Care Quality Commission

# Royal Liverpool and Broadgreen University Hospitals NHS Trust

# Royal Liverpool Site

## Quality Report

Prescot Street
Liverpool
Merseyside
L7 8XP
Tel: 0151 706 2000
Website: www.rlbuht.nhs.uk

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

## Ratings

# Summary of findings

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# Summary of findings

## Overall summary

The Royal Liverpool University Hospital is the largest hospital in Merseyside and is one of three hospitals that make up the Royal Liverpool and Broadgreen University Hospitals NHS Trust. It has over 40 wards and more than 750 beds (excluding day case and dialysis beds). It has the main accident and emergency (A&E) department for the city of Liverpool, the largest of its kind in the country, capable of dealing with major trauma and life threatening illness. There is a new hospital project underway, which is due for completion in 2017. As well as providing general services to local communities, the hospital provides regional and national specialist services and is considered to be one of the UK's leading cancer centres. The trust is closely linked with the University of Liverpool and John Moores University for teaching and research.

We inspected this hospital as part of our new in-depth hospital inspection programme. It was being tested at 18 NHS trusts across England, chosen to represent the variation in hospital care across England. Before the inspection, our 'Intelligent Monitoring' system indicated that the Royal Liverpool and Broadgreen University Hospitals NHS Trust was considered to be a low-risk provider. The Care Quality Commission (CQC) had inspected across both of the acute sites (The Royal Liverpool and Broadgreen hospitals) four times in total since it was registered in April 2010. It had always been assessed as meeting the standards set out in legislation. Before the inspection our analysis of data from our 'Intelligent Monitoring' system indicated that the hospital was operating safely and effectively across all key services. The analysis identified the trust was a low reporter of incidents which can indicate the culture within the trust did not support the open reporting of incidents and can affect the learning from incidents. At the time of the inspection the trust had no mortality indicators identified as risks.

We met with a group of local people representing people who can be more difficult to reach for their views before the inspection. We listened to people's experiences of the hospital and during the inspection we held a public listening event in Liverpool and heard directly from 20 people about their experiences of care. We spoke with more than 70 patients throughout the inspection. The areas of concern raised helped to inform the inspection.

At the inspection, we found the hospital provided excellent care in some areas, including the end of life care service, which was of a high standard and provided care seven days a week. We found that staff were following best practice guidelines when treating and caring for patients and there was clear evidence of local and national audit practice. Services were being delivered by a hardworking, caring and compassionate team of staff who were proud to work at the hospital. We found an open culture where staff could raise concerns. Doctors and nurses told us they felt supported in their roles and had good access to training. We were impressed by the Acute Medical Unit, which was well staffed and showed close integration with the emergency department. Ward areas were clean, there was hand hygiene gel in all areas and patients spoke positively about the general level of cleanliness throughout the hospital.

Although the hospital staffing levels at the time of the inspection were adequate this was supported by overtime, bank and agency work. The recruitment of substantive staff was being significantly delayed and this was impacting on staff morale. The number of junior doctors in the vascular and colorectal surgical areas was found to be lower than expected and affecting the quality of care.

We found the hospital system for monitoring outlying patients (i.e. patients not cared for on wards of the relevant speciality to their need) was not accurate or robust in securing ongoing monitoring of these patients by the specialists resulting in patients not being reviewed or receiving less frequent review which impacted on the quality of care they received.

The accident and emergency (A&E) department was seeing increasing numbers of patients, and it could not always maintain the privacy and dignity of all of its patients and infection control policies were not always followed.

The theatre recovery area was used as overnight accommodation for which it is not designed, and as such cannot ensure people are cared for in areas appropriately designed to provide facilities and care relevant to their

# Summary of findings

needs and provide dignity, privacy and independence. The observation room CDU6 in the emergency department was also used to provide overnight accommodation for which it was not designed.

We also found there was limited allocated space between beds in the Heart and Emergency Centre which posed a risk should patients need emergency equipment by the bed. This was also the case in the Post Operative Critical Care Unit (POCCU).

We found the provision of medication when people were admitted to hospital, medicines to take home at discharge and the supply of relevant medicines in the emergency department was impacting on peoples care and timely discharge.

There was confusion amongst staff regarding the roles of the Acute Response Team and the Critical Care Outreach Team which should be clearly defined to ensure the appropriate specialist skills are employed to deliver care to the vulnerable patients these teams care for. Care for patients whose condition is deteriorating would be further improved through supported training for ward staff in how to respond to the needs of these patients in order to ensure specialist intervention in a timely manner to promote the best outcomes.

The consultant leading the Post Operative Critical Care Unit was usually an anaesthetist and it was unclear if they were up to date on intensive care best practice.

We also identified two wards sharing a hoist inappropriately and noted issues regarding safe ongoing care of patients who had been discharged from the ward to the discharge lounge but who had not left the hospital.

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## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

The safety of services was supported by good assessment of patients' needs and provision of care to meet those needs. Records were maintained to a good standard in most areas. The hospital has a significantly lower number of reported incidents in comparison to other trusts of similar size. This can mean that not all incidents are reported and therefore appropriate lessons are not being learned.

We were concerned by the low level of medical staffing levels in vascular and colorectal surgery and the lack of pharmacy availability at the weekends. The space between beds was very limited in the Heart and Emergency centre. The hospital needs to improve adherence to infection control policies in A&E and ensure that the consultant leading the Post Operative Critical Care Unit has the appropriate training for the patients arriving on the unit.

### Are services effective?

We saw examples of good and excellent work which demonstrated patients were receiving effective care and treatment. We found staff were following best practice guidelines when treating and caring for patients and there was clear evidence of local and national audit practice. As a teaching hospital the trust had a wide range of services available on site, including Consultant presence in their A&E 24 hours a day, seven days a week. The Liverpool Care Pathway was no longer in use but the hospital had guidance in place for people in end of life care.

However, we found patients were regularly cared for on wards of a different speciality than the one they required which had an adverse effect on the frequency of medical review, care by specialist nurses and in one instance had delayed a discharge.

### Are services caring?

We found the services at the hospital were delivered by a hardworking, caring and compassionate team of staff who were proud to work at the hospital. All the people we spoke with were positive about their care and treatment at both hospitals. We observed staff treating people with dignity and respect and offering care to the best of their ability. We also saw examples of ways in which people were encouraged to share their thoughts of the hospital.

### Are services responsive to people's needs?

We found the hospital had many ways in which they responded to the varied needs of people. We found the palliative care responsiveness was excellent, operating seven days per week and seeing patients within 24 hours of

receiving the initial referral. The accident and emergency service was responding to patients experiencing problems with alcohol, drugs as well as a high number of patients who were homeless but had erratic performance against the national four hour target.

We found patients staying in unsuitable physical environments for longer than expected both in theatres recovery area and an observation room in A&E due to bed shortages. There were concerns regarding the responsiveness of the Acute Response Team and the Critical Care Outreach Team (CCOT) due to role confusion; surgical services on the wards which were hindered by the excessive workloads of junior doctors.

## Are services well-led?

We found there was an open culture where staff could raise concerns. Doctors and nurses felt supported in their roles and had good access to training and we saw monitoring of the quality of the service was happening.

However, training of ward staff in how to respond to the needs of deteriorating patients and care for those with tracheostomies to reduce the dependency on critical care beds as training was poorly attended; some staff said they felt that more senior staff within the organisation did not listen to their views. They felt the executive management team did not fully appreciate their workload or the effect that perceived low levels of staffing had on their morale. In response to outcomes in the 2011 staff survey, the trust developed a 'Every One Matters' Staff Engagement Strategy in 2012. This included 'partnership visits' (where members of the executive team visited the wards) and other engagement events. However, the 2012 staff survey did not demonstrate significant change from 2011 and they remained in the bottom 20% nationally for staff motivation at work. The risk management system failed to recognise some areas of concern despite them being identified and reported by staff and these were not clearly acknowledged at either division or board level. The process for the analysis of incident and complaints information meant the trust was not making full use of the information, instead only being directed by strategic targets and serious incidents.

# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

We found the emergency department service being provided was good, it was well-led at ward level and was supported by caring staff who strived to deliver good care. Staffing was found to be sufficient and utilised well and there was little use of agency staff. As with the rest of the trust, recruitment processes when needed were not timely.

