Blackpool Teaching Hospitals NHS Foundation Trust

# Blackpool Victoria Hospital

**Inspection report**

Whinney Heys Road
Blackpool
FY3 8NR
Tel: 01253655520
www.bfwh.nhs.uk

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## Ratings

| Overall rating for this service | Inspected but not rated |
|---|---|
| Are services safe? | **Inspected but not rated** |
| Are services effective? | **Inspected but not rated** |
| Are services responsive to people's needs? | **Inspected but not rated** |
| Are services well-led? | **Inspected but not rated** |

# Our findings

## Overall summary of services at Blackpool Victoria Hospital

**Inspected but not rated**

We carried out a focused inspection of Blackpool Victoria Hospital on 11 January 2021. This included an inspection of the urgent and emergency care service at Blackpool Victoria Hospital as part of our winter pressures programme.

We considered nationally available performance data and data and intelligence provided by the trust. We inspected against the safe, responsive and well-led key questions; we inspected key lines of enquiry relevant to the winter pressures programme.

We also carried out a focused inspection of medical care because we had concerns about the quality of services.

The focused inspection of medical care covered elements of three key questions; is the service safe, effective and responsive.

We did not inspect all the key lines of enquiry or domains and therefore have insufficient evidence to rate the services.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

**How we carried out the inspection**

You can find further information about how we carry out our inspections on our website:

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

# Urgent and emergency services

**Inspected but not rated**

**Key facts and figures**

The urgent and emergency care department at Blackpool Victoria Hospital provides emergency care for adults and children, 24 hours a day, seven days a week. The hospital is not a major trauma centre; however, it is the regional cardiothoracic centre and as such, patients with penetrating chest wounds are treated here. Annual attendances at the department are about 67,000 which includes 11,000 attendances for children and young people.

Following the outbreak of COVID-19, the department has designated three entrances and designated areas in the department, one for walk-in patients, one for ambulance drop-off and one for COVID-19 positive patients. The COVID-19 positive department is in the building that previously housed the primary care urgent treatment centre. The urgent care treatment centre has been moved to a building in the car park in front of the urgent and emergency care building. The COVID-19, or high-risk area, was designated as a red zone and the other areas of medium risk of COVID-19 were designated as amber zones.

The red zone had four assessment rooms and an ambulance handover space. There was an escalation area of eight cubicles with doors. There was not a separate resuscitation cubicle in the red zone but there was a resuscitation trolley and equipment that could be moved into cubicles as necessary.

In the amber area there was an assessment area with 13 bays and two additional bays which could be observed from the nurses' station. The ambulance drop-off had a triage area with a cubicle and two ambulance bays. There was a rapid assessment treatment area with five cubicles. There was a resuscitation area with four cubicles.

There was an assessment area which had a waiting area, four cubicles and three treatment chairs. This area was for lower acuity ambulatory patients and patients waiting for treatment before discharge.

Walk-in patients were triaged from a reception desk in the main reception area. There was a seating area adjacent to this for patients to wait, with appropriate social distancing measures in place.

The children's emergency department had a separate entrance with an intercom system to control entry. There was a waiting area for children and young people with controlled access to two triage cubicles and five treatment cubicles. One of the cubicles was suitable for patients with mental health problems and was ligature free.

We spoke with 18 staff during the inspection, including registered nurses, paramedics, consultants, middle grade doctors, flow matrons, pharmacy staff, senior managers from the emergency department and from the trust. We reviewed 23 records, including nursing records, doctors' records, risk assessments and prescription charts. During the inspection we attended a bed meeting, we observed a safety huddle and two handovers from ambulance staff to emergency department staff. We also observed the care and treatment of patients in the department.

**Overall summary**

Our findings were:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

# Urgent and emergency services

- The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks once they were in the department. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm, and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.
- Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced, including factors external to the service arising from the additional pressures of the COVID-19 pandemic. They were visible and approachable in the service for patients and staff.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and treatment including during periods of heavy demand. The service had an open culture where staff could raise concerns without fear.
- The service's senior clinical leadership team were able to describe the current issues that were impacting on the service's performance and response times. These included factors outside the service's control within the wider hospital and the community across the Blackpool, Wyre and Fylde Coast as a result of pressures from the COVID-19 pandemic that were leading to increased demand on the service and directly impacting on waiting times and performance.

However:

- People could access the service when they needed it but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Managers and staff monitored waiting times and took remedial action but could not always ensure that patients did not stay longer than they needed to.

## Is the service safe?

**Inspected but not rated**

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

- We reviewed the trust's safeguarding training rates. For safeguarding of children and young people, completion rates for level one training were 86.8%, level two 89.4% and level three 75.7%. For safeguarding of adults, training rates for completion rates for level one training were 92.3%, for level two 89.4% and for level three 55.7%. Prevent training rates were at 90% for levels one and two and 91.2% at level three; this is training to the risks of radicalisation and the roles involved in supporting those at risk. Training rates for the mental capacity act were 78.5%.

# Urgent and emergency services

- In the adult emergency department, there was a safeguarding navigator who supported the department 25 hours a week. Safeguarding support was available 24 hours a day, seven days a week. The trust's safeguarding team developed a COVID-19 safeguarding package to support staff during the pandemic. The trust had an independent domestic violence advisor who would support any patients attending the emergency department.
- The paediatric ward had developed a safeguarding trigger tool. A form was completed for every child who attended the department. Information collected included: details of the child, if they were known to a social worker and information about who had accompanied the child to the department. If a young person between 16 and 17 years attended the main emergency department the same information was collected, and the paediatric staff would support the main department in the collection of this information. All the information was sent to the trust's safeguarding team.
- Following several difficult incidents there had been a debrief for all staff in the paediatric emergency department. There was learning from the incidents and a review of what could have been done differently. The nurse manager said that there had been good feedback from staff about the session. There was safeguarding supervision for all the paediatric nursing staff every three months.

**Cleanliness, infection control and hygiene**

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

- The department was visibly clean. Throughout the inspection we saw cleaning staff working around the department and staff told us that the teams were responsive when areas needed to be cleaned. We saw that staff were cleaning trolleys and mattresses between patients and deep cleans were completed as necessary. There was a cleaning crew outside the hospital to decontaminate ambulances once a patient had been handed over to hospital staff.
- There were plentiful supplies of personal protective equipment (PPE) and we saw that staff used it. There was information on the walls of the department about appropriate PPE usage. There were sinks around the department with hand wash and alcohol gel and we saw that staff washed their hands and followed guidance on hand washing. Chairs in the waiting areas were made of wipeable material. Chairs were cordoned off to allow two-meter distancing between patients.
- Due to COVID-19 the department was divided into non-COVID-19 (amber) and COVID-19 (red) zones which had separate entrances which allowed patients to be segregated from each other. There was good signage in the department between the different areas. Patients could not be moved from the red zone until they had been swabbed for COVID-19. This allowed them to be placed in an appropriate area in the hospital for their treatment according to their COVID-19 status. This helped to reduce nosocomial infections in the trust.
- On the day of the inspection there was a delay in COVID-19 swab results. This was due to a machine failure and test results were taking up to five hours. We were told that usually results were available in two hours. The department was starting to use point of care testing on 14 January and those test results would be available in 15 minutes.
- In the children's emergency department there were two nurses on duty, one of them was designated for COVID-19 positive patients and one was for COVID-19 negative patients. This was displayed on the wall in the department.
- However, at the nurses' station in the adult emergency department, we observed that doctors and nurses did not always observe social distancing rules. We also saw that there were significant numbers of staff moving between the amber and red zones, although all staff that we observed followed appropriate infection control practices.

