered and locked away to remove risk. A quiet room, safe for children and young people with mental health concerns, had been included in the re-located children's emergency department. Three new treatment rooms, which were safe for patients with mental health concerns, had been created in the area previously occupied by the children's emergency department. However, staff stated that the three new treatment rooms were not operational at the time of our inspection in November 2018 due to staffing shortages. The trust was working to recruit additional staff, including mental health nurses.
- Following this inspection, we requested evidence of any risk assessments that had been carried out in areas used for the assessment and treatment of patients with mental health concerns. The trust provided the original risk assessment of the relatives' room, carried out in October 2017, but there was no evidence that a further risk assessment had been carried out after the necessary alternations had been made to the room.
- We observed that the clinical decision unit (CDU) remained an unsafe and inappropriate environment for the care of patients at high risk of deliberate self-harm or suicide. We observed ligature points and equipment that could be used to cause harm. Staff told us that the standard operating procedure for the CDU had been amended to state that only patients assessed as medium risk or lower on the Emergency Department Adult Mental Health Triage Form would be cared for on CDU. However, we spoke to one member of staff who stated that patients with mental health concerns, including patients at risk of harming themselves, were regularly cared for on CDU whilst waiting to be assessed and that security staff were often present to observe these patients. We reviewed one record which demonstrated that a patient who had been assessed as high risk and requiring one to one observations had been cared for on CDU. The record indicated that a family member had stayed with the patient, rather than a member of staff, and this did not sufficiently mitigate the risk for this patient in the CDU environment.
- Following our inspection, we requested information from the trust regarding the number of patients with mental health concerns who had been cared for in CDU in the four weeks prior to our inspection, and how many of these patients were under one to one observations or had been assessed as high risk on the emergency department adult mental health triage form. The trust provided a list of 64 patients, including 34 patients with a presenting complaint of 'deliberate overdose'. However, the trust stated that "We are unable to establish how many of the 64 mental health patients in CDU in the past 4 weeks were under one to one observations/'red' on ED adult MH triage form without reviewing each individuals paper record."
- As a result of the continuing concerns regarding the environment within which patients at risk of harming themselves or others were cared for in, we wrote to the trust following our inspection, asking for immediate and ongoing assurance that patients at high risk of deliberate self-harm were not admitted to the CDU, in line with the trust's standard operating procedure. If this could not be provided, we asked for immediate actions to be taken to ensure the environment in CDU was suitable for those with immediate risk of significant harm to themselves or others.
- In response to CQC's letter, the trust stated that they had carried out an audit of ED clinical records to review the

level of risk associated with each patient transferred to the CDU and to ascertain whether the transfer was appropriate. The audit focused on a seven-day period between the end of October and the start of November 2018, and included 45 records. The audit found that three high risk patients had been transferred to the CDU. All three patients had initially been clinically assessed as being appropriate for transfer to CDU. However, a further clinical review was carried out as part of the audit and two of the patients were not deemed to be appropriate for CDU. One of these patients required one to one observations and there is no evidence in the records that this was delivered.

- Following our inspection, the trust had carried out a ligature risk assessment for the whole of the emergency department, including the CDU. This had identified areas of risk but no specific changes were planned to the environment in the CDU. Instead, the trust stated that they would review their mental health triage form to ensure consistent use of language, clear identification of 'high' and 'low' risk patients, and clear staff guidance regarding the appropriate setting for a patient dependent on their risk. In addition, the trust would also review the deliberate self-harm protocol for the CDU, including the acceptance and exclusion criteria to ensure that the circumstances under which patients can be transferred is made explicit, as well as to recommend that a further risk assessment of the patient is conducted prior to their transfer from the emergency department, to facilitate the documentation of changes in risk.
- The trust's standard operating procedure for the CDU had not been reviewed since the time of our last inspection and did not specifically state that patients at high risk of deliberate self harm should not be treated on CDU. The SOP did state that clinical criteria for the use of the CDU had been written for a range of conditions, inducing deliberate self harm, and that this would be followed when deciding on admission to the CDU. We requested a copy of the clinical criteria but this was not provided. The trust provided an action plan following our inspection which stated that they would review CDU pathways for patients who present with mental health requirements and they would not admit patients to CDU with solely a mental health requirement. This action was due to be completed by the end of December 2018. The trust also planned to audit CDU patient records to ensure that patients fit the criteria for this area, this audit would commence in January 2019.