The physical environment in the emergency department was inadequate in size when demand was high and the team often treated more patients than there were beds. In addition patient flow was managed through a manual patient administration system whereby ward areas contacted the patient flow management team to ask for beds and to let them know of any beds that may be available. This had a significant effect on the efficiency of the team which meant patients could not be moved to the appropriate ward in a timely way and affected the services ability to meet the four-hour wait target. This may have also contributed to the inappropriate use of observation room CDU6 as overnight accommodation.

There were also concerns about staff not consistently following infection control procedures, a lack of high level cleaning and decontamination of equipment and availability of medicines, particularly out of hours.

### Medical care (including older people's care)

We were impressed by the Acute medical unit, which was well staffed and showed close integration with the emergency department. Ward areas were clean and patients we talked to spoke positively about the general level of cleanliness throughout the hospital. Essential equipment was available on most wards and most of the patients and relatives we talked to commented on the kindness, professionalism and patience of staff at all levels. We observed the staff to be hardworking and patient.

We noted that patients were not always admitted to an appropriate specialist ward affecting the timeliness of medical review and risking some patients not being reviewed on a daily basis. We also found concerns around the management of medicines. Most of the ward managers told us they were short of staff with most of the wards being supported by bank staff and permanent staff working overtime. In addition, there was no system in place to establish the dependency levels of patients and amend the staffing rotas accordingly. The trust had recognised this and had plans to implement one in the near future.

### Surgery

The staffing levels on the wards and in theatres were set so that they were able to meet patients' needs in a timely manner, but this was supported by overtime, bank and agency shifts due to recruitment delays. The theatre suites

had systems in place to improve patients' safety, including team brief and the World Health Organization (WHO) theatre checklist. On all the surgical wards most of the patients we spoke to were very complimentary about the care they had received.

We found theatre lists were regularly changed and operations were cancelled. At times, surgeons were not able to operate as recovery areas were full. On one day during our inspection 30 vascular patients were being cared for on other wards, increasing the workload of the junior doctors. They felt they were understaffed as the number of vascular patients had recently increased significantly. Most of the staff we spoke with told us that they felt supported by their immediate line manager but they felt that more senior staff within the organisation did not listen to their views. Some staff we spoke with were frustrated about the lack of their involvement in discussions about service developments.

## Intensive/critical care

The critical care service was well-managed locally and it was clear that it worked well with other departments within the hospital to ensure the best possible outcomes for patients. On all three units there were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care.

Patients' care needs were assessed and plans were in place to meet those needs. There was a formal critical care network in place with other local trusts to ensure the needs of patients were met effectively.

We found that the Post Operative Critical Care Unit (POCCU) functioned more like an Intensive Care Unit (ICU) with the range of care and treatment that was undertaken there. We found that the four beds with the POCCU were close together raising a potential infection risk as well as a safety hazard.

Senior nursing and medical staff told us that the overall bed availability across the hospitals often resulted in people staying in the unit longer than planned or required. We saw that there was an effective Critical Care Outreach Team (CCOT). Staff from the CCOT followed up patients on the wards who had been cared for on ICU or High Dependency Unit (HDU) for more than four days. The CCOT also supported ward staff when patients' conditions were deteriorating. As well as the CCOT, there was an Acute Response Team which responded to concerns from ward staff about individual patients which was confusing for ward staff and resulted in different approaches to accessing support to care for patients with deteriorating conditions.

## End of life care

The hospital had a multi-professional approach to end of life care and worked in partnership with the Marie Curie Palliative Care Institute Liverpool (MCPCIL). This meant that good research based practice was shared across the trust and MCPCIL.

# Summary of findings

The hospital no longer used the Liverpool Care Pathway for people in the last few days of their lives. However, it had implemented a care for the dying patient guidance document, based on the Integrated Care Pathway methodology. We saw this document was being followed from diagnosis until after death and that patients were receiving appropriate support and compassionate care.

The palliative care team focused on ensuring the provision of high-quality services that met the needs of the patients who used their service and their families. They underpinned their practices with the belief that care for the dying is part of the core business of their organisation. If care was necessary within the hospital environment the palliative care team provided support and information to the patient, their families and the care team working on the ward.

People told us that they were satisfied with the care they received from the palliative care team. For patients who remained in hospital plans were put in place to ensure that their wishes were respected.

## Outpatients

The outpatient areas were clean and well maintained. However, aspects of the physical environment were cramped and poorly laid out which may cause access problems for the physically disabled. We found that some outpatient areas did not respect patient's privacy and dignity in that people were seen in cubicles rather than rooms; this meant that consultations could be overheard. We also noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment. However, staff told us that this service was "hit and miss."

We found that there were a number of issues around the patient experience within the outpatient services. Patients told us that waiting times were still unacceptably long in some departments whereas other departments, for example x-ray, were seeing people quickly and efficiently. However, patients we spoke with told us that they were generally satisfied with the service they received.

We spoke to senior staff during our inspection who were aware of the issues with inconsistent service across different specialities. We saw evidence of improvement in some areas particularly around patient's appointment letters. It was acknowledged by the senior managers that there were still further improvements to be made.

We saw there were clear leadership structures in place and staff were aware of the issues around the outpatients department and were working proactively to address them.

# Summary of findings

## What people who use the trust's services say

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. The results have been used to formulate NHS Friends and Family Tests for A&E and inpatient admissions.

Royal Liverpool and Broadgreen University Hospitals NHS Trust achieved a score of 43 out of a possible 100 for the Accident and Emergency (A&E) Friends and Family Test, below the national average. The response rate was 9.4% for the department, which was also below the national average of 11.3%.

In August, 672 people completed the test following their admission to hospital. 88.8% of in patients asked were either "likely" or "extremely likely to recommend the ward they stayed in to friends or family. 561 people completed the test following their treatment in the A&E department. 81.2% of patients asked were either "likely" or "extremely likely" to recommend the hospital's A&E department to friends or family.

Analysis of data from the CQC's Adult Inpatient Survey 2012 showed that overall the trust scored within the expected range for all 10 areas of questioning. The trust scored better, on average, than other trusts in care and treatment. They scored particularly high in questions around information and inclusion in discussions regarding treatment, privacy and confidence and trust in the doctors treating them.

The trust performed within the top 20% for 21 of the 64 questions in the 2012/13 Cancer Patient Experience Survey. There are four questions in the lowest 20% of trusts nationwide. These questions were around having seen a GP before being told to go to hospital, information about support groups and the impact of cancer, and privacy when examined or treated.

## Areas for improvement

### Action the trust MUST take to improve

- Improve care received by 'outlier' patients
- Adhere to infection control procedures within the accident and emergency department
- Review the use of theatre recovery as an overnight facility for which it is not designed.
- Review the use of the observation room CDU6 as an overnight facility for which it is not designed.
- Clarify the roles of the Acute Response Team and the Critical Care Outreach Team
- Address the unsafe allocated space between beds in the Heart and Emergency Centre
- Ensure that the consultant leading the Post Operative Critical Care Unit has adequate experience and qualifications in intensive care medicine.
- Improve medical staffing in vascular and colorectal surgery.

### Action the trust COULD take to improve

- Resolve the issue caused by two of the care of the elderly wards sharing a hoist, despite being located on different floors.
- Information about patients' whereabouts needs to be more robust, to make sure patients can be located while they remain within the hospital particularly when they are moved to the discharge lounge.

## Good practice

Our inspection team highlighted the following areas of good practice:

- The end of life care service is of a high standard and provides care seven days a week. The hospital also has

a dedicated bereavement team which provides care and support to relatives following the death of their loved ones. This is supported by a large and well organised multi-faith spiritual support network.

- In critical care, there was an effective Critical Care Outreach Team (CCOT), which is a support team for patients who had received care within the ICU.
- We were told of a recent initiative to improve the knowledge of all staff in the hospitals regarding the appropriate responses to support a person breathed via a tracheostomy ('neck breather') should they face a breathing problem when visiting the hospital. This initiative had resulted in raised awareness across the trust – not just in the specialist areas. It had also been delivered outside the hospital setting.
- The cohesive way in which the A&E and Acute medical unit worked.
- The stroke service, which had the third highest overall performance scores in the country and the highest scores outside London in the most recently published Sentinel Stroke National Audit Programme (SSNAP) report.