**Environment and equipment**

# Urgent and emergency services

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However due to the size of the department and the lack of space due to building work it was cluttered.**

- There was extensive building work ongoing in the department at the time of the inspection. This building work was part of the emergency village development and was due to be completed in two weeks. There were large areas of the department that were screened off to allow building work and this had reduced available space in the department. The department had made best use of available space for maximum patient capacity and separation of areas for COVID-19 and non COVID-19 patients.
- The size of the corridors made social distancing difficult but in assessment areas we saw that hospital staff and ambulance staff managed to maintain social distancing. In the ambulance triage area, there was space for four trolleys, and we saw that ambulance crews worked with hospital staff to maintain social distancing in this area.
- The cubicles in the red zone were equipped with a defibrillator and patients could be intubated in these cubicles as necessary. There was an X-ray unit in the amber zone of the department and a mobile X-ray facility in the red zone of the department.
- Resuscitation trolleys and sepsis trolleys in the department were checked and this information was documented. Equipment had "I am clean" stickers and we saw that equipment was cleaned between patients.
- In the paediatric emergency department, there was an assessment room for children and young people with mental health problems. This was ligature free.
- However, the department's corridors were cluttered with trolleys and equipment.
- The emergency department pharmacist was involved in the 'emergency village' to ensure provision for medicines was appropriate. However, they had identified that the fluid store was not temperature controlled and hence may not maintain a suitable temperature for the safe storage of medicines.

**Medicines**

**The service used systems and processes to safely prescribe, administer and record medicines.**

- The trust's audits showed that standards for the administration of antimicrobials for sepsis within one hour were met.
- A specialist pharmacist and technician provided weekday support to the emergency department, working as part of the multi-disciplinary team, focusing on medicines quality and safety. The pharmacy team also ensured that when patients were admitted, any medicines the patient had brought with them went to the correct ward. A business case for extended pharmacy hours was in development.

**Assessing and responding to patient risk**

- **Once patients were in the department staff completed and updated risk assessments and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- The ambulance service used a pre-alert form provided by the trust to highlight any patient risks to the emergency department identified during the journey to the department. The form contained information about the patient's history and clinical observations. There was a process so that patient information from the ambulance service was transferred into the emergency department's electronic record for patients and could be reviewed by clinicians.

# Urgent and emergency services

- Information provided by the trust following the inspection stated, patients were prioritised using the details recorded on the pre-alert form. On arrival the Consultant or Senior Coordinator in the department would link in with the Ambulance Liaison Officer (ALO) to confirm if the pre-alert details were still correct and if there were any immediate safety concerns. Following this a joint agreement as to the priority order for patient transfer was made between the trust and the ambulance service.
- At the time of the inspection there was no written guidance for staff on managing patients waiting in ambulances. However, we were told that a standard operating procedure was being developed between the trust and the ambulance service. This was due to be completed by the end of January 2021.
- The paramedics reported that it was easy to ask for help or for a medical review of the patient when in the ambulance. During the inspection we saw consultants going out to ambulances if concerns about patients were highlighted. Delays in handover meant there was an increased risk to patients in the local community who were waiting for an ambulance.
- During the inspection we observed that there were two ambulances waiting outside the hospital in the afternoon. By the evening this had increased to four. On the day of the inspection performance data showed that the longest wait for handover to urgent and emergency care staff from ambulance arrival times was 2 hours and 24 minutes.
- We observed that the handover of two patients from the ambulance crew to the triage nurse was of good clinical quality. Triage of all patients was by a nationally recognised tool. There was a COVID-19 clinical triage support tool for patients showing symptoms of the disease.
- The department used an early warning score system as a guide to determine the degree of illness of a patient. We saw that was used to identify patients at risk of deterioration and that their care was escalated appropriately.
- There were safety huddles every two hours or more frequently if required. These were led by the nurse in charge of the department and the doctors in attendance. There was a set agenda with prompts. At the 2.00pm meeting on the day of the inspection, the overall numbers of patients were discussed, the plans for each patient were reviewed and issues or requests for tests and diagnostics were escalated. The huddle we observed was supportive of staff and their well-being and ensured that staff had taken breaks.
- All patients in the rapid assessment treatment area, who had been brought in by ambulance, had observations completed, COVID-19 swabs taken, and appropriate tests completed on arrival in the department.
- The resuscitation room appeared well-equipped and we observed that two seriously ill patients were seen to and received immediate care and treatment that was consultant-led.
- There were clinical guidelines available on the intranet and these were easily accessible; all guidelines were up-to-date, and all had been reviewed and revised as necessary within the last two years. In the paediatric department, there were laminated sheets for the most common pathways used in the department and these were easily accessible by staff.
- Records which included doctors, nurses and medicine administration records were fully completed. Risk assessments for pressure ulcers, falls and venous thromboembolism were started when the patient had been in the department for two and a half hours. This was in line with trust policy. We saw that patients who were in the department for a long time were transferred to trolleys with pressure relieving mattresses.
- In the paediatric emergency department, we reviewed triage times. In December 2020, there were 703 paediatric attendances, an audit of triage times examined 155 cases randomly. There was 89% compliance with the 15-minute standard from the Royal College of Paediatrics and Child health that an initial clinical assessment of the child occurs within 15 minutes of arrival in the department. A number of these breaches of the 15-minute triage standard were due to children receiving immediate medical intervention on arrival in the department. In September 2020 there was an

86.6% compliance with the 15-minute triage standard. There was CCTV in the paediatric waiting areas so that the staff could observe children and young people in the department to see any deterioration and act immediately if necessary. Staff could also monitor the access to the department from the adult area of the emergency department. The department was using the COVID-19 triage trigger tool which staff said provided consistency in care.

- Staff in the paediatric department told us that they had a good relationship with staff on the children's ward and senior nurses would come down to the department if requested. There were regular meetings between the two departments. Reviews and learning from incidents, including COVID-19 related incidents took place and we saw examples of change in practice following incidents in the department.
- There was simulation training around the unwell child and study days including a pre-alert study day for the receiving of an unwell child into the department. We also saw evidence of staff competency training. All staff in the department were in date for their advanced paediatric life support training. An annual update for paediatric immediate life support training was planned and the band 7 nurses from the adult emergency department were included in the training to support the paediatric staff if necessary.

**Nurse staffing**

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

- Managers told us that the nurse staffing in the department was at the establishment, as determined by the trust. The trust was using a staffing model which looked at acuity and risk. Staffing was reviewed daily across the division so that any gaps in staffing could be identified. Managers said that they supported staff, who may not have been in their comfort zone, if transferred from another area of the hospital to work in the department.
- There was a co-ordinator (band 7), 24 hours a day, seven days a week, to oversee the staffing in the department. The resuscitation area had two registered nurses for four beds and these nurses had undergone advanced life support training. In the triage area there was a registered practitioner from the local ambulance service, a streaming nurse and a triage nurse. The rapid assessment triage area had five bays with a co-ordinator, two registered nurses and three health care assistants. The Majors area had 13 beds with a co-ordinator, four registered nurses and four health care assistants. The COVID-19 red area had a co-ordinator, a registered nurse and a health care assistant.
- The clinical matron for the department told us that they were using between six and eight agency nursing staff every day to cover gaps in staffing through sickness and annual leave. Fill rates for registered nurses in December 2020 were 81.2% for day shifts and 100.4% for night shifts. In November 2020 fill rates for registered nurses were 82.3% for day shifts and 87.3% for night shifts and in October 2020 fill rates for registered nurses were 77% for day shifts and 83.3% for night shifts. For unregistered staff fill rates were about 80% for day and night shifts in December 2020. In November 2020 fill rates were 80.4% for day shifts and 86.6% for night shifts and in October 2020 fill rates were 77% for day shifts and 83.3% for night shifts for unregistered staff. All the bank and agency staff were known to the co-ordinators and had experience in the areas that they were allocated to. There was a thorough induction for agency staff, which included infection control processes and information governance.
- There were housekeepers in the department to help to provide patients with drinks and refreshments.
- In the paediatric emergency department, the nursing establishment was two registered children’s nurses for each shift supported by an emergency department assistant. In the period 1 December 2020 to 15 January 2021 there were six night shifts which were covered by one registered children’s nurse. This almost met the “Facing the Future Standards for Children in Emergency Care Settings” (Royal College of Paediatrics and Child Health 2018) that states

that there should be two registered children's nurses on every shift. To mitigate the risk the registered children's nurse on shift was supported by a registered nurse from the adult department so that there were two registered nurses in the paediatric department. Band seven nursing staff in the adult emergency department had received training in paediatric life support skills to support staff in the paediatric department if necessary.