Assessing and responding to patient risk

- **The trust had taken measures to improve assessing and responding to patient risk. However we found that the processes were not always followed.**
- Following our inspection in November 2018, the trust provided A Protocol for the management of patients with a mental health need within the Emergency Department interview room, which had been approved in October 2017. The protocol stated that "A named member of staff must conduct within eyesight observation (1:1) for all patients at risk to themselves or others and who flag as immediate or urgent risk on the Triage tool." "If 1:1 observation is not adequate the hospital security team must be requested through the ED Floor Coordinator / Lead nurse. Nursing observation of the patient must continue at all times, even when security staff are present." During our inspection a patient was being cared for in the emergency department interview room. The patient was under one to one observations by two members of security staff but was not under observation by nursing staff and this was therefore not in line with the protocol that we had been provided.

Records

- **Risk assessments for patients with mental health concerns had not always been completed appropriately and the service's audit programme had not identified this concern.**
- During our inspection in October 2017 we found that the healthcare records of service users were not always accurate and complete in relation to care and treatment provided to the service user, and of decisions taken in relation to the care and treatment provided. This included concerns about the completion of deliberate self-harm risk assessments and mental capacity assessments.
- An action plan provided by the trust included eight actions to address these concerns. The action plan indicated all ED staff had been reminded of the importance of the accuracy of patient documentation, the clinical educator had run bespoke sessions for clinical staff on the completion of documentation, and

the service had introduced a process to monitor the quality of medical documentation, including an audit of compliance with use of the deliberate self-harm proforma and mental capacity assessments.

- Following our inspection in October 2017, the CQC became aware of several serious incidents which indicated that the concerns raised in the Section 29A warning notice regarding the completion of deliberate self-harm risk assessments had not been resolved. In July 2018 CQC became aware of two serious incidents, one of which had occurred in May 2018 and another in July 2018, where patients had attended the hospital after an episode of deliberate self-harm and staff had not followed the trust's process to assess the risk of further deliberate self-harm. The patients were subsequently found attempting to harm themselves further. In one case, the mental health liaison team had carried out their own risk assessment but this had not been shared with ward staff.
- In July 2018 the trust provided CQC with immediate actions that had been put in place to improve the completion of deliberate self-harm risk assessments. This included raising awareness of the deliberate self-harm policy with staff and providing support to staff in completing the risk assessment document and escalating concerns. Matrons and ward sisters were instructed to carry out daily checks to ensure that the relevant risk assessments were completed. A patient safety white board was introduced in the operations centre to improve visibility of patients under a mental health section or at risk of self-harm and site handovers would include discussion around medium and high risk patients. The Mental Health Liaison service were asked to share any risk assessments they had undertaken. The use of the deliberate self-harm policy was added to the work plan for the mental health board and would be discussed at the next meeting.
- In October 2018, CQC became aware of a further serious incident that had occurred in September 2018, where a patient had attended the emergency department after attempting to deliberately harm themselves. There was no evidence in the notes that staff had carried out a deliberate self-harm risk assessment and the patient was subsequently found attempting to harm themselves further. Information provided by the trust in response to this incident stated that the most recent audit of compliance with mental health documentation in the emergency department showed 78% compliance. The trust stated that "To drive further improvements prospective audits are taking place, and will continue, over the next few weeks to support real time feedback, learning and discussions with staff." Action cards were being developed to support staff learning and the MCA and DoLS lead was planning further bespoke sessions with staff. A serious incident investigation was underway regarding this incident at the time of our inspection.
- During our inspection in November 2018 we reviewed 10 paper records for patients who had attended the emergency department due to a mental health concern. In nine cases the Emergency Department Adult Mental Health Triage Form had been completed. This was an improvement from our previous inspection and reflected our findings from speaking with staff, who had become more aware of the need to carry out a risk assessment to review whether patients could pose a risk of harm to themselves or others in order to determine whether actions needed to be put in place to mitigate this risk. However, in five cases we had concerns about the accuracy of scoring in the assessment and how the triage outcome had been determined. For example, the healthcare records of one patient showed that they felt violent to others and were 'obviously disturbed, threatening, agitated or unpredictable in their behaviour'. However, the outcome of the assessment was that no special observations were required. The healthcare records of another patient showed that they had attended the department after deliberately harming themselves. The mental health triage form showed that the patient had immediate plans to harm themselves or others or to damage property, and was 'obviously disturbed, threatening, agitated or unpredictable in their behaviour'. However, the outcome of the assessment was that no special observations were required. Whilst the Mental Health Triage Form stated that 'clinical judgement may override this form', there was no documentation to show the rationale for overriding the level of risk indicated on the triage form aggregation. The healthcare records of another patient showed that they had attended the department after attempting to harm themselves, whilst under section at a local mental health hospital. However, no Emergency Department Adult Mental Health Triage Form was completed for this patient. This meant that the patient's risk of attempting to harm themselves further had not been assessed and as a result there was no indication in the records that there had been any consideration of the