# Royal Liverpool Site

## Detailed findings

**Services we looked at :**
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; End of life care; and Outpatients

## Our inspection team

**Our inspection team was led by:**

**Chair:** Mike Bewick, Deputy Medical Director, NHS England.

**Team Leader:** Lorraine Bolam, Care Quality Commission

The team of 33 included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience and senior NHS managers.

## Why we carried out this inspection

We inspected this hospital as part of our new in-depth hospital inspection programme. . Before the inspection, our 'Intelligent Monitoring' system indicated that the Royal Liverpool and Broadgreen University Hospitals trust was considered to be a low-risk service.

We held a focus group for people who found it more difficult to give their opinions and a listening event, during which we spoke to a wide range of people who shared their experience of the hospital with us. Some of the issues they identified were that staff were caring despite being busy, information from the hospital was not always in an acceptable format, interpreter services were inconsistent and the provision of reasonable adjustments for people with disabilities could be better. We used this information during our inspection.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following core services at the inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery

# Detailed findings

- Intensive/critical care
- End of life care
- Outpatients.

Maternity and family planning and Children's care services are usually included in the inspection but due to the local health provision they are not provided at the Royal Liverpool hospital.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. It should be noted there are no Maternity and family planning or Children's care at the Royal Liverpool Hospital.

The announced inspection was carried out over two days on 28 and 29 November 2013. This was followed up with a one day unannounced inspection on 11 December 2013.

We inspected this hospital as part of our new in-depth hospital inspection programme. It was being tested at 18 NHS trusts across England, chosen to represent the variation in hospital care across England. Before the inspection, our 'Intelligent Monitoring' system indicated that the Royal Liverpool and Broadgreen University Hospitals NHS Trust was considered to be a low-risk provider. The Care Quality Commission (CQC) had inspected across both of the acute sites (The Royal Liverpool and Broadgreen hospitals) four times in total since it was registered in April 2010. It had always been assessed as meeting the standards set out in legislation. Before the inspection our analysis of data from our 'Intelligent Monitoring' system indicated that the hospital was operating safely and effectively across all key services. The analysis identified the trust was a low reporter of incidents which can indicate the culture within the trust did not support the open reporting of incidents and can affect the learning from incidents. At the time of the inspection the trust had no mortality indicators identified as risks. There had been two instances where the trust had been identified as a mortality outlier in August 2012 with regards to emergency cases with a primary diagnosis of acute myocardial infarction and the management of acute myocardial infarction and coronary sclerosis. The trust conducted audits and developed action plans to address the findings. The progress against these action plans was monitored by the CQC's local compliance team. We also reviewed information that we had asked the trust to provide and received valuable information from local bodies such as the clinical commissioning groups (CCG), Healthwatch, Health Education England and the medical Royal Colleges. The information from the royal colleges did not identify any risks however the information we received from the CCG's supported the low reporting of incidents.

We met with a group of local people representing people who can be more difficult to reach for their views before the inspection. We listened to people's experiences of the hospital and during the inspection we held a public listening event in Liverpool and heard directly from 20 people about their experiences of care. We spoke with more than 70 patients throughout the inspection. The areas of concern raised helped to inform the inspection.

During the inspection we observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the hospital. We conducted interviews with members of the trust executive team and interviews with senior staff as required. Focus groups were held with a range of staff in the hospital, nurses, doctors, physiotherapists and occupational therapists. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments, mortuary, chaplaincy and the A&E departments. We placed comments boxes around the hospital and held drop in sessions to receive comments from people who used the service and staff. We held a listening event on the evening of 28 November 2013. People were able to talk to us about their experiences and share feedback on how they thought the hospital needed to improve.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

The safety of services was supported by good assessment of patients' needs and provision of care to meet those needs. There were procedures in place to keep people safe. Records were maintained to a good standard in most areas.

There were a number of areas that required improvement. These included: medical staffing levels in vascular and colorectal surgery; adherence to infection control policies in the emergency department especially at times of higher demand; the number of outlier patients; the space between beds was very limited in some ward areas, particularly in the Heart Emergency Centre and POCCU, and the responsiveness of pharmacy for medicines reconciliation and provision of discharge medication.

## Our findings

### Staffing

Staffing throughout the hospital was found to be adequate to meet the needs of the people using the service in the majority of cases There were some staff shortages within A&E and on the wards but overall we saw there were sufficient numbers of staff on duty at any one time. However regular staff were working extra shifts to ensure consistency of care for patients. Staff told us that these staffing levels were being maintained through the good will of staff and was not sustainable and staff shortages were having a detrimental effect on sickness levels which was 6.3% and 6.1% for nursing and other staff respectively. The national averages are 4.4% and 4.2%. Medical staff sickness was very low at 0.3% against a national average of 1.2%.

Staff told us that delays in recruitment (the majority of which were caused by the process of recruiting through an external source) had caused some people to look elsewhere for employment. Ward managers told us it was common to wait six months from the date of interview to the staff member joining the hospital. The executive team acknowledged this and had taken steps to address the issue but the problem had not been resolved. This was impacting on the consistency and quality of care as well as the morale of staff.

We found the junior doctor levels in the vascular speciality were low in comparison to the demand on the service which had increased since a recent remodelling. Patients were receiving the care they required and we saw patients were safe but the doctors could not always attend to patients needs in a timely manner. On one day during our inspection there were 30 vascular patients on other wards because all of the beds on the vascular unit were full. This increased the workload of the junior doctors and it meant that they were consistently working around four hours extra each day.

There was no intensive care medicine consultant on the Post Operative Critical Care Unit (POCCU) at the Royal Liverpool Hospital as this was led by a consultant anaesthetist. It was not clear to us whether they had all undergone specialist intensive care training. On all three critical care units there were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas provided a balanced skill mix and allocation of staff.

The analysis of diagnostic tests and assessments were undertaken by qualified staff in outpatients and advice was sought from other healthcare professionals, where necessary. However, the X-ray department had several job vacancies and required more staff.

### Escalation policies

Staff were aware that the greatest challenge faced by the hospital was the pressure of the demand for beds. Staff were aware of the escalation procedure when the A&E department was busy, and the systems in place to find beds for people who were to be admitted. The Trust full-capacity protocol was part of the major incident plan. This meant that the patient flow management team followed the consultants to see who was best placed in the discharge lounge and who could be discharged home.

The patient flow management team aimed to place each patient in the appropriate bed for their problem or, when this was not possible, ensure they were looked after by the right consultant. At the end of every shift they checked to see which beds were available and moved patients as required. However, we found patients who were not on the appropriate ward were not reviewed by their specialist medical team in a timely manner and the systems did not ensure that patients were allocated an appropriate consultant or that teams were fully aware of the location of patients under their care. This meant that patients were at

increased risk of inappropriate care or treatment due to less frequent specialist review. This was demonstrated on the morning of the unannounced inspection when we were provided with the current outlier information. The information showed 26 patients not in the appropriate bed for their problem. No patient identification numbers were used on the document to ensure accuracy in the identification of these patients. Of these 26 patients, 10 did not have a consultant allocated and one patient was accommodated in the emergency department. We spoke with 12 of these patients and found two did not know they were on the wrong ward, one person's discharge had been delayed, one person had been reviewed less frequently than if they had been on the relevant ward and one person had received no review by the specialist team despite being in the hospital for two days. We also noted the patient who had been cared for in the theatre recovery area was not accounted for on the list we were given. These concerns were raised with the trust at the time and they assured us they would address the issues.

### Equipment and environment

Staff had access to the equipment they required. Essential equipment, such as commodes and hoists were available on all wards and were clean and well maintained. We did note that two of the medical wards caring for frail elderly people had to share a hoist which meant patients had to wait inappropriately. This had been exacerbated by the temporary move of one of the wards to the seventh floor. Most of the patients' records that we checked had been completed in a way that promoted safe practice.

Some of the resuscitation equipment in the outpatients' clinics had not been regularly checked to see if it was in good working order. In addition some of the equipment was stored in poorly accessible areas which meant that it would not be readily available in an emergency.

### Medicines management

Medicines were administered and stored safely throughout the hospital. However, some patients informed us that they had been without at least one item of medication for more than a day during their stay and staff told us the system for obtaining medication for patients to take home once they had been discharged did not work efficiently, particularly at weekends. We noted that there was not a pharmacy service after 12 mid-day on a Saturday until 9am on Monday. This resulted in patients missing doses of their regular medication on admission and waiting for long periods of time on the wards or in the discharge lounge awaiting their discharge medication.