**Medical staffing**

**The service had mitigating actions in place to ensure enough medical staff with the right qualifications, skills, training and experience were in place to keep patients safe from avoidable harm and to provide the right care and treatment.**

- At the last inspection in 2019, one of the actions for the trust was to increase medical staffing numbers at the trust to 18 consultants. There was currently a business case to uplift the numbers of consultants as part of the trust improvement plan and was waiting for approval following some changes to the business case.
- There were 12.5 consultants who worked in the department and no consultant vacancies. There was a consultant available in the department for 16 hours every day. There were three during the day until 5pm and then two until midnight. From midnight to 8.00am, the department was covered by an ST4 doctor or above.
- There was a shortage of middle grade staff. There were gaps in middle grade staffing with four vacancies at ST4 (two had been recruited to) and four at ST3 (two had been recruited to). There was one shift between 1 December 2020 and 15 January 2021 which did not meet the Royal College of Emergency Medicine standards on medical staffing of the emergency department. This was because agency staff were used to cover the staffing gaps.
- The culture of the department was very supportive across grades and professional groups.
- Feedback from staff was that their on-going educational needs should be considered and that this may support recruitment of further middle grade staff.
- The trust had been unsuccessful in the recruitment of a Paediatric Emergency Medicine consultant. However, there was a senior specialty doctor who had taken a lead role with an interest in paediatric medicine and there was access to the specialty paediatric team, 24 hours a day, seven days a week. There was an advanced nurse practitioner (ANP) for paediatrics and a business case to recruit and train an additional two ANPs for the department to provide cover 24 hours a day, seven days a week.
- The emergency department pharmacist supported junior doctor induction, providing education sessions and promoting sharing of learning through a monthly 'lessons learnt' newsletter that focused on medicines incidents and near misses within the emergency department.
- The emergency department pharmacist clinically checked and prescribed medicines supporting patient flow through the department, enabling the admitting doctor to focus on clinical history taking and clinical examination of the patients.

## Is the service responsive?

**Inspected but not rated**

**Access and flow**

# Urgent and emergency services

**People could access the service when they needed it but did not always receive the right care promptly. Waiting times, arrangements to admit, treat and discharge patients were not in line with national standards. Managers and staff monitored waiting times but could not always ensure that patients did not stay longer than they needed to.**

- The urgent and emergency care service was available 24-hours a day throughout the year.
- The average attendance by ambulance was 79 patients per day in the week beginning 11 January 2021. On the day of the inspection performance data showed that the longest wait for handover to ED staff from ambulance arrival times was 2 hours and 24 minutes. This was the highest handover time for the week. The next longest handover time was on the following day and was 52 minutes. The average handover time for the trust was 19 minutes 47 seconds; the average for the region was 21 minutes and 37 seconds in this week. There were 56 patients with an extended turnaround time of one to two hours and five patients with an extended turnaround time of two to three hours in this week beginning the 11 January 2021.
- On the day of the inspection the trust had their highest number of COVID-19 positive patients being admitted since the start of the pandemic. There were 12 patients who were COVID-19 positive, with seven patients arriving by ambulance in a time period of 90 minutes. The small number of cubicles in the red area (five), combined with the delayed wait for the results of a COVID-19 swab, contributed to the ambulance handover delays.
- The service's performance data showed that in October 2020 the percentage of ambulances remaining at the hospital for more than 60 minutes was 4.3%, this compared with an England average of 7.3%. Time from arrival by ambulance to initial assessment was six minutes (October 2020) and time to treatment was 65 minutes (October 2020). The percentage of patients who spent less than four hours in the department was 51.2% compared to the England average of 72% (December 2020).
- The percentage of patients in the department spending more than 12 hours from decision to admit to admission was 51% in December 2020. Admissions waiting four to 12 hours from decision to admit to admission were 60% (December 2020) and were worse than the England average of 24% for the same period.
- There were daily bed meetings at 8.30 am,12 am, 4pm and 8pm. The meetings had a set agenda and were well-structured. Issues and concerns were raised at the meetings from each department in the hospital. There was representation from the emergency department at the meeting and there was an ambulance liaison officer who attended meetings. Following the meeting, a dashboard was produced highlighting information about flow in the emergency department and across the trust. Information for the emergency department included current patient numbers, breach times of current patients with a decision to admit and waiting times for ambulance handover. The dashboard provided the bed status of the trust in each speciality, current and forecasted and capacity at other sites. The operational pressures escalation level (OPEL) was included in the dashboard for the emergency department and the hospital. The bed meetings were chaired by more senior managers as the OPEL level increased.
- We observed the 4pm bed meeting on the day of the inspection. There had been 91 attendances during the day and there were 45 people in the department. Performance against the four-hour standard was 72.4% with 25 breaches of this standard. The average wait to be seen was two hours 16 minutes. There were 23 patients who had a decision to admit, 14 of these patients were for a medical bed, six for a surgical bed, one for an orthopaedic bed and two for a cardiology bed. Ten patients had waited for four to eight hours in the department and there was one patient who had waited for eight to 12 hours.
- There were clinical flow matrons who worked across the trust twenty-four hours per day, seven days a week. These were senior nursing staff who had oversight of patient flow, clinical oversight and had overarching management of the hospital out-of-hours. There were two matrons on duty out-of-hours. They looked at capacity and demand,

infection control and staffing and ensured quality and safety around flow and were the escalation point for the emergency department. The matrons produced an overnight summary report for the bed meeting. Senior nursing staff in the emergency department told us that they had a good relationship with the matrons and that they provided support to the department.

- All patients in the department who required an admission, needed a review by a senior clinician and a care plan in place, before they were transferred to a ward. Staff reported that the waiting time to see the medical admission team and be clerked by them was often several hours. They said that there were some consultants who would not see patients on the post-take ward round. This negatively impacted on flow through the department, with a delay for patients who needed a bed in the hospital. It was noted by the inspection team that there was marked repetition between the emergency department and admitting team, which could be reduced with a single clerking system.
- We were concerned that there could be a lack of consultant oversight of patients, because of the delays to see the medical admission team following a decision to admit the patient and that some of the consultants would not see patients on the post-take ward round. This could impact on the 14-hour quality standard from the National Institute for Health and Care Excellence, that patients should be reviewed by a consultant within 14 hours of their admission to hospital. There was a risk to patients, as there was no consultant responsible for their care.
- There were some medicine and surgery direct admission pathways into the trust and a cardiac arrhythmia clinic had been set up which took direct referrals.
- There was a hospital discharge team who reviewed patient pathways and looked for issues that could be preventing discharge. They met twice daily and information from this meeting was fed into the bed meetings.
- There was open access to the children ward for appropriate patients so that they did not have to go through the paediatric emergency department.

## Is the service well-led?

**Inspected but not rated**

### Leadership

**Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced including factors external to the service arising from the additional pressures of the COVID-19 pandemic. They were visible and approachable in the service for patients and staff.**

- Most senior managers and executive directors at the trust had been recent appointments and had worked to change and improve the culture and the quality of care in the emergency department. Managers said that changes had been implemented and embedded because staff from the department had been involved in the implementation of the change. Senior managers said that when they arrived at the trust it was evident that the staff were caring and compassionate and that they wanted to shape change to improve services for patients. Senior managers described the pace of change as rapid.
- There was effective senior leadership of doctors and nurses in the department. Junior doctors stated that they were supported and that consultants were open and easy to speak with.
- A senior nurse in the department told us that there was strong support from their manager and from the director of unscheduled care. They said that there had been massive leaps in patient care and patient safety following the appointment of the executive team.

