The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Quality Report

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

Ratings

Urgent and emergency services	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Dudley Group NHS Foundation Trust operates acute hospital services from three hospital sites:

- Russells Hall Hospital
- Corbett Outpatient Centre
- Guest Outpatient Centre.

In addition, the trust provides community services in a range of community facilities.

Core services provided at Russells Hall include urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care. The trust has approximately 669 inpatient beds, 31 escalation beds and 152-day case beds. The trust employs around 4,147 whole time equivalent staff (WTE). These included 482 medical staff, 1,225 nursing staff and 2,440 other staff.

The emergency department (ED) includes a paediatric ED and both provide care for the population of Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

Our inspection of the trust covered only the Emergency and Urgent Care core service of Russells Hall hospital.

We carried out an unannounced, focussed inspection starting on the morning of 08 August 2018 starting before 6am. We specifically looked at the safe aspects of our key lines of enquiry within the emergency department at Russells Hall. We further focussed on the areas of assessing and responding to patient risk, nurse staffing, medical staffing, leadership, governance and risk management. This was based on our findings of previous inspections and to monitor compliance of the conditions that we had previously imposed on the trust's registration.

Our Key findings were:

- Patients presenting to the emergency department still did not always receive a robust assessment of their clinical presentation and condition during the triage process.
- There was still a lack of accountability for the safety of patients pre and post triage who were located within the waiting room.
- Staff were still unable to describe what 'fit to sit' meant or any criteria for this assessment and patients were left unattended in this area.
- The electronic tracking system did now allow for patients to be assigned correctly within the department but staff did not monitor this effectively.
- We remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions.
- Some patients with suspected sepsis were still not being identified or managed appropriately.
- Staff continued to be frustrated at the focus on sepsis and did not fully engage with the need to assess for sepsis.
- Staff were still not always using clinical judgement alongside NEWS scoring criteria.
- Care records were still not always written and managed in a way that kept patients safe.
- There was insufficient senior medical and specialist oversight and in reach to the department. This affected the safety and management of patients.

However

Summary of findings

- Some staff could recognise signs of sepsis and deterioration and acted on this appropriately.
- The ambulance triage area was functioning more effectively with clear and appropriate medical input and leadership.
- Some improvement in patient flow through the ambulance triage assessment area were seen.
- AEC was well run and escalated patients that they couldn't manage.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust MUST:

- The trust MUST ensure that all systems and processes in place to identify and manage patients with deterioration effectively are followed.
- The trust MUST ensure that staff record an accurate, complete and contemporaneous record of the care provided to patients.
- The trust MUST ensure all service users are safeguarded and protected from abuse and improper treatment.
- The trust MUST ensure that specialist clinical expertise is secured to ensure expertise across the emergency department. The clinicians should provide the oversight of care provision, ensuring all patients receive care from senior clinicians that is safe, effective, timely and in line with best practice.

Following the inspection, we told the provider that it must take some action to comply with the regulations and that it should make other improvements, even where a regulation had not been breached, to help the service improve.

Following this inspection, we imposed an urgent condition to safeguard patient's safety immediately following the inspection. This condition related to the provision of specialist medical in reach and support into the emergency department.

Ted Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	**We Previously inspected all of this core service in December 2017and it was rated inadequate overall. This inspection was not rated as we specifically looked at the safe aspects of our key lines of enquiry. Therefore the overall rating for the entire department in December 2017 still stands.** • Patients presenting to the emergency department still did not always receive a robust assessment of their clinical presentation and condition during the triage process. • There was still a lack of accountability for the safety of patients pre- and post-triage who were located within the waiting room. • Staff were still unable to describe what 'fit to sit' meant or any criteria for this assessment and patients were left unattended in this area. • The electronic tracking system did now allow for patients to be assigned correctly within the department but staff did not monitor this effectively. • We remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions. • Some patients with suspected sepsis were still not being identified or managed appropriately. • Staff continued to be frustrated at the focus on sepsis and did not fully engage with the need to assess for sepsis. • Staff were still not always using clinical judgement alongside NEWS scoring criteria. • Care records were still not always written and managed in a way that kept patients safe. • There was insufficient senior medical and specialist oversight and in reach to the department. This affected the safety and management of patients. **However**

Summary of findings

- Some staff could recognise signs of sepsis and deterioration and acted on this appropriately.
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- AEC was well run and escalated patients that they couldn't manage.