There was no electronic drug dispensing system in use in the emergency department and staff told us that the pharmacy was not always open and accessible. Staff told us that they did not stock all the necessary drugs in A&E so they often ended up running to other wards. The emergency department was not set up for ward type drug rounds when people were accommodated for longer periods than usual. This meant that the dispensing of drugs was often not safe, there was an additional drain on staff resources and records were not always kept for auditing purposes.

### Cleanliness

Overall, we observed that the hospital was clean and infection prevention and control procedures within the hospital were being used in most cases. However, in the Accident and Emergency department we found trollies and mattresses were not always cleaned appropriately and staff hand hygiene was not consistent. We observed thick levels of dust at high levels such as the curtain tracks and on ledges, and the clinical areas were not consistently cleaned between patients. A nurse told us it was often the case that there was not sufficient time in between patients for staff to clean the area and to decontaminate the equipment. There was a checking process in place but this did not demonstrate decontamination was being carried out effectively. This meant patients were at risk of hospital acquired infections.

Information regarding infection control at the trust showed infection rates for C. Difficile and MRSA were the same as for other trusts of a similar size. However, the 2012 Department of Health NHS staff survey showed only 62% of staff reported that hand washing materials were always available.

### Learning from incidents

Before we inspected we reviewed the large amount of information we held or the trust had sent to us regarding the hospital. This information highlighted that:

# Are services safe?

The trust was a low reporter of incidents including serious incidents. This can indicate a lack of identification and internal reporting of incidents. We noted the reports made did not demonstrate regular reporting of near misses which inform improvements in safety without harm to patients.

The percentage of people suffering falls with harm were unstable regularly rising above the national average.

We found that the trust had taken action in response to the information, for example, footwear with anti-slip soles had been introduced throughout the hospital to reduce the number of falls in response to the incidence of falls with harm.

Staff at all levels and within all disciplines were familiar with the incident reporting system and told us they were encouraged to report incidents. However, there was no clear analysis and action of some areas of concern reported by staff, at either division or board level. It was felt that the trust was being directed by strategic targets and serious incidents rather than using complaints and near misses to proactively identify areas of concern.

The surgical wards had introduced and monitored a number of initiatives to increase patient safety. We saw that information for some incidents was recorded visually so that staff were reminded how many had occurred or how many days had passed since the last incident. This included incidents such as pressure ulcers and falls. The system used to record the information is a nationally recognised method for collecting and presenting this information.

However, not all clinical incidents in theatre were reported to senior staff. Some nursing staff told us that they were encouraged to report incidents and knew what to report, but they said they did not always report incidents due to a lack of time. Some of the junior doctors we spoke with were not aware what to report and very few had ever reported an incident. When an incident occurred and was reported, we saw that it was followed up and action was taken to prevent reoccurrences.

### Safeguarding

The hospital had safeguarding training in place and attendance was good. We saw staff were aware of the Mental Capacity Act and it's implication for patients in their care. One example was on one ward where we saw that the correct procedures had been followed for a patient who was not able to consent to the treatment themself. A "best interest" meeting had also been held and appropriate staff had been involved. This meant that the rights of person who could not make some of their own decisions had been protected.

### Patient records

Patient records had been completed in a way that promoted safe practice in most cases but there were concerns raised around written information provision when patients moved between service areas. . An example of this was that transfer documents were not always completed when patients were transferred from one ward to another or from the high dependency unit to a ward. In addition we found that some records were not always fully completed.

Although we found that some care records were not personalised and did not contain evidence that patients had been involved in planning their care, when we spoke with patients they told us they knew what was happening and that staff listened to them and explained their care. Patients commented, "Care staff explain what they are doing" and "the consultant has explained everything and I understand and I am happy with that".

# Are services effective?

(for example, treatment is effective)

## Summary of findings

In general we found that patients were receiving effective care and treatment and best practice guidelines were being used.

The hospital was regularly participating in clinical audit and this was clearly priority for the trust. We saw examples of local and national audits in all service areas, and many departments were able to demonstrate changes to practice made as a result.

Departments held regular morbidity and mortality meetings and staff at all levels were encouraged to attend.

## Our findings

### Intelligent Monitoring

Prior to our inspection we reviewed the data we had about the effectiveness of the care provided at the Royal Liverpool Hospital. All of the effective indicators were within expected range, indicating that the care provided was mostly effective.

The trust had one mortality outlier for patients diagnosed with an acute myocardial infarction (heart attack). This was discussed with the trust who had investigated this internally. Their review had concluded that the issue was one of miscoding, in that patients were attributed to have died from an acute myocardial infarction (MI), when in fact this was the terminal event caused by their co-morbidities or illness. The trust did discover that their management of patients with a non-ST elevation myocardial infarction (NSTEMI) could be improved and as a result had put in place an action plan.

### Critical Care Outreach Team and Acute Response Team

Our inspection team found that the trust had both these teams in place. There appeared to be some confusion on the wards which of these teams should be called in the event of a deteriorating patient as nurses on different wards gave us conflicting responses as to who they would call. The critical care outreach team was responsible for reviewing patients following their discharge from the Intensive Care unit, which is in line with good practice.

### Policies and guidelines

Patients were receiving effective care and treatment and best-practice guidelines were being used. For example, the (Malnutrition Universal Screening Tool (MUST) was used to assess patients on admission so that appropriate action could be taken if the person was at risk of malnutrition.

### Working with others

We saw several examples of good co-operation with other providers, which included the prompt acquisition of a breast pump for a nursing mother on one ward and an efficient transfer of care for one patient from another hospital. There was a consultant-led GP advice line which was provided by the cardiology department each lunchtime. However, we were informed by the consultants that, due to a recent restructuring of the administrative staff, letters to GPs and patients following out patients appointments were subject to delays of up to four weeks. This meant that there was a significant delay in information which may have an effect on the way in which a patient's care is managed from returning to their GP.

We also saw examples of co-operation with other hospitals resulting in efficient transfers. We also saw an example of a memory café session initiative for people suffering with memory problems which had been organised between a number of agencies.

### National and local clinical audit

We were informed that Clinical audit sits within the Trust Governance and Quality directorate. We saw evidence that an annual report was compiled and presented to the Clinical governance committee. This was used to advise the Medical Director with his board Assurance paper. Medical and surgical divisions held quarterly meetings with the clinical audit leads.

The trust contributed to 90% of National clinical audits and all of the national confidential enquiries. Departments were able to demonstrate that they regularly compared themselves with national benchmarks and comparable providers. In many departments, such as the Critical care unit, the results of the audits were displayed on the walls.

On the vascular wards we saw that a nursing quality audit had been completed and an action plan was in progress to address the concerns that had been raised. Within theatres we saw that an audit had recently been completed on compliance with the WHO surgical safety checklist which showed 100% completion with 92% of the sections being

# Are services effective?

## (for example, treatment is effective)

completed although it should be noted that the audit covered only one week and the results had not been verified. It showed 100% of team briefs had been completed, 100% had the sign in section completed, 100% had the time out section completed and 100% had the sign out section completed. The staff within theatres had regular meetings that included a review of the quality of care provided.

The palliative care team monitored ward referrals and all end of life care concerns and complaints. A coding system of red green and amber was in place to prioritise urgent cases and trigger additional reviews. A regular sample audit was carried out around deaths within the hospitals and the information gathered was used to direct which wards required additional support or extra training.

# Are services caring?

## Summary of findings

Services at the hospital were delivered by, caring and compassionate team of staff. All the people we spoke with were positive about their care and treatment at both hospitals. We observed staff treating people with dignity and respect and people were encouraged to share their thoughts and experiences of care in the hospital.

## Our findings

### Patient experience

The majority of patients we spoke with were positive about their care and treatment. They could not speak highly enough about the caring and professional attitude of the staff. One patient told us, "Our experience has been wonderful, the staff were courteous".

We spoke with outpatients and they told us that overall they were satisfied with the service they received though they often experienced long waits. We noted that there was some confusion around appointment times in some outpatient departments. One patient arrived to be told that their appointment had been cancelled. They were then told that they had not contacted the department to 'opt in' to their appointment. However, on examination of these patients appointments letter it was not clear that the patient had to 'opt in' to their appointment.