- Staff told us that senior staff were visible in the department including the executive team.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care, including during periods of heavy demand. The service had an open culture where staff could raise concerns without fear.**

- Staff felt that they were at the centre of operations in the department and that they had been involved in the governance and processes of the department. It was their knowledge and expertise that was driving improvement and we were given examples of staff chairing meetings and how their ideas had been implemented.
- Managers told us that the freedom to speak up guardian role had been important because it had allowed staff to speak up, in confidence, about any issues with change that might directly impact on them, and this had helped to improve the culture.
- The atmosphere in the department, whilst busy, was calm and staff were aware of their roles and what they needed to do. Despite the pressures on the department, staff were appeared very supportive of each other.

**Managing risks, issues and performance**

**The service's senior clinical leadership team were able to describe the current issues that were impacting on the service's performance and response times. These included factors outside the service's control within the wider hospital and the community across Blackpool, Wyre and the Fylde Coast as a result of pressures from the COVID-19 pandemic that were leading to increased demand on the service and directly impacting on waiting times and performance.**

- There were systems and processes in place so that senior leaders were aware of the issues in the department. The report produced after each bed meeting was comprehensive and provided information across the trust to support access and flow. There was also oversight of the trust, 24 hours a day, seven days a week from the flow matrons. The appointment of these staff, who were dedicated to access and flow and patient safety, allowed the other hospital matrons to focus on the clinical issues in their areas.
- There was executive oversight of the issues and risks that impacted on the emergency department, including patient flow and patient discharge.
- The trust held a clinical command meeting every morning, which was chaired by the director of nursing and the medical director. This provided oversight of the trust and partner organisations at an executive level in the organisation.
- There was ongoing work to improve the flow through the department. Some of this was reliant on the imminent opening of the emergency village. There would be a same-day emergency care (SDEC) facility as part of this development. There was work to develop hot clinics and a review of GP pathways to look at direct admission of patients on appropriate pathways. The medical director told us that there was a meeting planned in January 2021 to look at frailty models and how these could be implemented. These interventions will provide alternatives to the emergency department and the hospital and help ensure timely intervention for patients in an appropriate and safe environment. The department was using quality improvement methodology to implement these changes.
- We saw that there was a departmental risk register and the main risk identified was about the ambulance delays, their causes and mitigating actions. Each incident with a delayed ambulance was incident reported and the deputy director of nursing was conducting a root cause analysis of the issues around these delays.

# Urgent and emergency services

- There was evidence of strong partnership working across the emergency department and this was particularly evident with the local ambulance trust. The two organisations had worked to support and maintain patient safety during their journey to the hospital and through their handover processes.
- The trust had developed strong processes in the emergency department to support safeguarding including the safeguarding navigator role, an independent domestic violence advisor. They had won an award for their work for victims of rape who attended their department.

## Outstanding practice

- There was an advanced paramedic who worked with the mental health liaison team to deflect admissions from the department to other services. Patients who requested an ambulance would be contacted by phone or visited by this team. This had been effective in reducing admissions to the department and shown a reduction in section 136 admissions to mental health services.
- The trust had developed strong processes in the emergency department to support safeguarding including the safeguarding navigator role and an independent domestic violence advisor. They had won an award for their work for victims of rape who attended their department.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. (Regulation 12 (1))

Action the service SHOULD take to improve:

- The trust should ensure the planned standard operating procedure is implemented to guide staff when patients are in ambulances waiting for their care to be handed over. (Regulation 12)
- The trust should continue to work to recruit a Paediatric Emergency Medicine consultant. (Regulation 18)

# Medical care (including older people's care)

**Inspected but not rated**

The medical care service at Blackpool Teaching Hospitals NHS Foundation Trust provides care and treatment for:

- General medicine
- Care of the older person
- Diabetes and endocrinology
- Infectious diseases
- Gastroenterology
- Stroke and tertiary haematology

There are 443 medical inpatient beds located at Blackpool Victoria Hospital across 21 wards or units. The division has an ambulatory emergency care unit (AEC) and a short stay unit, with the primary aim that patients admitted to these areas can be typically discharged within 72 hours.

The trust had 55,058 medical admissions from October 2019 to September 2020. Emergency admissions accounted for 24,544, 1,992 were elective, and the remaining 29,522 were day case. Admissions for the top three medical specialties were: General medicine, gastroenterology and clinical haematology. The average length of stay was 7.1 days.

We carried out an unannounced focussed inspection of the medical care core service at Blackpool Victoria Hospital on 11 January 2021, because we received information that gave us concerns about the safety and quality of the services.

We looked at parts of the safe, effective and responsive domains. We did not rate the service because this was a focussed, unannounced inspection in response to specific areas of concern.

We observed care and treatment and specific documentation in 15 patient records, including risk assessments, do not attempt cardiopulmonary respiratory (DNACPR), mental capacity and Deprivation of Liberty Safeguards (DoLS) documents. We reviewed 19 prescription charts. We interviewed key members of pharmacy, nursing and medical staff along with the senior management team who were responsible for leadership and oversight of the service. We spoke with 43 members of staff in and five patients.

We observed patient care, infection control management, a ward handover and trust level staffing and flow meetings.

On this inspection we were limited to the wards we could visit due to the COVID-19 infection risk. We visited medical wards which included the acute medical unit (AMU), the stroke unit, Ward 10 and Ward 12. We reviewed prescription charts and patient records remotely from Ward 23.

Our findings were:

- The service did not always control infection risk well; especially in relation to a lack of clear signage in place to indicate COVID-19 risk areas.
- The service did not always have sufficient medical staff with the right qualifications, skills, training and experience. However, managers regularly reviewed staffing levels and skill mix.

# Medical care (including older people's care)

- We found that there was an inconsistent approach to the completion of patients' care and treatment records and we found that not all patient records were stored securely on the wards we visited.
- We found examples of delayed or omitted antimicrobial medications. The trust antimicrobial stewardship group was sighted on this and was focusing on raising the profile of antimicrobial stewardship.
- Fluid balance charts were not always fully completed; out of the 15 records we reviewed we found three patients had incomplete fluid balance charts for each day they had been admitted.
- Staff did not always support patients to make informed decisions about their care and treatment or follow national guidance to gain patients' consent. Staff had received training and understood how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always follow best practice and trust policy around the Mental Capacity Act and deprivation of liberty safeguards.
- People could not always access the service when they needed it and receive the right care promptly. Arrangements to admit, treat and discharge patients were not always in line with national standards and flow through the hospital was a challenge.

However:

- Staff used equipment to protect themselves and others from infection and they kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Although at the time of inspection there were a number of nursing staff vacancies, managers regularly reviewed and adjusted staffing levels and skill mix, and there were recruitment plans in place. Nursing and support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Medicines were mostly stored, prescribed, administered and reviewed appropriately and patients had their allergy status recorded.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

## Is the service safe?

**Inspected but not rated**

**Cleanliness, infection control and hygiene.**

**The service did not always control infection risk well, especially in relation to a lack of clear signage in place to indicate COVID-19 risk areas. Other control measures were in place and staff used equipment to protect themselves and others from infection and they kept equipment and the premises visibly clean.**