Russells Hall Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Russells Hall Hospital

Russells Hall hospital is in the heart of the Black Country, it covers a population of around 450,000 people in mainly urban areas. Russells Hall is part of The Dudley Group NHS Foundation Trust.

Core services provided at Russells Hall include urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care. The trust has approximately 669 inpatient beds, 31 escalation beds and 152-day case beds. The trust employs around 4,147 whole time equivalent staff (WTE). These included 482 medical staff, 1,225 nursing staff and 2,440 other staff.

The emergency department (ED) includes a paediatric ED and both provide care for the population of Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

The main ED consists of a dedicated ambulance triage area, a separate triage room for walk in patients, a resuscitation area with a dedicated space for paediatric patients. The treatment cubicles in the major's area include high dependency cubicles to monitor patients who are not yet ready to be transferred to a ward, and a minors' area with a dedicated ophthalmology assessment room.

Patients also have access to the Ambulatory Emergency Care Unit (AEC). Patients can also be directly admitted to paediatrics department, stroke unit, and cardiology unit when appropriately referred from other settings.

Our inspection team

An inspection manager led our inspection. The team included an enforcement manager, a CQC children's inspector, a CQC inspector, a CQC assistant inspector and two consultant specialist advisors.

How we carried out this inspection

We carried out an unannounced, responsive, focussed inspection to establish whether the trust was meeting their duties under The Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and the conditions that had previously been imposed upon the trust's registration. We inspected specific parts of the safe domain within the Emergency and Urgent Care Core service.

Detailed findings

We previously inspected all this core service in December 2017 and it was rated as inadequate overall. We conducted a further inspection of the safe domain of the Emergency and Urgent Care core service in March 2018 which was not rated however we found serious issues remained within the department. We conducted a further inspection of the safe and well led domains of the Emergency and Urgent Care core service in June 2018 which was not rated however we found serious issues remained within the department.

During this inspection, we inspected the Emergency and Urgent Care department on the 08 and 09 August 2018.

We spoke with medical, nursing and clinical support staff about their experience of working in the department. We also spoke with patients so we could obtain their views on the quality of care they were receiving.

During the inspection we reviewed patient records which included observation charts, screening tools and risk assessments, care plans and medical clerking documentation. We also observed a staff handover where the nurses discussed the patients in the department, their needs and levels of required observation.

Urgent and emergency services

Safe	
Overall	**Inadequate** 

Information about the service

The trust had one Emergency Department (ED), located at Russell's Hall hospital.

Russells Hall hospital is in the heart of the Black Country area it covers a population of around 450,000 people in mainly urban areas. The emergency department (ED) provides care for the population at Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

The trust also provides a paediatric emergency department which also provided a 24-hour service. The paediatric emergency department was a small area within the main department and consisted of a small reception area with a corner for children to play with toys, three cubicle spaces and one triage room. The paediatric department was segregated from the main department by lockable doors which were only accessed by authorised staff using a swipe card system.

The main ED consisted of a dedicated ambulance triage bay with 12 (could be flexed to 18) cubicles, and a separate triage room for patients. A four-bedded resuscitation area, with one dedicated space for paediatric patients. 16 treatment cubicles in the major's area (nine that were used for newly presenting patients and seven High Dependency cubicles to monitor patients who are not yet ready to be transferred to a ward). There was also a dedicated minors' area with a dedicated ophthalmology assessment room.

There were 170,000 accident and emergency attendances from April 2017 to March 2018 at The Dudley Group NHS Foundation Trust. There were 33.8% of patient attendees to accident and emergency admitted from April 2017 to March 2018. There were 22,100 children attending accident and emergency from April 2017 to March 2018.

There was an urgent care centre co-located with the ED. An external provider ran this centre. At the main ED reception desk, a 'streaming nurse' who worked for the urgent care centre (UCC), saw all self-presenting patients who attended ED at the hospital. Patients with minor illnesses or injuries were diverted either to UCC or to the minors' area within the ED.

ED at Russells Hall hospital was last inspected by CQC in December 2017, as part of the new hospital inspection programme. At the time urgent care services were rated as 'Inadequate'

We conducted further inspections of the ED department in March and June 2018.

We inspected the service but did not rate it as we focussed our inspection on specific areas.

We reviewed 87 patient records throughout our inspection and we spoke with 26 staff and 13 patients.

Urgent and emergency services

Summary of findings

For what we found on our previous inspection, look here:

http://www.cqc.org.uk/provider/RNA

Are urgent and emergency services safe?