### Patient-centred care

Patients felt involved in their care and well looked after. Patients we talked with told us they were involved in their care knew what was happening and that staff listened to them and explained their care. Patients commented, "Care staff explain what they are doing" and "the consultant has explained everything and I understand and I am happy with that". However, during the unannounced inspection we spoke with 12 patients who were being cared for on wards which were not the specialty they required. None of them knew they were on an alternative ward or understood they were being cared for by nurses with a different speciality knowledge and that medical staff from another ward should be reviewing their care regularly.

Also some care records were not personalised and did not contain evidence that patients had been involved in planning their care.

One person in A&E said, "The treatment is very good; the nurses have been very helpful and cheerful. They have kept the family involved". We saw an instance where a nurse called a patient's family to inform them their relative was going to be admitted overnight. Patients received information and follow-up advice when they left the outpatients department. There were a range of information leaflets, and these were available in different formats and languages. Patients were given information in a format they were able to understand. There was a support group for patients who had received care within the ICU. Staff gave patients information about this group and patients decided for themselves if they wanted to attend the meeting.

The staff were aware of and asked for a "Passport to health" when caring for people with learning disabilities. This document provided information for professionals to aid people's care and support. The staff also told us that if one wasn't available they would complete one.

The hospital had dedicated staff to cover a number of specialist roles; in the Accident and Emergency department there were teams to support people with mental health needs, the homeless and those with drug and alcohol problems. The palliative care team had 86 ward-based nurses who linked with them to ensure good practice was observed. They had received additional training and supported people at the end of life.

The Chaplaincy provided a good service to patients and families in the hospital and we saw volunteers supporting patients in a number of ways. We also spoke with staff in the mortuary who had taken action to change the way that relatives were received through the development of a family room to ensure caring, compassionate support to bereaved families.

We spoke with two of the palliative care team's case managers whose role was to support patients in their final days. The case managers told us that they had systems in place to ensure that patient's wants and needs were met efficiently and in a timely manner.

### Patient feedback

People were encouraged to share their thoughts and experiences of the hospital. For example through surveys

and noticeboards on the wards where people could anonymously post suggestions. One ward had a comment board where patients could attach notes containing their views and thoughts while on the ward. This gave patients an opportunity to express their feelings anonymously and enabled staff to understand how patients were feeling while they were delivering care.

### Dignity and respect

We observed staff treating people with dignity and respect and offering care to the best of their ability. We saw extra time being given to those patients who required it. Staff ensured that the environment allowed privacy so that they could meet the intimate care, treatment and support needs of the patient. Curtains were drawn around each bed and discussions with patients were sufficiently confidential.

Suitable arrangements were in place for single-sex accommodation, with separate male and female bays on wards which had designated bathroom and toilet facilities. All the patients we talked to gave us positive feedback about the ways in which staff showed them respect and ensured their dignity was maintained. One person described the staff to us as "polite, calm and respectful". We saw that notices were pinned to the curtains in wards while staff were delivering personal care in order to preserve patient dignity.

We visited the mortuary and spoke with the bereavement staff. They explained that there were processes in place to support relatives once their loved one had died. This included help with death certificates, how to stop unwanted mail and how to collect personal belongings. The mortuary staff had created a pleasant environment to speak with people and had two rooms where relatives could view the deceased. Staff also told us that they worked closely with spiritual leaders to make sure that people's wishes and traditions were observed after death. For example they were able to give us examples of rabbi's attending post-mortem examinations to ensure that religious practices were followed.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

The hospital had a seven day services for patients requiring palliative care and the accident and emergency service was responding to needs of patients experiencing problems with alcohol, drugs as well homelessness. The trust had improved its responsiveness to complaints but still need to share the learning from complaints to improve services

However, there were concerns regarding the responsiveness of the Acute Response Team and the Critical Care Outreach Team (CCOT) due to confusion regarding their specific roles in relation to supporting ward staff to manage patients with deteriorating conditions. Training to support ward based staff to care for patients with deteriorating conditions and to care for patients with tracheostomies meant patients were staying longer on the critical care unit than expected. This was having an adverse effect on the use of theatre recovery which was being used as an overnight facility. The observation room CDU6 in A&E was also being used as an overnight facility when beds were not available in the main hospital. Some patients with complex needs had delayed discharge which was also having a negative effect on the availability of beds and so adding pressure to accommodate patients overnight in inappropriate environments. We also saw there were delays for patients waiting for take home medicines at discharge.

## Our findings

**Access**

Between April and June 2013 the trusts bed occupancy was 93.7% compared to the England average of 86.5%. It is generally accepted that when occupancy rates rise above 85% it can start to affect quality of care provided to patients and the orderly running of the hospital. (Dr Foster guide 2012). The palliative care team operated seven days per week and aimed to see in patients within 24 hours of receiving the initial referral. In the meantime they offer telephone support for both patients and professionals. Patients were seen and assessed promptly. We observed that the team also worked closely with ward staff to support them to deliver good end of life care. This showed that the team was responsive to the needs of patients.

There is a national Department of Health (DH) target for 95% patients to be discharge, transferred or admitted within four hours of arrival at A&E. The trust performance has varied but overall it was not meeting this target between April 2012 and October 2013. In June 2013 it reached around 100% for patients waiting less than four hours in A&E, but in March 2013 it dipped to 88%, the Trust's poorest performance, and 90% in October 2013.

In the emergency department we saw a number of ways in which the service was responding to the needs of the population of Liverpool. They routinely dealt with a high number of patients experiencing problems with alcohol, drugs as well as a high number of patients who were homeless. The trust had responded to these needs and commissioned specific teams to treat patients and reduce their time in hospital. There was a hospital alcohol nurse specialist team; a hospital outreach worker for homeless people which tried to ensure that no one was discharged back onto the street and offered referral to various shelters throughout Liverpool. We saw positive relationships between the services and saw this enhanced patient care.

The vascular services at the Royal Liverpool Hospital had been redesigned to include patients from a much larger geographical area. This resulted in many more patients within the vascular service than there were beds, so patients were given beds on other wards. On one day during our inspection there were 30 vascular patients on other wards because all of the beds on the vascular unit were full. This increased the workload of the junior doctors and it meant that they were consistently working around four hours extra each day. The junior doctors thought that they were gaining excellent experience within the surgical rotation but were obviously concerned about their working hours. The vascular patients were often placed on medical wards and some of the doctors we spoke with expressed concern about the nurses' ability to care for these patients as this was not their area of expertise. Theatre staff at the Royal Liverpool Hospital told us that the vascular surgery lists often over ran and this impacted on the work and finishing times of theatre staff. We were told that no action had been taken to address this.

There was a formal critical care network with other local trusts to ensure that the needs of patients were met effectively. For example, patients who required neurological care (conditions affecting the brain and the nervous system) were transferred to another local hospital.

# Are services responsive to people's needs?

## (for example, to feedback?)

Staff also contacted the network when they had a patient who required ICU or HDU care and there were no beds available at the Royal Liverpool Hospital. This ensured that patients received the most appropriate level of care, although it may not have been at their local hospital.

We identified a number of concerns in surgical and medical areas stemming from the pressure on bed availability. The high numbers of patients in the hospitals at any one time meant the flow of patients through the services needed to be well managed. However, we found there were many examples of patients being cared for in inappropriate settings both in the Accident and Emergency department and in theatres. We also found examples of delayed discharge from critical care beds and back to the community. In theatres from September 2013, 250 patients were kept in the recovery area for longer than required. The vast majority of these delays occurred because beds were not available. Since September 2013 the theatre records showed 11 patients had stayed in the recovery area overnight, three of them for two nights. When we visited for the unannounced inspection we found that one person had stayed overnight in the theatre recovery area as there was no bed in the POCCU for them.

An observation room in the emergency department (which is known as the CDU6 room) for patients before they go to the ward area, had also been used to care for patients overnight. These facilities were not designed or equipped for this purpose and did not provide facilities for showering and toileting and there was a lack of privacy. There are also issues regarding food and drink in the recovery room and people's access to their family under these circumstances. Adjustments were being made by the hospital regarding staffing and nutrition but peoples dignity and recovery needs were not being met. These practices also had a knock on effect on the efficacy of the departments as it altered normal safe practices. For example safety checks prior to theatre lists the next day were not completed due to staff looking after resident patients in theatre. Staff told us that they spent a lot of time trying to secure beds on the wards for patients. Most of delays that occurred were longer than an hour but were less than six hours. It was clear that this was not effective use of the recovery area; however we were most concerned about the privacy and dignity of the patients.