need to implement actions to mitigate this risk. This meant that, whilst the number of risk assessments had increased, we were not assured that they were being completed accurately to ensure steps were taken to keep patients safe. We raised our concerns with the senior executive team on site at the time of inspection.

- Following our inspection, we requested documentation audit results and any associated action plans, including any audits that reviewed deliberate self-harm risk assessment completion, carried out in the six months prior to our inspection. Information provided by the trust showed that two documentation audits had been carried out to review the completion of emergency department mental health documentation, one in June 2018 and one in July 2018. The audit proforma stated 'a sample of ten sets of case notes should be reviewed from the first week of every month.' However, the audit results we were provided indicated that audits had not been carried out every month. The audit included 10 criteria but did not review whether the ED Mental Health Triage form had been completed accurately, such as whether staff had assigned an appropriate level of risk. The audit results for June 2018 showed a 73.3% compliance rate; there were a range of different areas of non-compliance but the most common areas of non-compliance were the need for a safeguarding referral not being documented and the mental health triage form not being complete. It was not clear whether any actions had been taken as a result of the audit findings. The results for July 2018 showed 83.8% compliance rate; the main area of non-compliance was that the need for a safeguarding referral was not documented. There was no formal action plan to accompany the audit results. However, we were provided with a copy of an email from September 2018 which showed that a request was made to add an additional question to the triage sheet regarding whether a safeguarding referral was required, in response to the July 2018 audit results.
- As a result of the continuing concerns identified regarding the healthcare records of service users, we wrote to the trust following our inspection asking for information about immediate actions that they had taken to monitor and review completion of the Emergency Department Adult Mental Health Triage Form to ensure appropriate triage outcome and observation levels were adopted to ensure patient safety. In response, the trust stated that the Emergency Department Adult Mental Health Triage Form and audit tool had been reviewed and revised. The revised documents were due to be implemented in November 2018, after approval at the mental health board. Audits would be conducted after a week.
- We reviewed the revised ED Adult Mental Health Triage Form and found that a scoring system had been added to the form, based on the answers that staff selected to the questions on the form. Staff added up the total score for all questions and the form indicated the level of risk and observation required based on this. The form was to be completed at the time of initial assessment, once a shift, following review from the mental health liaison team or if any behavioural of physiological changes were noted. The changes to the form meant that the assessment of risk was clearer and more straightforward for staff.
- The revised audit tool reviewed the timing of the ED mental health risk assessment, whether all domains were assessed, whether a total score was recorded, whether the patient's physical presentation was recorded, whether a mental capacity assessment was completed, whether a risk rating was recorded and whether a review had taken place if applicable. The audit was to be completed once weekly and results were to be grouped and later presented at clinical governance meetings and the mental health board, and disseminated through the ED newsletter monthly. There would also be daily spot audit checks, the results of which would be shared with the ED team, along with recommendations and actions when found to not be compliant. The form and audit would be reviewed a month post implementation. The trust planned to communicate the new form to all staff prior to roll out, and the mental health and MCA matrons would work with staff in the emergency department to give on the job training for how to best use the forms and look after these patient groups.
- As part of our inspection we requested the trust's deliberate self-harm policy. We found that the policy had not been amended since the time of our last inspection and was due for review in May 2018. The trust stated that "the policy review is overdue, however, it is still in use until the updated version is agreed and published." The policy had therefore not yet been updated to reflect changes in documentation and processes that had been implemented since the time of