We did not rate the safety of the service on this inspection, but we found:

- Patients presenting to the emergency department did not always receive a robust assessment of their clinical presentation and condition during the triage process.
- There was still a lack of accountability for the safety of patients pre- or post-triage who were located within the waiting room.
- Staff were unable to describe what 'fit to sit' meant or any criteria for this assessment. We found this area unmanned when patients with care needs were accommodated in there.
- We remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions.
- Some patients with suspected sepsis were still not identified or managed appropriately. This included children.
- Staff continued to be frustrated at the focus on sepsis and did not fully engage with the need to assess for sepsis. This included discontinuing sepsis treatment and pathways without clinical review.
- There was no clear accountability of which team was responsible for the patient once they had been referred to a medical speciality.
- Staff were still not always using clinical judgement alongside NEWS scoring criteria.
- Care records were not always written and managed in a way that kept patients safe.
- There was insufficient in reach and support from specialities in complex cases. An example of this was in the case of an unwell child where the ED team had not requested support from the paediatric team.

However,

- Some staff could recognise signs of sepsis and deterioration and acted on this appropriately.

- The ambulance triage area was functioning more effectively with clear and appropriate medical input and leadership.
- Some improvement in patient flow through the ambulance triage assessment area were seen.
- AEC was well run and escalated patients that they couldn't manage.

Environment and Equipment

- Cubicles in the ambulance triage area were not visible from the nurses' station and the environment was not fit for purpose.
- Cubicles in the ambulance triage assessment areas were small. This meant that ambulance crews could not transfer patients from ambulance to hospital trolleys in the cubicle. Instead the transfer was carried out in the corridor and patient dignity was compromised. However, patients were only held in this area for short periods due to the improvements in the flow of the area.
- The trust had opened a 'fit to sit' area in the emergency department (ED) two days before our inspection. This area was not secure and could be accessed from the main corridor. It also allowed patients to leave the area unseen. During our inspection we visited this area on three separate occasions and found it unstaffed. On these occasions patients were present and had significant care needs. This posed a significant risk that patients were left unattended or could leave without being observed.
- AEC had enough room to meet the needs of its patients. However, it was situated approximately ten minutes' walk away from the ED. Patients were required to walk unescorted which posed a risk if they were to deteriorate and become unwell or get lost on the way to the AEC.
- We also observed an occasion where a nurse had taken a child to be x rayed in the x ray department. The child was very unwell and suffering breathing problems. The nurse transferred the patient without a trolley, oxygen or means to call for help. This case is further described in assessing and responding to risk.

Records

- Care records were not always written and managed in a way that kept patients safe. The records we looked at were not always accurate and complete.
- Records were not always kept secure. During our inspection we found patient records in the fit to sit area which were not stored securely and could have been accessed by members of the public.
- The service used two different computer systems and paper records. This meant that staff could have difficulty accessing the full patient record. The trust was in the process of implementing an Electronic Patient Record system to resolve this issue and to bring enhanced patient safety benefits.
- The trust had a paediatric assessment tool which included a section to record details of adults accompanying the child. The completeness of this section in records we looked at was variable. In many cases a first name only was recorded and the relationship to the child was not always recorded. Recording of professionals known to the child and key information such as the child's family or school and whether the child has a social worker is free text and dependent upon the individual practitioner completing the document.
- The trust had a transfer document which was used when transferring patients between the Children's ED and the Children's Ward. This was a general trust transfer document for all patients and had not been adapted to meet the specific needs of children and young people. This meant that there was reliance on the individual practitioner who completed the verbal handover to the Children's Ward staff to ensure relevant safeguarding related information is passed on.
- Staff did not routinely record the child's words in the records of their care. In the records we looked at there was no information recorded to indicate if the child had been asked to provide their own history or tell their own story.

Safeguarding

- The trust had recently appointed a new Head of Safeguarding Adults and Children and an additional Named Nurse to work across the trust. The trust's safeguarding team could be contacted during normal

office hours every working day to provide advice and guidance to staff. Outside these hours, an on-call consultant paediatrician was available to support staff across the trust with any concerns about children they encounter.