### Treatment of vulnerable patients

We observed a variety of systems used throughout the hospital to alert staff when a person was vulnerable. However, there was no common system throughout the hospital, which meant there was a risk of nurses who moved between wards misinterpreting the information symbols.

The hospital had nurses who were specially trained in dealing with patients with learning disabilities called who were referred to as "Learning Disability Champions". The nursing staff told us they would ask for a "Passport to Health", which is a document which captures the patients care needs, and if one was not available, they would complete one. We saw signage and posters to encourage staff to adhere to this system.

The emergency department routinely dealt with a high number of patients experiencing problems with alcohol, drugs as well as a high number of patients that were homeless. The hospital had responded to these needs and commissioned specific teams to expedite their discharge. The department had a team in place to treat patients with mental health issues. We saw a dedicated team in place who were part of the Mersey Care NHS Trust. There were a number of support staff as well as a mental health nurse specialist who assessed any potential patients.

Staff were aware of the Mental Capacity Act and it's implication for patients in their care. On one of the wards we saw that the correct procedures had been followed for a patient who was not able to consent to the treatment themself. A "best interest" meeting had also been held and appropriate staff had been involved. This meant that the rights of person who could not make some of their own decisions had been protected.

### Accessible Information

Patients told us they had received all the information they needed about their care and treatment in a way that they could understand. A welcome pack was available on all the wards and contained information about the hospital including visiting times and how to make a complaint. However, some of the welcome packs were in an old format and contained out-of-date information.

# Are services responsive to people's needs?

## (for example, to feedback?)

We saw a variety of information leaflets were available. These were available in many languages on the Trust intranet and could be downloaded by staff when needed. Interpreter services were available on all wards, either by the use of a telephone or face-to-face.

### Discharge planning

The 2012 Department of Health Adult Inpatient Survey showed the hospital was performing better than expected in relation to delayed discharges. Staff on most of the wards we visited told us that patient discharges were not always managed as efficiently as they could be, particularly for the elderly patients with complex needs. The introduction of case managers to proactively manage patient discharge from the time of their admission had speeded up the discharge process, but staff were aware that some discharges were still subject to avoidable delays. We found patients still experienced delays in obtaining their medicines to take home resulting in some patients going home without their medicines and others waiting long times for medicines when there was a very high demand for beds.

The hospital discharge lounge (an area where some patients waited for transport to take them home) was not well staffed. One nurse was unable to take their meal break until one hour before the end of their shift. Some patients we talked to had used the discharge lounge before and although they had waited for up to three hours they were happy with the care they received. They had been provided with appropriate food and hot drinks while they waited.

When patients leave the ward they are recorded as discharged on the hospital computer system even though they are still on the premises awaiting transport. This means that if an enquiry is made, inaccurate information could be given regarding the whereabouts of the patient. We observed an example of a staff member trying to unsuccessfully locate a patient who was to be taken home by ambulance when family rang to check the situation as they had been discharged from the computer when they were sent to the discharge lounge.

### Complaints

Copies of the complaints procedure were available throughout the wards we visited. There were also details of how to complain and how to give feedback in the hospital's welcome pack. Patients we spoke with were aware of the Patient Advice and Liaison Service (PALS) and how to access their services should this be necessary.

A review of the complaints team and introduction of the complaints manager had seen significant improvements in the response times and quality of the letters sent to complainants. However, information from complaints was not routinely used to improve services.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Summary of findings

The hospital had an open culture where staff could raise concerns. Doctors and nurses felt supported in their roles by their direct line managers and said they had good access to training; they were very dedicated, compassionate and proud to work at the hospital. However, some staff said they felt the leadership team within the organisation did not listen to their views. They felt the executive management team did not fully appreciate their workload or the effect that staffing levels and workload had on staff morale.

The trust was monitoring quality of the services at the hospital through their risk management system but some areas of concern being recognised and reported by staff were not clearly acknowledged at either division or board level. The process for the analysis of incident and complaints information meant the trust was not making full use of the information, only being directed by strategic targets and serious incidents. Use of incident data was looking at recognised areas of risk but not seeking to find new risks from the raw data. This is demonstrated by the lack of documentation of some of the concerns we have identified at division and board levels.

The hospital needs to support the training of ward staff in how to respond to the needs of deteriorating patients and the care of patients with tracheostomies to reduce the impact this is having on the critical care service and to maintain patient safety.

## Our findings

### Leadership and vision

The trust board had four directors who had been with the trust for some time and the Chief Executive had joined the trust in 2012 from another acute NHS trust. However the Director of Nursing who had also held the chief operating officer role left the trust shortly before our inspection and an interim Director of Nursing had been in post for only five weeks. The chief operating officer role was being covered by the chief executive until they could recruit to the position.

The trust presented to the inspection team prior to the inspection sharing the strategy of the trust. This included plans for a new hospital which is due to be completed in 2017.

Leadership at service level was apparent. We spoke with a large number of clinical staff including, consultants, nurses, junior doctors, student nurses and domestic staff. Some staff told us there was an open culture where they could raise concerns and these would be acted on others felt their suggestions and opinions were listened to and valued by their immediate line managers. However they told us they felt the executive management team did not fully appreciate their workload or the effect that low levels of staffing had on their morale.

The three critical care units were under the nursing leadership of a matron and there were clear lines of accountability in place.

Some service areas were proactively managing risks for example, on critical care the leaders were clear about issues within their service and they had taken action where this was required including submitting two business cases: one to reduce the amount of money spent on agency staff and another to increase the number of critical care beds on the Royal Liverpool Hospital. However, at the time of our visit, neither of these business cases had been approved but they demonstrated that staff had a clear idea of where improvements could be made.

However, staff in other areas for example theatres, were not assured that the information they raised about concerns was being escalated as they did not see improvements based on their concerns. This was supported by the lack of information regarding the concerns we have identified in theatres, at higher levels.

An example of management response to busy periods which supported safe practices was when the A&E department was extremely busy and a red status was in place, all training was cancelled and the staff worked their respective shifts.

### Valuing Staff

Clinical and nursing staff were very dedicated and compassionate about their jobs. Staff said they were proud to work at the hospital. Staff we spoke with said there was good morale in the hospital and things work well but it was the great staff that kept things going not the leadership.

# Are services well-led?

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Staff felt undervalued and some told us they felt they had not been consulted regarding changes to services for example the redesign of the vascular services when staff had good ideas on what could work well and what would cause problems but felt they had not been heard.

### Training

The hospital had training available for its staff to access and appraisals were undertaken to identify further training needs of individuals. Staff reported higher non-attendance due to shortages of staff on the wards.

Most of the staff had received an appraisal during 2013, which included a discussion regarding their learning and development needs. Senior staff informed us that the way in which the training for staff was organised did not work efficiently, as consideration was not given to the staff off-duty rotas prior to the Learning and Development staff booking them onto training courses. Details of bookings on training courses were given to staff after their duty rotas had been organised and meant that some staff were unable to attend as they were on night duty or annual leave. The staff in the CCOT told us that there were more acutely ill patients being cared for on the wards. They ran training courses for staff in recognising deteriorations in patients' conditions and appropriate care and treatment for patients who were acutely unwell but these were poorly attended as staff could not be released from the wards. This meant the ward staff were less able to respond to the needs of deteriorating patients. There were no plans in place to resolve this situation

The staff we spoke with were very positive about the support they had received. All the staff confirmed they had received mandatory training, and told us there were opportunities for continuing professional development for them to enhance their skills. There was evidence of regular teaching sessions for junior doctors. This included weekly teaching and one-to-one teaching with a consultant. Every doctor was supported by a clinical supervisor. Doctors we spoke with confirmed they felt well supported and were able to approach their seniors if they had any concerns. The nurses we spoke with felt supported in their roles and told us they had good access to training. The training figures supplied by the trust current to October 2013 showed that 83% of the training had been completed.

We were also told of a recent initiative to ensure people who were "neck breathers" were supported appropriately should they face a breathing problem when visiting the hospital. This initiative had resulted in the production of a DVD educational tool which staff across all areas had been trained in. The tool had also been utilised outside the trust by other agencies.

### Risk management

Reported incidents were dealt with at local, service and trust level but if the incident was resolved locally the opportunity for more widespread learning from that incident was lost. This challenges the openness and transparency for dealing with incidents and risks.