our last inspection, and this meant that there was a potential risk to patient safety as staff did not have an up-to-date policy to refer to when caring for patients at risk of deliberate self-harm.

Incidents

- As part of our inspection, we reviewed the serious incident root cause analysis investigation reports for the deliberate self-harm incidents which had occurred in May and July 2018, as referred to in the records section. The investigation reports raised concerns about the robustness of incident investigation processes.
- The investigation for the May 2018 incident had concluded that although the patient's risk of deliberate self harm had not been assessed, "based on the information available, an enhanced level of supervision was not indicated". However, the information available in the investigation report showed that the patient had a history of mental health problems or self-harm and had previously been transferred to a specialist mental health unit for further assessment. According to the ED Adult Mental Health Triage Form, this would mean that the patient was a medium risk, which meant staff should have considered 15 minute special observations. In addition, the investigation report showed that the patient had been found attempting to harm themselves further on the hospital site within an hour of being discharged from the ED. The patient subsequently re-attended the emergency department and was then sectioned (detained) under the Mental Health Act 1983. This meant we were not assured that the investigation process had taken into account the patient's previous medical history and potential indication for a higher level of observation.
- The trust informed CQC that for the serious incident that had occurred in July 2018, the mental health liaison team had carried out their own risk assessment but this had not been shared with ward staff. However, there was no reference to this in the serious incident investigation report. It was therefore not clear that this concern had been appropriately investigated and reviewed, despite CQC asking the trust in July 2018 for a review of the effectiveness of joint working and communication between the trust and the mental health liaison team to be added to the terms of reference for the investigation. The mental health liaison team had not been involved in either investigation, despite reviewing both patients.

Are urgent and emergency services effective?

(for example, treatment is effective)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff training and understanding of the Mental Capacity Act had significantly improved. However, we found that records were not always completed appropriately.**
- In October 2017, we raised concerns that mental capacity assessments were not always being completed when required and staff training and understanding of the Mental Capacity Act (2005) was poor. The trust submitted an action plan to address these points and all actions were due to be completed by the end of 2017.
- The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the MCA and they aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.
- During our inspection in November 2018 we found that staff understanding of the Mental Capacity Act had significantly improved. Staff were able to describe the principles of the Mental Capacity Act, and how and when a possible lack of mental capacity to make a particular decision should be assessed and recorded. Staff said that their confidence in assessing patients' capacity had improved since the time of our last inspection. Staff had been provided with MCA and DoLS prompt cards to carry with them, which meant that they had easy access to information about MCA and DoLS when necessary. In addition, there was a folder in the emergency department with more detailed information which staff could refer to.
- Data provided by the trust following our inspection showed that training compliance had improved. As of 31 October 2018, 83.9% of medical staff and 87.5% of non-medical staff had completed MCA and DoLS training. In addition, the trust stated that further training sessions were being held in November and December 2018. Staff spoken to during our inspection were positive about the matron who delivered MCA and DoLS

training but also expressed a desire for further training on responding to patients with mental health concerns and patients who lacked capacity to make a decision, including scenario based training. Since our inspection in October 2017, the trust had appointed an MCA and DOLS matron and staff spoke positively about the impact that the matron was having.