- The trust had a Safeguarding Children Policy which included information on safeguarding processes to be followed by trust staff for a range of circumstances. It also included information on training and support. The policy included brief reference to children in specific circumstances and a link to the local safeguarding children board website procedures. However, the policy did not include emphasis on recognition and reporting in relation to key topics such as child sexual exploitation and domestic abuse.
- The trust safeguarding children policy included details on unexpected child deaths and the rapid response process. The trust followed the West Midlands regional policy and pathway for child deaths. Within the resuscitation area in the ED and on the Children's Ward a 'red pack' is available which included a range of information in relation to child deaths. A Rapid Response Rota was in place and the red pack included specific information on how to contact the on-call professional. Staff we spoke to told us how all child deaths are reported on the incident reporting system and the safeguarding team receive an automatic copy of the incident form.
- The trusts intranet safeguarding children page provided a range of useful information and contact details. This also included briefings providing learning from serious case reviews, and updates on key safeguarding topics. Links to policies and procedures and documents viewed were up-to-date.
- Practitioners working in the Children's ED could access a children's safeguarding red folder. This contained useful information and guidance regarding safeguarding children including direct numbers and information about processes, for example referral to children's social care and the rapid response child death process.
- The trust had a current Safeguarding Children Training Policy and competency workbooks for the different levels of training required by staff. Training at level one and two was delivered as a joint programme for children and adults safeguarding together. This supports the principles of 'Think Family'. The trust had recently undertaken a review of level three training within the trust. A new programme was being delivered by the safeguarding children team. The trust recognised the programme is a single agency programme rather than multi-agency as advised in the intercollegiate document safeguarding children roles and competences for health care staff. We were told that additional multiagency safeguarding training can be accessed from the training programme of the local safeguarding children board.
- The trusts safeguarding assessment for children's ED was guided by five tick box questions. These questions are a mandatory part of the assessment document. These questions were completed in all clinical records reviewed. However, these are not sufficiently detailed to explore additional vulnerability and do not ask the practitioner to clarify if they have any overall safeguarding concerns. Free text recording was available however this is reliant on individual practitioner's knowledge, awareness and expertise. There was no audit currently taking place in the ED of the completion of these questions. There was no written guidance for staff to follow in relation to completion questions.
- The national Child Protection Information Sharing (CP-IS) programme was not yet fully in place in Dudley. We heard how the roll out has recently commenced. This will help identify children on a child protection plan and looked after children. At the time of our inspection as part of the booking in progress process a check was made to identify if children and young people are on a child protection plan currently or have been previously. This was then identified and flagged on the electronic record. This does not include those children who are looked after.
- There was no formalised or written protocol in place when children are removed from the ED by the accompanying adult before they are seen by a clinician or before treatment has been completed (Did Not Wait). This meant the trust did not guide staff to have consistent and appropriate responses. Without a clear protocol, the trust cannot be fully assured of the effective practice.

- The trust has a Paediatric Liaison Nurse who reviewed all ED attendances of children and young people up to the age of 18. The primary role of the Paediatric Liaison Nurse is to effectively information share with external partners. However, the department was heavily reliant on this system to identify and act upon missed cases and not just to share information with external partners which is the primary role of the paediatric liaison nurse. As this service was a Monday to Friday 9am to 5pm service there was a risk that safeguarding cases would not be picked up for a number of days if missed on a Friday or at the weekend.

Assessing and responding to patient risk

- We were still not assured that all staff knew how to follow the sepsis pathway and screen patients appropriately for sepsis. We saw that some staff could describe the signs of sepsis and outline what action was required, however this was inconsistent with other staff unable to do so.
- We observed a practice of nurses showing completed sepsis pathway documents to senior doctors and the doctor then signing the pathway to indicate it was not needed. We observed this happening when patients had clear signs of sepsis and we saw that in all the cases where we observed this practice the doctor did not take a clinical history of the patient.
- A number of clinical staff we spoke with including senior doctors and nurses still did not understand sepsis and were frustrated by the need for screening and pathways. In another case a nurse told us that a patient did not have signs of infection and therefore did not require screening. This was despite them being actively treated with antibiotics and showing red flags for sepsis.
- In four out of five cases we reviewed where patients had signs of infection they did not have a sepsis pathway in place. In two out of five cases we reviewed patients encountered a significant delay in starting antibiotics. In one case this was over 11 hours.
- There were still delays in taking observations for very unwell patients.
- In one case a patient with sepsis waited over 3 hours for observations at which point their NEWS had increased from 2 to 5.
- Staff used a recognised tool to monitor patients, known as the National Early Warning Score (NEWS). Nursing staff still did not always use clinical judgement and remained unclear on how frequently to undertake patient observations and these were not always linked to clinical condition. The chief nurse told us that there were no two hourly observations in the trust policy. The policy stated that frequency was 30 minutes, 60 minutes and four hourly. However, staff told us that all patients in majors were placed on two hourly observations.
- We observed an occasion when the department became busy. At this point three patients with NEWS over 6 were up to one hour delayed in their observations.
- In a specific case a patient who presented as very unwell had a very raised troponin reading (a blood test to ascertain cardiac issues). They had their observations taken at 11.12am and they were still not repeated at 2pm.
- In another case a child presented at 12.55pm with a Paediatric Early Warning Score (PEWS) of 10 and shortness of breath. Their observations were not repeated on the system by 2pm. The nurse told us they were 'written on a bit of paper'. We were present with the child from 2pm until 3pm and their observations were not repeated until they arrived on the paediatric ward. At this point their respiratory rate remained above 60 and their oxygen saturations below 90%.
- Staff were not utilising the resuscitation area for unwell patients. At a time when there was capacity a number of patients who required a higher level of care were placed in the major's areas. In one case a patient had a NEWS 6-8 and was managed in the major's area. Although they were moved for short periods to the resuscitation area, they remained in the major's area whilst very unwell and did not receive one to one care. In another case a patient with severe infection and deranged observations resulting in a high NEWS score was cared for in the major's area.