The risk management system failed to recognise some areas of concern despite them being recognised and reported by staff and these were not clearly acknowledged at either division or board level. The process for the analysis of incident and complaints information meant the trust was not making full use of the information, only being directed by strategic targets and serious incidents.

An example of this is the level of concern raised by staff working in theatres about patients being kept in the recovery area for longer than required , including those who stayed overnight in the recovery area. They had reported the incidents and raised it with managers. Despite this the staff had seen no improvement. It was not recorded on the risk register that we were shown. The Clinical Director for theatres told us that they asked the commissioners of the service if they could open the extra beds in the Intensive Care Unit and High Dependency Units to try to relieve some of the pressure but this request had been declined. This was because the commissioners believed that there were sufficient numbers of critical care beds across all of the neighbouring hospitals. It was not clear from the information that we were given if the trust Board were aware of issues with patients being kept in the recovery area for extended periods of time. The trust was unable to provide documented evidence of discussions or actions taken to address the issues.

# Accident and emergency

| | |
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| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Information about the service

The Accident and Emergency (A&E) department provides a Consultant led 24-hour service, seven days a week. It is the biggest and busiest in Merseyside. In the year 2011 to 2012, 108,325 patients were seen here.

The A&E consists of an initial reception and booking-in area, a minor's area with 17 single cubicles, a major's area of 12 single cubicles with trollies, four high-dependency cubicles and a resuscitation room with eight cubicles. Three of these cubicles are designated specifically for trauma.

There is an emergency assessment unit (EAU) with six cubicles with trolley beds and two areas with seating. A satellite x-ray unit is in close proximity to the A&E department which provided x-ray and specialist scans. Priority was given to A&E patients.

## Summary of findings

We found the emergency department service being provided was good, it was well-led at ward level and was supported by caring staff who strived to deliver good care. Staffing was found to be sufficient and utilised well and there was little use of agency staff. As with the rest of the trust, recruitment processes when needed were not timely.

The physical environment in the emergency department was inadequate in size when demand was high and the team often treated more patients than there were beds. In addition patient flow was managed through a manual patient administration system whereby ward areas contacted the patient flow management team to ask for beds and to let them know of any beds that may be available. This had a significant effect on the efficiency of the team which meant patients could not be moved to the appropriate ward in a timely way and affected the services ability to meet the four-hour wait target. This may have also contributed to the inappropriate use of observation room CDU6 as overnight accommodation.

There were also concerns about staff not consistently following infection control procedures, a lack of high level cleaning and decontamination of equipment and availability of medicines, particularly out of hours.

# Accident and emergency

## Are accident and emergency services safe?

### Staffing

There were some staff shortages within A&E but overall we saw there were sufficient numbers of staff on duty at any one time, and there was little use of bank and agency staff. Regular staff were working extra shifts within the department to cover gaps in the roster. This meant there was always a sufficient number of staff who were familiar with the department and the way it worked, ensuring consistency of care for patients. We looked at the skill mix figures for the Emergency Department (ED) from October 2013 and saw there was a good balance.

We also observed that if a specific number of patients were in the corridor emergency triage area, additional staff were allocated to care for these patients. The hospital had therefore taken steps to minimise the risks for patients when the department was over capacity.

The sister in charge told us that any sickness was escalated to the nurse bank but they preferred their own nurses. We also observed that when the department was very busy, the staffing levels were stretched and staff seemed rushed and tired. The management team told us there was a low rate of absenteeism due to sickness. There was support in place for staff who returned to work after sickness and there were back to work interviews.

We spoke with several staff members in the A&E department including the management team, the matron, sisters in charge, as well as staff nurses. All the people we spoke with told us that there were issues with an external company the trust had a recruitment contract with. The staff told us there were extensive delays in the paperwork and this had led to some people, who were due to start in the A&E department, looking elsewhere for employment. Staff we spoke with told us there were also issues in relation to the payment of overtime for staff who worked additional shifts. The same company was not always paying staff on time which discouraged them from volunteering.

### Environment and Equipment

The A&E department consisted of an initial reception and booking-in area. This was a secure area which led to the rest of the departments either by using a secure pass or access was granted by the reception staff. There was a minor's area with a waiting room and 17 single cubicles where patients could be seen. Patients in the minor's area tended to be people with cuts, limb fractures or muscular/sports injuries.

There was a major's area which consisted of 12 single cubicles with trollies, four high-dependency cubicles and a resuscitation room with eight cubicles. Three of these cubicles were designated for trauma such as road traffic accidents, shootings or stabbings. The major's area was for people with ailments such as chest pains, abdominal pains, significant fractures or overdoses.

There was an emergency assessment unit (EAU) with six cubicles with trolley beds and two areas with seating while patients awaited further tests for example. There were two rooms that were originally set up for treating people with suspected flu. There was a secure room known as the 136 room which was specifically used to accept patients from the police who were being held under the Mental Health Act.

During busy times, when the other cubicles in A&E major's area were fully occupied, an additional seven trolley beds were utilised in the corridor area between the majors and minors, and an emergency triage (ET) area was set up. We saw several occasions where the privacy and dignity of the patient was compromised due to the patient being treated in the corridor. We overheard several conversations between the consultant and the patient. We also saw bloods being taken in the open and a patient vomiting in the emergency triage corridor.

The hospital responded appropriately where equipment was required; we saw there was plenty of equipment available for staff to use. The emergency department had a resuscitation room with three cubicles designated for trauma which were well-equipped. We saw equipment in place for specific procedures which may only be carried out several times a year. All the equipment we saw was serviced and where possible, single use items were being used.

### Medicine management

We saw that drugs were being stored in secure cabinets in the emergency department areas. We looked at the controlled drugs and noted that they were being administered according to the policy. We saw the book was countersigned by two staff members at all times.

# Accident and emergency

There was no electronic drug dispensing system in use in the emergency department. The staff told us that the pharmacy was not always open and accessible. Staff told us they didn't stock all the drugs in A&E and often ended up running to other wards. Staff told us the emergency department was not set up for ward-type drug rounds which meant this was an additional drain on staff resources. This meant that the dispensing of drugs was often not safe and records may not always be kept for auditing purposes.

### Cleanliness and infection control

The areas we saw were generally clean, well-maintained and in a good state of repair. However, we saw some areas that were in need of repair. In the EAU plaster was off coming off the walls behind the beds where the rail was hitting the wall which meant the area could not be cleaned effectively.

We looked inside a number of cubicles in the major's area during our inspection. Although they were generally clean, we saw thick levels of dust behind the blood pressure monitoring device (BP) and on top of the suction unit. There was also a high level of dust at high levels such as the curtain tracks and on the ledges.

The domestic staff had just cleaned three of these cubicles. They explained they only cleaned the environment and did not decontaminate any of the equipment. They told us decontaminating the equipment was the nurse's duty. The domestic staff told us they couldn't always access all the cubicles if there were patients in them and there was no system of recording whether a cubicle had been missed so they could return when it was not occupied. A staff nurse told us the regular housekeeper and domestic staff were not sufficient.

A nurse told us it was often the case that there wasn't sufficient time in between patients for staff to clean the area and to decontaminate the equipment. She said, "Sometimes the patients are waiting in the corridor as we are changing the sheets".

We saw a nurse's checklist that stated the items to be decontaminated and included the BP and suction unit. It had been signed daily to say these had been done; however, there were no checks in place to confirm the decontamination was being carried out effectively.

During our inspection we looked at a number of trolley beds and mattresses in the A&E areas. We saw four trolley mattresses in ET of which two were stained on the outside covers and three were stained on the inside of the cover when we unzipped them. We saw the mattress in one cubicle for people with suspected flu which was sticky and torn on the outside and when we unzipped this, it was heavily stained on the inside. The second cubicle for people with suspected flu contained a bariatric wheelchair which was torn and the foam was showing which meant that it could not be effectively decontaminated. We looked at three mattresses inside the cubicles in the major's area and saw they were stained on the outside with a sticky substance and when we unzipped all three they were also stained on the inside. These mattresses could pose a potential infection risk.

We spoke with the sister in charge who told us that all staff should unzip the mattresses to ensure they were clean but she confirmed the majority of staff didn't. The nursing staff we spoke with told us they didn't unzip the mattresses regularly to check if they were clean. A staff nurse said, "We clean the mattresses on the outside but I don't look inside". We looked at the cleaning policy which defined the roles and responsibility of each staff member. We noted the policy did not specifically state that mattresses should be unzipped.