# Medical care (including older people's care)

- Signage to indicate areas where there were COVID-19 positive patients was poor. We did not see evidence of signage at the entrance to the wards we visited, to inform staff or visitors of the COVID-19 status of the area. There was a risk that staff and visitors could enter these areas and be at risk of transmission of the virus or not be wearing the appropriate personal protective equipment.
- Staff rooms had maximum numbers of people that could be inside at any one time; this was to enable social distancing. On Ward 10 we were told they had increased the number of staff rooms to three, and there was a maximum of three staff allowed in at a time. We were told staff were aware of the maximum allowance, however, we saw that there was no signage to support this. There was a risk that staff who were unfamiliar with the ward would not be aware of this.
- Some wards which were identified as COVID-19 negative areas had isolated bays containing patients who had been in contact with COVID-19 positive patients. We observed that most of the side rooms and isolation bays where patients were being treated, who either had an infection or were at risk of infection, had doors which could be closed; we found that these were closed to prevent the spread of infection. However, two of the bays on Ward 12 did not have doors and were being used for patients who were isolating after being in contact with COVID-19 positive patients, there was a risk that infection could spread outside of these areas.
- We found that not all wards we visited had handwash basins located at the entrance and exits. We observed some of these were only located within patient bays. However, antibacterial gel dispensers were available. Domestic staff checked and refilled hand gel dispensers.
- Entrances and exits to the wards had stations which contained masks, hand sanitiser and visors, these were known as 'donning and doffing' stations. This is an area where staff and visitors can change their personal protective equipment when entering and leaving the ward. Staff advised that the side rooms on the entrance to two of the wards, had been initially allocated as 'donning and doffing' areas. However, at the time of our inspection these were being used to accommodate patients.
- We observed clinical waste bins located at the stations to dispose of personal protective equipment. However, on Ward 12 the bin was labelled as 'general waste' and contained a clinical waste bag with discarded personal protective equipment.
- All areas we visited were visibly clean and tidy. We observed planned cleaning taking place following the transfer of patients. Staff kept equipment clean and we saw 'I am clean' stickers used to indicate when it had been cleaned.
- We observed staff using personal protective equipment (in particular, masks) and we saw that they adhered to 'bare arms below the elbow' guidance. Staff had access to personal protective equipment at the entrance to the wards and to each bay, and we saw that they used it when providing patient care. Each bay contained facilities for staff to wash their hands and we saw staff washing their hands and using hand gel before and after contact with patients.
- Patients were encouraged to wear masks if they could tolerate them. We observed some patients wearing masks when they moved from their bedside.
- There was a process in place to identify and isolate patients who were at risk of or had a suspected or confirmed infection.
- We reviewed nationally published weekly nosocomial COVID-19 infection data from 1 November 2020 to 17 January 2021 (these are COVID-19 infections which have been acquired in hospital). The trust had reported 297 nosocomial infections in total, this was the fifth highest total number across the North West. The highest number of infections reported in one week was 50, this was in the week ending 15 November 2020.

- We noted that the number of nosocomial infections at the trust had in the main been higher than the average for North West hospitals. The data had shown a decrease in infections from the middle of November 2020 to the beginning of January 2021, when the infection rates came in line with the North West average. There has been a rise in infections since the start of January 2021, which had also been seen across the North West.
- Information showed that the trust was in the bottom 25% of trusts for E.Coli and Clostridium difficile rates per 100,000 bed days for the last three months. This was based on data from October 2020 to December 2020.
- The trust's infection prevention and control team conducted audits to monitor compliance with infection prevention controls. This included observational assessments of staff washing their hands and feedback was provided to the ward managers. Matron audits monitored environmental and equipment cleaning and staff adherence to the use of personal protective equipment and hand hygiene. Following the inspection, the trust provided details of hand hygiene audits covering the unscheduled care division for October to December 2020. These showed that overall compliance for the audit completed by the ward was 98.3% and the covert audit completed by the infection prevention and control team was 64.3%. These had shown improvement from the previous quarter. We observed quality boards on individual wards containing infection control rates and hand hygiene compliance were consistently updated.
- We were told that staff were offered weekly routine COVID-19 testing using the Loop-mediated Isothermal Amplification (LAMP) tests.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Comprehensive risk assessments were carried out for patients who used the service and risk management plans were implemented for patients who were identified as 'at risk' these were in line with national guidance.**

- The service used national early warning scores (NEWS2) to assess the health and wellbeing of patients. This tool supported staff to identify if the clinical condition of a patient was deteriorating and required early intervention or escalation to keep the patient safe. We observed that the tool was electronic or paper-based, dependent on the area we visited.
- Staff received training to support them to recognise deteriorating patients; this was called 'recognise and act'. In November 2020 the service reported that 80% of staff had received the training. The trust had a planned "deteriorating patient collaborative" to improve the management of deteriorating patients. This was due to start in February 2021.
- We reviewed 15 patient records and found appropriately completed NEWS2 assessments. We saw evidence that staff had escalated NEWS2 scores in line with policy and that care plans had been updated. Records showed that patients at risk of sepsis had been identified and sepsis pathways were in place.
- Staff had access to a critical care outreach team 24 hours a day, seven days a week, where they could escalate concerns and seek support for patients who were showing signs of deterioration.
- Matrons monitored the completion of NEWS2 monthly as part of the matron audits. They checked that staff were appropriately monitoring patients and taking the required action dependent on the scores and that this was documented. Audit data provided prior to the inspection from February to November 2020, demonstrated that compliance with completion of NEWS2 across the service was between 92% and 100%.
- Matrons were ward based and did regular walkarounds. Staff told us that matrons were supportive and that they felt comfortable escalating concerns if needed.

# Medical care (including older people's care)

- All patients were assessed using an acute admission nursing assessment document. Risk assessments were completed for falls, skin, moving and handling, malnutrition universal screening tool (MUST), and bed rail assessments. Records showed that these were well completed, and care plans were in place as a result. There was evidence of referrals to speciality teams such as dieticians where necessary. However, we found that there was an inconsistent approach to the completion of venous thromboembolism (VTE) assessments, six out of the 15 records we reviewed did not have these completed.
- Staff on the Acute Medical Unit told us they used a COVID-19 triage assessment tool. The document contained a patient bedside checklist which covered checks such as the nurse call bell and that oxygen and suction was working. Records showed these assessments had been completed.
- We saw evidence that patients received a consultant review within 14 hours of admission and there were regular medical reviews and clear care plans in place.
- Patient visiting had been suspended, in line with government guidance. As a result, patients reported feeling isolated and relatives/carers were concerned about a lack of patient improvement or deterioration. In response, the communication clinic was commenced, which shared information about patients' care and treatment with their families or carers. Senior nursing teams carried out spot checks to make sure that patients, relatives and carers had been communicated with. The Swan team (the hospitals palliative care team) provided the families of patients who were at the end of their lives with additional communication and support.
- We saw that the stroke unit had access to an electronic device where patients could contact family or carers with assistance from a member of the team. The unit had also introduced a daily communication call, in agreement with the patient and their relatives, to update them on key developments of the patients progress and care pathway. Staff told us that they received positive feedback as a result.

**Nurse Staffing**

**Although at the time of inspection there were a number of nursing staff vacancies, managers regularly reviewed and adjusted staffing levels and skill mix and there were recruitment plans in place. Nursing and support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**

- At the time of our inspection there were 145 whole time equivalent registered nurse vacancies across the Unscheduled Care Division. Leaders told us that the highest vacancy rates were within the elderly care division. There were 106 whole time equivalent nurses who were going through the recruitment process, 62 of these had been recruited from overseas and so required additional training upon arrival and 44 were registered and working in the UK.
- Senior leaders told us there was a rolling programme of overseas recruitment ongoing and that it was expected the service would recruit an additional 120 nurses up until October 2021. Nurses who were recruited from overseas had to undertake a structured training programme over a three-month period and they remained supernumerary on the ward throughout this time.
- There was a 'grow our own programme' in place which introduced additional supporting and development roles to supplement the nursing workforce, these roles were apprentice nurses and assistant nurse practitioners.
- The sickness rate for the service was 7.32% which was higher than the trust's average of 6.58%. The leadership team identified the main reasons for absence were COVID-19, staff who were shielding and those suffering from stress related illness. It was recognised that this was a difficult time for staff and there was support from the Swan team (palliative care team) with de-briefs, access to clinical psychologists, human resources and well-being huddle rooms.