Urgent and emergency services

- Staff still struggled to differentiate between categories of patients. A large number of patients were placed into ESI category 2 'cannot wait'. A large number of these patients were placed into the waiting room to wait.
- A high number of these patients waited a number of hours to be seen by a doctor. Some examples included a child with burns to their body who waited over three hours to be seen, a three-year-old with temperature of 40 degrees and hallucinations who waited two hours to be seen, a child under one with a temperature waited 1 hour 30 minutes to be seen and a baby involved in a fire waited nearly two hours to be seen.
- The oversight of the waiting room remained a concern. Staff were not always aware who was waiting to be seen in the waiting room or where people were. Since the last inspection the trust had updated their system to allow staff to allocate patients to the waiting area. However, during the inspection not all patients who were in the waiting area were showing on the system as being in the waiting area.
- Since the last inspection the trust had assigned a member of staff to monitor the waiting room at all times. This member of staff could be from anywhere in the hospital and was either a registered nurse or a clinical support worker. This member of staff did not always have triage training and they told us they were not always aware of what they should be monitoring to keep patients in the waiting room safe. Staff reported they did not feel that this member of staff assigned to the waiting area had made a difference to the safety of patients.
- While CQC staff were in the waiting room on 08 August they noted a patient, who appeared to be sleeping or unconscious on the chairs in the waiting room. Staff present told CQC that they were worried about the patient because they didn't know their name and they were worried they had been there for a number of hours. They advised that they had escalated their concerns twice to the triage nurse. No one in the reception or triage area knew the patient's name or why they were there. It was later established that the patient was not booked in to the department but had been present for a number of hours.
- We spoke with three clinical support workers (CSW's) who were overseeing the waiting room area. Only one out of the three told us they knew their role and could describe what type of patient required escalation. Two CSW's told us they were unclear on their role. We spent considerable amounts of time in the waiting room and there was no registered nurse presence.
- Despite senior staff telling CQC that the nurse in charge was accountable for the waiting room and ensuring no high-risk conditions were waiting, we observed that the senior nurse consistently had their 'tracking screen' on 'majors' only. This only gave a view of the major's area and not the waiting room.
- Nursing staff told us that unwell patients were still accommodated in the waiting room when 'there was no room'. We saw examples of this in records we reviewed including a case where a patient with chest pain and a cardiac history was placed in the minor's area.
- The new 'fit to sit' area had no clear criteria for which patients were fit to be placed in this area. There was also no specification on how long the patients should be there. Three separate staff members of CQC attended this area to find it unmanned with patients present. These times were up to 10 minutes. At these times patients who required admission were accommodated there, included a patient with infection and high risk of falls. This was closed immediately following raising our concerns.
- The management of some patients with chest pain was a concern. We were advised that CSW's referred patients with chest pains to ambulatory care without seeing a doctor or senior nurse. We observed a CSW come in to the triage area with an ECG and ask the triage nurse if patient could now be moved to AEC and this was agreed without nurse reviewing the ECG.
- Some examples included a case where a patient presented with cardiac chest pain not relieved by GTN spray. Their troponin was raised but they did not receive aspirin until 6 hours later and did not receive additional essential medication at all. In another case a patient had a troponin of 131 and experienced a delay of over two hours to receive treatment. They were both in an un-monitored bay in ED majors.