- We reviewed 10 patients' records during our inspection and found that the mental capacity assessment proforma had not been completed in six out of 10 cases where the patient presentation was appropriate for this to be completed. The mental capacity assessment proforma we reviewed stated that this document should be completed in conjunction with the ED Adult Mental Health Triage Form and was to be completed for all patients with a mental health presentation. In three out of 10 records there was some reference to the patient's capacity in the clinical notes, but a full assessment had not been documented. There was also a lack of documentation regarding best interest decisions, where applicable. This therefore meant that the concerns raised at the time of our last inspection had not been addressed. Following our inspection in November 2018, we wrote to the trust to raise concerns regarding the completion of mental capacity assessments. In response, the trust revised the ED Adult Mental Health Triage Form to include the mental capacity assessment within the same form. The trust planned to carry out weekly audits of the triage form from November 2018 onwards.
- Following our inspection, we requested documentation audit results, including any audits that reviewed mental capacity assessment completion, carried out in the six months prior to our inspection. Information provided by the trust showed that two documentation audits had been carried out, which included a review of whether a capacity assessment was documented. The audit results showed that in June 2018, a capacity assessment had been documented in 88.9% of cases and in July 2018 a capacity assessment had been documented in 90% of cases.
- The trust had also carried out an audit of emergency department documentation to review the adherence to MCA and DoLS in December 2017. This audit demonstrated that there was inconsistency in the detail and quality of the assessments undertaken. The audit found that in 100% of applicable cases the person's impairment or disturbance of the mind or brain was clearly documented in the clinical record, it was clear why the patient's capacity was questioned and it was clear in the documentation who the decision maker was. However, the audit also found that the trust's mental capacity assessment form had been used in 0% of cases. In addition, the decision maker had not documented the second stage of their assessment clearly in any of the cases reviewed. The second stage reviews whether the patient is able to understand information relevant to the decision, retain the information relevant to the decision, use or weigh up the information and whether they are able to communicate their decision by any means. The audit results also highlighted concerns regarding evidence of best interest decision making. As the audit report stated, "The results from the audit continue to confirm that there are ongoing issues with the application of the MCA theory to practice." The report noted that an MCA and DoLS lead had been appointed and had commenced a bespoke MCA and DoLS training programme in the emergency department to support improvement in this area.
- The trust was re-auditing emergency department documentation to review adherence to MCA and DoLS at the time of our inspection; the data was being analysed but the final report was not yet complete to enable us to report on the findings.
- As part of our inspection in November 2018, the trust provided their Shared Decision Making Policy, formerly called their Consent Policy. This policy was overdue for review at the time of our inspection. The policy was originally due for review before 1 November 2017 and this had been extended to 1 June 2018 to allow a working group to be set up to review the policy and compliance levels. An action plan provided by the trust following our inspection in November 2018 showed that a policy review lead had been identified and benchmarking with other trusts and a review of updated guidance was underway. This therefore meant that staff did not have an up-to-date policy to refer to when assessing capacity and gaining consent. Information provided by the trust showed that work was also underway to set up a consent working group, and there were plans to review consent forms and revise the consent audit in 2019.

Urgent and emergency services

Are urgent and emergency services well-led?