# Medical care (including older people's care)

- The trust had recently implemented the 'safe care' staffing tool to monitor staffing skill mix, this was based on national guidance. At the time of our inspection the use of this across the service was in its infancy; it had been fully rolled out in December 2020. Ward managers added information about planned and actual staffing into the tool, with information about the acuity of the patients on the ward three times a day. The tool was reviewed for each ward twice daily as part of the 'safe care' staffing meetings. The tool highlighted red flag areas as a result of the information inputted into the system.
- 'Safe care' staffing meetings were held twice daily, in the morning and in the evening, and it was chaired by a divisional director or above. We observed one of the meetings. We saw that red flags were discussed, these included areas where there were patients with complex care needs, patients subject to a deprivation of liberty safeguard, patients requiring continuous positive airway pressure and areas where there were staffing shortages. Matrons and ward managers at the meeting, were asked to give their professional judgement on the staffing in their area and any mitigation in place to ensure staffing was safe. Divisional nursing leads sought assurance about red flag areas and identified where additional staff, such as bank or agency staff were needed.
- We heard a discussion relating to deprivation of liberty safeguard applications and the actions taken to ensure patients were safely cared for. Staff confirmed completion of appropriate paperwork, involvement of the safeguarding team and security on the ward where needed.
- Weekend staffing was planned on a Thursday. At the time of our inspection there was no formal process for review of the tool during the weekend. This was currently being done informally led by a divisional director of nursing or above, who dialled in at an agreed time in order to support and lead the staffing call. We were told there were plans to implement the staffing tool at the weekend in the future.
- Matrons told us they had good oversight of staffing for their areas and had regular walkarounds. Ward managers could escalate concerns with staffing throughout the day to the 'matron of the day' via a bleep system.
- The service had access to bank and agency staff to fill gaps in rotas based on the establishment. This could be exceeded if the acuity of the patients on the ward required it at that time, and if staff were available. We were told that due to the pandemic, and the demand for agency staff across the region, they often struggled to get cover and as a result, the trust had to pay enhanced rates to secure staffing. A concern was raised that the trust's bank service was only available Monday to Friday within working hours, which meant they could not access the team to allocate bank staff outside of these hours.
- Staff told us that the service relied heavily on registered agency staff to support and cover vacant shifts.
- We reviewed the planned versus actual staffing whilst we were onsite for the acute medical unit, the stroke unit and Ward 12. We found that actual staffing was in line with or close to the planned figures.
- The stroke unit was working towards the status of a hyper-acute stroke unit (HASU) to treat patients who required thrombolysis, which is a time critical procedure. There was work ongoing to increase the establishment of registered nurses to care for stroke patients, in line with national guidance. Although at the time of our inspection the trust had not achieved the HASU status they were providing services for acute stroke patients. We saw that planned staffing on the unit was not consistently met and staff told us there was often a shortfall in qualified staff to manage the acute stroke beds, which was not in line with national guidance.
- The service provided average fill rates for nursing and care worker staffing covering October to December 2020, for wards C,1, 3,11, 23, 24 and 25. The data demonstrated that in the main, fill rates were maintained across all wards for day and night staff. However, we noted that in October 2020 the average fill rate for care worker staff on the day shifts on Ward 23 was 61.2% and in December 2020 the registered nurse average fill rate for day staff on Ward 11 was 69%.

- Between October and December 2020, we saw that the service had reported 19 incidents relating to nurse staffing shortages. In the main we saw that these were categorised as “low harm”. Common themes reported within these as a result of the limited staffing, were around missed and delayed medication including critical medicines, the inability to provide enhanced care to patients who needed it and delayed observations. There had been four patient falls and one of these had been categorised as “moderate harm”.
- There had been a registered nurse staffing review of all establishments across the service which resulted in an increase of planned levels. We were told that the new establishments would be in place from April 2021. However, staff told us that health care assistant establishment did not meet with the needs of the service and had not been altered for over two years this was due to high agency expenditure. Following our inspection, the trust told us that there was a planned uplift of 62.5 whole time equivalent healthcare assistant staff as part of the establishment review.
- Ward staff used handovers to communicate information about patients care and needs. We observed a handover on the stroke unit which was thorough. The stroke unit had introduced a daily safety huddle and were able to evidence these through audit practice. The safety huddle template had been developed by the team which included patient updates, issues/concerns, risks, falls/slips and trips and equipment checks. There was a section which included important messages to share with staff regarding wellbeing, staffing concerns, COVID-19 update, discharges, delayed transfers of care and daily patient communication clinic for patient relatives/carers.

**Medical Staffing**

**The service did not always have sufficient medical staff with the right qualifications, skills, training and experience. However, managers regularly reviewed staffing levels and skill mix.**

- At the time of our inspection there were 26 whole time equivalent consultant vacancies across the service. We were told that the area with the highest consultant vacancies was care of the elderly. We were told that these areas were the most difficult to recruit to.
- The service used locum medical staff to fill gaps on rotas, which we were told was a challenge. The service used a high number of locum consultant staff to support the general medicine rotas. The senior leadership team recognised this was not ideal and were monitoring the impact on the wards which were locum-led.
- The service provided fill rate data for medical staff broken down into consultants, senior and junior medical staff for wards C, 1, 3, 11 and 23. In the main, we saw that fill rates were lower than planned. We saw that wards 3, 11 and 23 had the lowest reported fill rates. The average total fill rates overall for medical staff on these wards, for October to December 2020, were 74.93% on Ward 3, 86% on Ward 11 and 68.19% on Ward 23. We noted that the lowest fill rates were 50% for consultants, 40.91% for senior medical staff and 41.67% for junior medical staff.
- Staff we spoke with told us the medicine service still had gaps in medical staffing, they felt this was because of national shortages in certain specialities. Staff told us that advanced nurse practitioners worked closely with the medical team to provide medical cover including the out-of-hours service. The stroke unit had an establishment of four advanced nurse practitioners. At the time of our inspection there were two vacancies for this post on the unit.
- Rota coordinators highlighted medical staffing rota gaps to the senior clinical teams in advance, to assist in the planning of rotas and securing additional staff.
- Daily staffing meetings were held to review medical staffing across the service. The meeting looked at each ward to ensure that there was medical cover in place, escalate any concerns in relation to medical staffing and to monitor that all patients had received a medical review. Leaders felt assured that all patients across the service received a medical review daily.

# Medical care (including older people's care)

- Patient flow meetings monitored assurance of medical review, medical cover and that ward and board rounds had taken place.
- The senior leadership team told us there was a planned review of the general medical rotas to align them with other specialities and update the job plans in order to attract recruitment of medical staff. There were links with the local commissioners to support this.
- There was ongoing work to introduce alternative specialist roles to support the medical workforce such as advanced nurse practitioners, physician associates and non-medical consultants.
- All specialities we visited had medicine consultant cover Monday to Friday (consultant of the week), with on call 24 hours a day, seven days a week for weekends and out-of-hours. The trust had a policy for the identification of the responsible consultant.
- All the services we visited had a daily consultant review and multi-disciplinary team meetings (MDTs).