Urgent and emergency services

- We were not assured that paediatric patients presenting with medical conditions were managed safely. We saw one case where a child presented with a serious medical issue. We identified a child with a PEWS of 10 (very high and indicates serious illness) and shortness of breath. The child was observed in x ray and appeared very unwell. It was established that the carer of the child had had to carry them from ED to X-ray and not been offered a trolley or chair. The nurse had accompanied them with no way to call for help. The child was to be transferred to the ward. A CQC clinical advisor had to accompany the child as they were concerned for their safety. Their breathing deteriorated en route to the ward and on arrival their respiratory rate was 66 (very high) and oxygen saturations were 81% (low). Their x-ray showed infection and they were commenced on treatment for infection/sepsis. It was later found that the ED had completed the pathway for sepsis and it guided them to start the sepsis 6 but the doctor overruled and discontinued the pathway despite all boxes indicating sepsis being ticked. The child was discharged well from the hospital the following day.
- Senior medical staff in the department told us that consultants in the department were unable to make decisions about complex medical patients as they had a lack of confidence, experience and didn't want to listen. A senior member of staff in another team said they felt the department was unsafe because as soon as it reaches capacity there is a 'tipping point'.
- In the paediatric department we reviewed 34 records to look at triage times. 15 patients had a triage time of under 30 minutes whereas 19 patients had a triage time of over 30 minutes recorded up to 3 hours. The national standard for time taken to triage is 15 minutes.
- Doctors who treated young people age 16-18 in 'adult' ED could choose whether to use the paediatric assessment tool or the adult assessment tool. The adult assessment tool does not include the five safeguarding questions that are within the paediatric assessment tool. This means that safeguarding risks may not be considered for this cohort and that there is inconsistent practice.
- The trust was completing daily audits of sepsis and NEWs to fulfil the conditions on their registration. However, staff we spoke to were not aware of any learning from these audits and could not tell us who was completing them.
- Staff were still not linking the clinical conditions with the frequency of observations required, for example a patient who was at high risk was on four hourly observations and was placed in an interview room which could not be visualised easily by staff working in the ED.
- The arrangements for the monitoring and escalation of patients waiting to be admitted to acute medical wards remained unclear, with no clear accountability of which team was responsible for the patient once they had been referred to medicine. The department was working in silo of the specialities and staff remained unclear on who cared for these patients.
- AEC was well run and escalated patients that they were not able to manage. However, staff told us that they received inappropriate referrals from the triage area from health care support workers.
- The trust had a six-bedded ambulance triage area which could be flexed up to twelve beds when needed. Ambulance staff reported that triage is generally very quick but they can be made to wait afterwards.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Following our previous inspection, we took enforcement action to ensure the trust were addressing the risks to patients. In addition to this action the hospital MUST take the following action to improve:

- The trust MUST ensure that all systems and processes in place to identify and manage patients with deterioration effectively are followed.
- The trust MUST ensure that staff record an accurate, complete and contemporaneous record of the care provided to patients.
- The trust MUST ensure all service users are safeguarded and protected from abuse and improper treatment.
- The trust MUST ensure that specialist clinical expertise is secured to ensure expertise across the emergency department. The clinicians should provide the oversight of care provision, ensuring all patients receive care from senior clinicians that is safe, effective, timely and in line with best practice.

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
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. 2. Systems and processes must be established and operated effectively to prevent abuse of service users. 3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. 4. Care or treatment for service users must not be provided in a way that— A. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user, B. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint, C. is degrading for the service user, or D. significantly disregards the needs of the service user for care or treatment. 5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. 6. For the purposes of this regulation—'abuse' means— A. any behavior towards a service user that is an offence under the Sexual Offences Act 2003(a), B. ill-treatment (whether of a physical or psychological nature) of a service user, C. theft, misuse or misappropriation of money or property belonging to a service user, or D. neglect of a service user.

This section is primarily information for the provider

Requirement notices

7. For the purposes of this regulation, a person controls or restrains a service user if that person—
   A. uses, or threatens to use, force to secure the doing of an act which the service user resists, or
   B. restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A. assessing the risks to the health and safety of service users of receiving the care or treatment; B. doing all that is reasonably practicable to mitigate any such risks; C. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; **Following this inspection we varied the conditions on the providers registration.**