Vision and strategy

- **Although progress had been made in the expansion of the service and senior staff were able to describe plans to further develop the service, there had been a lack of formal and ongoing review of the emergency department strategy.**
- At the October 2017 inspection senior managers told us that there were various plans in place for the moving and expansion of the ED service, including the children's ED service. However, at that time they also stated that these plans were still largely under consultation, that workforce planning for these plans had not been considered, and that there was no agreed completion date for any such work.
- We requested the emergency department strategy as part of our inspection in November 2018 and the trust provided the same strategy that we were provided with at the time of our last inspection in October 2017. The trust stated that the ED strategy was "under review with a deadline of 21st December 2018. There have been key personnel changes and progress since the writing of this strategy and the deadline will allow for staff engagement." This therefore indicated that there had been a lack of review and development of the strategy at a local level since our inspection in 2017. However, we also found that significant progress had been made in the expansion of the ED service.
- The children's emergency department was re-located and the older people's emergency department was opened in December 2017. In March 2018 the funded establishment levels for qualified nursing staff in the emergency department had been significantly increased, from 135.7 whole time equivalent to 179.3 whole time equivalent. However, in September 2018 there were 44.7 whole time equivalent vacancies for registered nurses in the emergency department, which amounted to a vacancy rate of 24.9%. During our inspection we found that vacancy rates were impacting on service development. For example, three new treatment rooms, which were safe for patients with mental health concerns, had been created but were not operational at the time of our inspection due to staffing shortages.
- During our inspection, senior staff were able to describe plans to further develop the urgent and emergency service. For example, building work was underway to double the size of the rapid assessment and treatment area by December 2018 and there were plans to make the older people's emergency department available seven days a week from January 2019. It was therefore clear that progress had been made in the service's strategic priorities and that further future plans had been developed but there was a need for these to be formalised into a strategy which could be regularly reviewed and monitored. The trust had recognised this and the revised strategy was in progress at the time of our inspection.

Governance

- **We found that there was a lack of progress in developing and implementing effective governance systems within the department.**
- Progress against the concerns identified during our last inspection was not being effectively monitored through the urgent and emergency service's governance processes. In December 2017, the trust provided CQC with an action plan in response to the concerns we raised in the Section 29A warning notice issued after our inspection in October 2017. The action plan stated that progress against some of the actions would be monitored at monthly emergency department governance meetings. This included MCA and DoLS training compliance rates, results from documentation and infection prevention and control audits, and evidence of compliance with revised standard operating procedures.
- As part of our inspection in November 2018, we requested the last six months of emergency department clinical governance meeting minutes. The meeting minutes showed that progress against the actions identified in the action plan had rarely been monitored or discussed at a local level in the six months prior to our inspection. In addition, there was a lack of monitoring to ensure that audits implemented as a result of the concerns identified in 2017 were being carried out as intended. The meeting minutes showed that the results of audits to review the completion of emergency department mental health documentation were noted twice, in April and October 2018. The audit was not being carried out on a monthly basis as intended but this was not identified or addressed at the

meetings. There was no evidence of further discussion regarding the completion of mental health documentation, despite several serious incidents highlighting concerns, as described in this report under the safe domain. The results of an audit regarding infection prevention and control alerts on the electronic system were noted on one occasion in October 2018. Infection prevention and control audits were being carried out on a weekly and monthly basis within urgent and emergency services but the results had not been monitored or discussed at meetings. The service had intended to introduce cleaning log audits but there was no evidence that these were being carried out; this was not identified or addressed at the meetings. There was no further evidence in the minutes we reviewed that progress against the concerns identified in 2017 were being monitored and this raised concerns about the level of oversight at a local level. Whilst the concerns identified at our inspection in 2017 were being regularly monitored at a trust level through a monthly oversight and assurance group meeting, which included external stakeholders, this did not review progress at the same level of detail that would be expected at a local level.