**Patient records**

**We found that there was an inconsistent approach to the completion of patients' care and treatment records and we found that not all patient records were stored securely on the wards we visited.**

- There was an electronic patient tracking system which was used alongside the paper-based records. The tracker recorded vital information about patients, including their presenting complaint, past medical history, plan of care and estimated date of discharge. The tracker could be accessed by ward staff and specialist staff. Staff told us that there was poor completion of the electronic tracker and that staff often just updated the paper case notes; there was a risk information could be missed. Matrons confirmed that the tracker was not audited for completion.
- Staff told us that admission documentation was lengthy and there was often duplication of information, however there was work ongoing to improve this.
- We reviewed 15 patient records in total. We found there was an inconsistent approach to the completion of patient records in line with trust policy. We found that patients' identifiers were not always present on each page. There were missing dates and times of some assessments, which meant we could not always judge if assessments were made in a timely manner. Not all entries were legible, we found that in some records there was missing documented evidence of care planning discussions with patients or their families and whilst some entries had been signed the name had not always been printed and dated.
- We found three patients had incomplete fluid balance charts for each day they had been admitted. For two of the patients, staff had recorded 'inaccurate' on the charts for the balance carried over and for one of the patients the total balance was not always recorded. One of these patients was on a fluid restriction and the urine output was not measured. There was no documented evidence in the patients records to show that staff had reported the inaccuracies that they found, or that any changes had been made to improve this.
- Weekly matron audits covered different aspects of documentation on different weeks. We saw that this included risk assessments, bedside checklists, admission documentation, care plans, fluid balance charts, Malnutrition Universal Screening Tool (MUST) risk assessments, intentional rounding charts, NEWS 2, pressure care and the security of records. The audits provided a red, amber or green rating, to demonstrate which areas were non-compliant, partially complaint or compliant. We were told by a matron that there had been an improvement in the completion of risk assessments and fluid balance charts on the wards they covered since the start of the audits.

# Medical care (including older people's care)

- We reviewed the matron audit data for the completion of fluid balance charts and Malnutrition Universal Screening Tool (MUST) risk assessments, which covered January 2021 for wards C, 11, 23, 24, 25 and 26. The results demonstrated an inconsistent approach to the completion and documentation of fluid balance and MUST assessments and highlighted areas of non-compliance. The audit identified that wards 24 and 25 were red, Ward C and 11 were amber and wards 23 and 26 were green.
- We reviewed matron audit data for these wards for January 2021 covering admission documentation, care planning, all risk assessments and intentional rounding. We saw that the wards were not all compliant with the completion of admission documentation and care plans, and that the wards were mostly red for these indicators. However, wards were compliant with the documentation and completion of risk assessments and intentional rounding.
- Patient records were not always stored securely. We observed the storage of patient records in unlocked note trollies on both the acute medical and stroke units. The security of patient records was monitored as part of the matron audits. We reviewed the results covering November and December 2020 for wards C, 11, 23, 24, 25, and 26. We saw that each ward scored red on both audits (except Ward 11 which did not provide a score for November), which meant that they were not compliant with the security of patient record requirements.

**Medicines**

**Medicines were mostly stored, prescribed, administered and reviewed appropriately and patients had their allergy status recorded. However, we found examples of delayed or omitted antimicrobials. The trust antimicrobial stewardship group was sighted on this and was focusing on raising the profile of antimicrobial stewardship.**

- The trust continued to show good compliance with choice of antibiotic but poor compliance with recording of 48-hour treatment reviews (54% in September 2020). A trust audit of reported antimicrobial incidents (August 2019 to September 2020) showed that missed doses were most common, followed by delayed doses. We similarly found delayed or omitted doses in five of the eleven prescription charts we reviewed, where antimicrobials had been prescribed. We also saw one example, of an inappropriate switch from an intravenous to an oral antibiotic that works only in the intestines and will not treat infections in other parts of the body.
- A delayed business case for increased support for antimicrobial stewardship remained in development.
- The trust showed good compliance with standards for safe and secure storage of medicines (Audit February 2020). Funding for probes to facilitate monitoring of fridge temperatures was in place. New lockable medicines storage had been rolled out to wards.
- Prescription charts were clearly presented, and allergy status was recorded for most records we reviewed. The trusts self-administration policy had been re-drafted and was ready for review and approval.

## Is the service effective?

**Inspected but not rated**

**Nutrition & Hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

# Medical care (including older people's care)

- Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. The Malnutrition Universal Screening Tool (MUST) tool was used to identify adults who were malnourished or at risk of malnutrition. Patients had their nutritional needs assessed and these were recorded in care plans.
- We reviewed 15 patient records and we saw that most Malnutrition Universal Screening Tool risk assessments and food and rounding charts had been completed appropriately. We saw that patients were referred to the dietician for additional advice and support if required. However, matron audit results demonstrated an inconsistent approach to the completion of Malnutrition Universal Screening Tool risk assessments.
- Individual and multicultural patient needs were catered for, this included vegetarian, vegan and halal choices. Drinks were readily available and in easy reach of patients. Patients assured us that the food was warm, fresh and of good quality. We observed food being distributed to individual patients; the food looked appetising and fresh.
- The service had protected mealtimes and we saw patients were supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking. Staff we spoke with, were aware of the patients on the ward who required support with eating and drinking and shared the responsibility to support these patients. We observed housekeepers offering wet wipes to patients before meals so that patients could wipe their hands prior to eating.
- Most patients said the food was good and that the menus were varied. The quality and quantity of food was monitored through patient-led assessments of the care environment (PLACE) which showed an overall satisfaction with food provided. The PLACE scores for 2020 demonstrated that ward food scored 96.90%, which was higher than the national average of 92.62%.
- We saw records in the notes for patients who received nutrition via nasogastric tubes, including the date and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained. Nurses completed initial swallow assessments at the point of admission with appropriate referral to the speech and language therapists (SALT) if concerns were highlighted.
- The service used bowel charts to monitor patient's bowel movements. We saw evidence that these were completed, and staff had responded appropriately to the information recorded.

**Mental Capacity Act and Deprivation of Liberty**

**Staff did not always support patients to make informed decisions about their care and treatment or follow national guidance to gain patients' consent. Staff had received training and understood how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always follow best practice and trust policy around the Mental Capacity Act and deprivation of liberty safeguards.**

- Staff did not always carry out an assessment of a patient's capacity to consent to decisions about their care and treatment when it was indicated, in line with best practice and trust policy.
- We found that there was limited documented evidence of patients or their families being involved in decisions relating to do not attempt cardiopulmonary resuscitation (DNACPR) decisions. We reviewed 11 records and found that for two patients' staff had recorded "cognitive impairment" as a reason for not discussing the DNACPR decision with the patient. However, we could not find evidence that capacity assessments had been completed for these patients and there was no record of the patients' families being involved in the decisions. One of the forms did not have a clear reason listed for the DNACPR decision and there was no entry in the medical notes to support this.

# Medical care (including older people's care)

- We reviewed 10 deprivation of liberty safeguard documents; two out of the 10 records evidenced that a Mental Capacity Act assessment had not taken place. Record entries were inconsistent, some had been signed but the name of the signatory had not been printed and dated. One of the deprivation of liberty safeguard documents had expired three days earlier. We raised this with staff at the time of our inspection.
- Due to the National issue of DoLS authorisations not being reviewed by the Local Authority in a timely way, the trust had implemented a deprivation of liberty safeguard assurance process where patients were reviewed every seven days. This allowed for professional challenge between colleagues over whether the application was still required, to ensure any deprivation of a patient's liberty was kept to a minimum.
- DNACPR forms were clearly visible and stored in the front of the medical notes.
- Staff recorded the DNACPR status of patients on the staff handover form and were able to identify patients subject to a DNACPR order.
- Mental Capacity Act and deprivation of liberty safeguards documentation was audited monthly. It had been identified that improvements were needed and staff on the ward were being supported by the safeguarding team with the completion of documentation and review of patients. There was bespoke training with real life examples being provided. We were told that deprivation of liberty safeguard applications being sent to the local authority had increased as a result.
- Matron audits of mental capacity and deprivation of liberty safeguards documentation covering wards C, 11, 23, 24, 25 and 26, demonstrated compliance across all wards in January 2021.
- The trust provided figures which demonstrated that as of 31 December 2020, 78.53% of staff across the trust had received training in the Mental Capacity Act.
- Staff we spoke with had attended mandatory training for Mental Capacity Act and deprivation of liberty safeguards training, and understood capacity was decision and time specific. They also understood that it was everyone's responsibility to assess capacity.

## Is the service responsive?

**Inspected but not rated**

**Access and flow**

**People could not always access the service when they needed it and receive the right care promptly. Arrangements to admit, treat and discharge patients were not always in line with national standards and flow through the hospital was a challenge.**

- Patients accessed the service from various routes, such as the accident and emergency department, referral from their GP and sometimes following outpatient appointments. All patients admitted through the accident and emergency department who required inpatient care, were admitted through the acute medical unit and the ambulatory care unit. Patients were not routinely admitted directly to inpatient medical wards.
- The hospital had an acute medical assessment unit. The unit was open 24 hours a day, seven days a week and had access to medical cover. The assessment unit allowed patients to be streamed quickly from the emergency department and helped reduce hospital admissions.

# Medical care (including older people's care)

- During our inspection we saw the assessment units were well supported by therapists and specialist support teams. The units had access to a dispensing pharmacist as well as rapid access therapists. The quick response to meet patient needs helped to support flow throughout the hospital.
- We were advised that due to access and flow pressures, it was not always possible for patients to be matched to speciality wards. For example, some patients admitted with respiratory conditions were cared for on wards other than the respiratory wards and some medical patients were placed on non-medical wards such as surgical wards. This was due to pressures for medical beds, these patients were referred to as 'outliers'. We were advised it was very unlikely that these patients would be repatriated to more suitable beds due to the ongoing pressures within the hospital.
- We reviewed the bed capacity list on the day of inspection on the Acute Medical Unit (AMU) which evidenced that 21 out of 35 patients had been admitted and cared for on the acute medical unit between two to three days. Staff told us that hospital capacity was stretched due to the current pandemic which impacted on bed availability. Patients who had a length of stay of seven days or more were referred to as "stranded" patients. Stranded patients were reviewed regularly to assess the potential to transfer to specialty wards so that beds could be made available for emergency admissions to the unit.
- Bed meetings were held four times per day. We observed a teleconference trust bed meeting which covered aspects surrounding, review of actions from the previous day, updates for all speciality areas, patient flow within the trust, bed capacity position, emergency department position, update from the discharge team, community beds update, infection control update relevant to patient flow within the hospital and an ambulance update.
- The trust used a business intelligence tool which tracked medical patients who were being cared for on wards which were not the speciality they required. 'Outlier' lists were generated daily, which identified where patients were, when the patient had last received a consultant review and a summary of their care plan. The 'manager of the day' had oversight of the medical allocation for these patients between the specialities. There were two medical escalation teams (dependent on staffing) who supported the review of these patients.
- Medical staff on each ward looked after the medical outliers with input from the specialist medical team concerned. They could track patients using the trust's electronic patient record system. Staff we spoke with on the stroke unit reported concerns about the number of medical outliers on the unit, they felt it impacted on patient safety and outcomes. We saw that an incident had been reported in September 2020 where an urgent stroke patient had a delayed admission of eight hours and 45 minutes to the unit, from the emergency department, due to the availability of a bed. The incident was graded as low harm.
- There were two winter escalation wards in use, which we were told had been open for two years. Staffing was provided by a substantive nursing team and supported by the medical escalation team.
- The senior leadership team told us the biggest challenges to discharging patients were those who had tested positive for COVID-19 and required ongoing care in a nursing home. There was difficulty in accessing providers who could accept these patients. The service utilised the Clifton Hospital site for some of these patients, however there was only access to two wards which we were told was a challenge.
- There were designated beds available in the local area which were identified to take COVID-19 positive patients requiring step down care. However, we were told due to the acuity of the patients, the beds were not always suitable, particularly those where accommodation was provided in side rooms. Therefore, these beds in the local area, could not be utilised.
- Staff told us there were twice daily board rounds attended by the nursing and medical teams. The second board round focussed on patient discharge. We were told that discharge planning started from the point of admission.

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- Delayed discharges were escalated to the ward manager and then to the matron in the morning staffing meetings; these were then raised with the bed management team.
- We were told that out-of-hours discharges only occurred for those that had been planned.
- At the time of our inspection, we were told that there were five delayed transfers of care across the service.
- We reviewed daily discharge data and found that overall, from 1 November 2020 to 10 February 2021, of the patients who were medically unfit for discharge, 4.9% had stays of 21 days or longer. Of the patients who were medically fit for discharge, 39.3% had stays of 21 days or longer. The percentage of patients who were medically unfit for discharge had been a consistent level of around 5% from November 2020 to February 2021. The percentage of patients who were fit for discharge fluctuated between 31% and 48%. There was a trend where the percentage of patients increased towards the end of each month, before declining through the first couple of weeks of the month.
- There had been 14 incidents reported relating to discharges for medical specialities between September and November 2020. Four of the incidents reported issues with missed referrals for ongoing care and treatment, these were categorised as low harm incidents.
- There were a number of incidents relating to patients, where concerns had been raised about discharges. These related to discharges from the hospital between January 2020 and December 2020. Examples included, discharge information and medication not being sent with patients; information on wounds or pressure area damage not being accurate or shared with relevant services and COVID-19 guidance not always being followed when patients were discharged.
- Further information related to these incidents was requested and provided by the trust when we were made aware of them. The trust shared actions which had been put in place in response to the incidents.
- Staff had access to teams who provided support for discharging patients, there was the 'hospital discharge team', the 'single point of discharge team' and the 'patient first team' who were community based.
- Staff utilised the single point of discharge team to support complex discharges. We were told that prior to the COVID-19 pandemic, the team would regularly attend the board rounds. Currently they had access to the team via telephone and a bleep system, and they described the team as supportive.
- There was mixed feedback about the effectiveness of the hospital discharge team, we were told that communication with the team was limited and there was poor visibility on the wards and at board rounds. The senior leadership team told us that there was work ongoing to improve the structure and functions of the teams and to improve discharge pathways.
- By being close to the ward areas, the dedicated pharmacy discharge team supported improved discharge times through their involvement in writing-up and dispensing take home medicines for the acute medical unit and care of the older person services.

## Outstanding practice

- Due to the National issue of DoLS authorisations not being reviewed by the Local Authority in a timely way, the trust had implemented a deprivation of liberty safeguard assurance process where patients were reviewed every seven days. This allowed for professional challenge between colleagues over whether the application was still required, to ensure any deprivation of a patient's liberty was kept to a minimum.

# Medical care (including older people's care)

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must ensure that patient records are complete, legible and kept securely at all times, so that they are up to date, clear and only accessed by those authorised to do so. (Regulation 17 (1) (2) c)
- The trust must ensure that medical staffing is sufficient to meet the needs of patients and ensure actual staffing meets with or is close to the planned numbers. They should continue work to improve the recruitment and retention of medical staffing to reduce vacancies. (Regulation 18 (1))
- The trust must continue to progress and implement improvement work in relation to the timely administration of antimicrobials in line with how they are prescribed and increase the awareness of antimicrobial stewardship. (Regulation 12 (1) (2) b)
- The trust must make sure that when a patient is unable to consent to their care and treatment staff follow trust policy and the requirements of the Mental Capacity Act 2005. Patients and/ or their families should be involved in decisions made about their care and treatment. (Regulation 11 (1))
- The trust must continue to progress work and focus on making improvements to flow through the hospital, so that patients receive appropriate care and treatment in the right place when they need it and that discharges happen safely in line with national standards. (Regulation 12 (1) (2) a i)

Action the service SHOULD take to improve:

- The service should consider a review of the signage on wards in relation to COVID-19 so that it is clear to staff, patients and visitors where there are patients who have tested positive or those who are isolating for COVID-19. Where wards had a mix of negative and contact patients the signage for the segregation of facilities should be reviewed so that it is clear to patients to prevent any potential transmission of the virus. (Regulation 12)
- The service should continue to review nurse staffing to ensure that it is in line with national guidance, meets the needs of the patients and keeps them safe from avoidable harm. (Regulation 18)

# Our inspection team

The team comprised of five inspectors, two pharmacist specialist inspectors and three specialist advisors. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

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