- The clinical governance meeting minutes we reviewed as part of our November 2018 inspection raised general concerns regarding the service's governance processes. An action log had only been commenced for monthly emergency department clinical governance meetings in October 2018. Prior to this, there was no system in place to ensure that actions identified at previous meetings were monitored and progressed on an ongoing basis. A meeting proforma was in place for the monthly emergency department clinical governance meetings and this covered the topics of patient experience, incidents, information governance, risks, quality and standards, audit and research, workforce, productivity and performance, and items for escalation. However, the minutes for some topics were sparse. For example, in one set of minutes, under the clinical audit heading, the minutes simply stated 'acute paracetamol overdose audit' and under the research and development heading the minutes simply stated 'middle grade research' without any further context or detail. In addition, there were no entries documented for some topics. For example, there was no indication that quality and standards or productivity and performance had been discussed at any of the meetings between April and October 2018. In addition, only one item had been marked for escalation between April and October 2018. This meant that the service's governance processes were not functioning effectively in order to ensure that all relevant areas were regularly discussed, that actions identified as part of meetings were completed and followed-up, and that relevant information was regularly escalated.
- The trust established a mental health board following our previous inspection; the first meeting took place in November 2017. The purpose of the mental health board was to provide a forum for the planning and operational oversight of services related to the care of patients with mental health issues in the trust to optimise patient experience, staff support and ensure regulatory compliance. Membership of the mental health board included external stakeholders. We requested the minutes from the last six meetings as part of our inspection in November 2018. The meeting minutes showed that concerns arising in mental health care at the trust were regularly discussed. For example, the mental health board had received a presentation, discussed and agreed actions regarding delays in accessing mental health beds for patients in the emergency department. The mental health board had also reviewed the findings of a ligature risk assessment and discussed actions to address areas of concerns. However, whilst governance was a standing agenda item, the only meeting where themes from incidents were discussed in detail was in June 2018. The meeting minutes referred to a mental health risk register being in place but the minutes did not indicate that the contents of the risk register were ever discussed. There was no indication in the meeting minutes that the mental health board had reviewed any local audit findings regarding staff knowledge of or documentation regarding mental health care. The meeting minutes did not show discussion about the deliberate self-harm serious incidents which had raised concerns regarding the completion of risk assessments and staff knowledge or use of the deliberate self-harm policy. Therefore, whilst the mental health board had improved the focus on mental health care within the organisation, the level of scrutiny and oversight that the mental health board was providing could be further improved.

Managing information

- **Information was not always collected, analysed, managed and used well to support all the service's activities.**
- The service was not always gathering data to monitor whether areas within the emergency department were being utilised as intended. For example, the service had no way of formally recording which patients were treated in the review clinic room or the number of high risk patients that had been treated in the clinical decisions unit. This mean that service leaders did not have oversight over whether patients were being treated in appropriate environments and whether one of the concerns identified at our last inspection had been addressed.
- Serious incident investigations had not always reviewed all relevant information. We reviewed two serious incident investigation reports as part of our inspection in November 2018. We found that the mental health liaison team had not been involved in either investigation, despite reviewing both patients. In addition, the trust had not reviewed the effectiveness of joint working and communication between the trust and the mental health liaison team, despite a request from CQC to do so. We were therefore not assured that the investigation had identified and reviewed all relevant information. This meant that the improvement actions identified as a result of the investigation findings may not address all areas of concern.
- The trust's consent policy and deliberate self-harm policy were both overdue for review. The policies had therefore not yet been updated to reflect changes in documentation and processes that had been implemented, and this meant that staff did not have an up-to-date policy to refer to when caring for patients. This demonstrated that the trust did not have effective processes to ensure that policies were regularly reviewed in a timely manner, to ensure that information referred to by staff was up-to-date and accurate.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are effective governance processes in place to ensure timely and appropriate capacity and risk assessments for mental health patients are undertaken.
- The trust must review and monitor the use of the clinical decisions unit for patients who present with mental health requirements, to ensure that patients are protected from potential harm.
- The trust must ensure that effective governance and quality assurance processes are in place to measure service improvement. Including escalation of concerns and monitoring of actions arising from meetings, local audits, recommendations from regulators and external reviews.
- The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance.
- The trust must improve staff understanding of isolation procedures and ensure that compliance is regularly monitored.

Action the hospital SHOULD take to improve

- The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing and medical staff with the appropriate skill mix to care for patients in urgent and emergency services.
- The trust should ensure that the emergency department strategy is regularly reviewed.
- The trust should ensure that all relevant information is gathered and reviewed during incident investigations, including input from all relevant staff, external stakeholders and specialist providers.
- The trust should ensure that information is gathered to monitor whether areas within the urgent and emergency service are being utilised as intended.
- The trust should review the level of scrutiny and oversight that the mental health board provides.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must ensure they assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. The registered person must ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Systems or processes must enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(1)(2)(a)(b)