On the first day of our inspection we saw the ET area was very busy and there were a high number of bed changes. We noted several occasions where patients were transferred to beds without them being cleaned in-between. We saw that some of the trolleys in the majors walk in area were torn and many were in need of repair.

We saw an announced hand hygiene audit had been conducted weekly from August to October 2013 in the A&E areas and the result was always 100% compliant. However, unannounced hand hygiene audits in October showed poor compliance. On the first day of our inspection we saw a consultant and a number of nurses working in the Emergency Triage area. We noted that they often went from one patient to another without carrying out any hand hygiene procedure in between. We also saw six gel dispensers around the A&E area with no gel in them. This meant that staff, patients and visitors could not decontaminate their hands in those areas. We saw a number of staff carrying small gel dispensers, but we saw they were not always used.

# Accident and emergency

### Learning from incidents

Staff told us there was an open culture where they could raise concerns and these would be acted on. Clinical and nursing staff were very dedicated and compassionate. Staff said they were proud to work at the hospital. Staff we spoke with said, "There is good morale in the department and it works well but it's the great staff that keep A&E going not the leadership" and "There are good senior staff who often work with no break to keep everything going". We observed that the sister in charge was managing very well on both days of the inspection.

### Escalation policies

At times, the availability of beds in wards can cause a backlog of patients in A&E, which may cause some patients to breach the target times. We spoke with the patient flow manager, a case management co-ordinator and a patient flow co-ordinator who was co-ordinating the medical beds. The current patient administration system used by the team was manual whereby ward areas contacted the patient flow management team to ask for beds and to let them know of any beds that may be available. The patient flow co-ordinator told us there was no real-time system in place to let the team know where the beds were available and when they would potentially become available. The team were constantly ringing and visiting the wards. One member of the team said, "The current system is not the best; it's slow and hard to work. We try to estimate where capacity is but it doesn't always work." All the staff we spoke with told us staff on the wards were not reporting the availability of vacant beds in a timely manner. This meant patients could not be moved to the appropriate ward in a timely way. We spoke with the patient flow management team who told us this meant they had to increase their frequency of visits to the wards to check for empty beds and caused additional work. Staff in the emergency department told us this meant the four-hour wait was often breached.

There was an observation room known as the CDU6 room which was used for patients before they went to the ward area. Four members of staff told us this room was used to care for patients overnight. However, this room was not suitable for patients to remain overnight as it was very cramped and the layout made it difficult to manoeuvre. There were no lockers or storage facilities for the patient belongings and the patients had to go into the adjoining ward to use the showering and toilet facilities.

The patient flow management team informed us they aimed to place each patient in the appropriate bed for their problem and if they couldn't then they tried to ensure that they were looked after by the right consultant. At the end of every shift they checked to see which beds were available and moved patients as required.

## Are accident and emergency services effective?

(for example, treatment is effective)

### Clinical audit

The department contributed to a number of National and College of Emergency Medicine (CEM) audits, including the National Audit of Seizure management in Hospitals (NASH), Consultant sign off in ED and management of sepsis. Their performance was found to be on par with or better than trusts of comparable size and activity.

They were able to demonstrate evidence of local audit activity, including closing the audit cycle loop resultant changes made.

### IT support

We saw that the hospital PAS system was outdated and didn't show real time patient movements. The hospital PAS and the emergency department systems did not communicate with each other which meant the flow of information was broken. A manual process was in place which was cumbersome, slow and time consuming.

The sister in charge in the A&E majors explained and showed the manual system which was in use. Essentially there was a whiteboard where the patient admission times, status and estimated discharge time was recorded. The sister in charge told us the admission times were recorded electronically but discharge times were entered manually. She confirmed that staff were honest with the discharge times and this was evidenced by the Grant Thornton review.

Overall, not having the electronic systems in place meant that accurate records may not be made at the time of an event happening and some records were being updated retrospectively. This also meant that auditing the information was difficult and the results may not always be accurate.

# Accident and emergency

### Working with others

We found that as the Acute medical unit and A&E were situated next to it, there was exemplary communication between the two departments. They both considered themselves part of the 'Emergency Floor' rather than two distinct departments. We witnessed seamless transfer of patients between the two and arrangements had been made to avoid duplication of documentation, thus improving the efficiency of the floor.

## Are accident and emergency services caring?

### Patient experience

We spoke with 17 patients and visitors or family members in the various areas of A&E during both days of the inspection. The majority of patients we spoke with were positive about the care and treatment they had received within the A&E departments.

A number of patients commented on the high number of patients that came to the A&E who were under the influence of either alcohol or drugs. Patients and visitors told us, "The hospital is very good, it's just the clientele it attracts isn't very nice. It's too convenient for drunken people to come here. They should have a separate area". One patient told us, "The nurse's deal with alcoholics and abusive people in a nice way".

Patients told us, "Our experience has been wonderful, the staff were courteous" and "We have nothing but praise for the staff". One person told us, "The service is smashing, just perfect! The sister came with me when I got transferred to Broadgreen Hospital and helped me settle in".

Patients felt that staff were compassionate and that they included their relatives in discussions about their health needs when appropriate. Staff were respectful and treated patients with dignity. They closed curtains when interacting with patients and they asked relatives to leave when they needed to discuss intimate issues with patients. We saw several patients who were being regularly observed due their conditions such as mental health. They were offered refreshments as well as food where possible.

### Patient-centred care

Patients received information and follow-up advice when they left the department. There were a range of information leaflets, and these were available in different formats and languages. Patients were given information in a format they were able to understand.

The hospital provided staff access to "Language Line" which is an interpretation service. Clinical staff we spoke with confirmed they could have an interpreter on the telephone or in person if required. Staff were happy with the service and told us they utilised it when required. We spoke with a number of nurses who told us there internal staff who could also speak some of the more common languages such as Polish and French who may be called in the first instance.

We observed a member of staff with a drinks and food trolley who was walking around the A&E areas offering refreshments to patients were in the cubicles. We noted that she was in contact with the nursing staff to ensure the patients could eat and drink and were not restricted in any way.

### Patient involvement

Patients felt involved in their care and well looked after. One person said, "The treatment is very good; the nurses have been very helpful and cheerful. They have kept the family involved". We saw an instance where a nurse called a patient's family to inform them their relative was going to be admitted overnight.

### Observation

During our inspection we observed all staff treating people with dignity and respect and offering care to their best ability in the limited time they had. We saw staff taking extra time with patients who were under the influence of alcohol and those who were homeless to ensure they fully understood the advice being given.

Patients and their relatives were treated with privacy and dignity. Staff ensured that the environment allowed privacy so that they could meet the intimate care, treatment and support needs of the patient. Curtains were drawn around each bed and discussions with patients were sufficiently confidential.

Staff of all grades from the domestic staff to the senior nurses told us they all enjoyed working in the department and felt they were a close knit team who wanted to do their best for every patient. All the staff we spoke with told us

# Accident and emergency

they would be happy to have their family members treated in A&E if needed. This was reflected in the patient comments when one patient said, "All the staff were very professional but I would like to mention a young staff nurse who looked after me with the most care and respect and made me feel at ease. She went above and beyond her duty". We observed several patents come into A&E who shouldn't have been there and staff helped them even though they were busy.

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

### Access
There is a national Department of Health (DH) target to discharge or admit 95% of patients within four hours of arrival at A&E. The data for wait times between 8 April 2012 and 6 October 2013 showed that the hospital performed erratically against the national target and England average. In June 2013 it reached around 100% for patients waiting less than four hours in A&E, but in March 2013 it dipped to 88%, the hospital's poorest performance, and 90% in October 2013.

The patient flow management team told us that A&E were generally good at meeting the four-hour target and kept in touch with them to clear the beds. However, they were currently on red alert and had initiated the trust full-capacity protocol as part of the major incident plan. This meant that the patient flow management team followed the consultants to see who was best placed in the discharge lounge and who could be discharged home. We reviewed the trust's full-capacity protocol and saw it contained useful information for staff in all areas.

### Treatment of vulnerable patients
The emergency department routinely dealt with a high number of patients experiencing problems with alcohol, drugs as well as a high number of patients that were homeless. The hospital had responded to these needs and commissioned specific teams to expedite their discharge.

There was a hospital alcohol nurse specialist team which consisted of nurses and consultants to review patients who were under the influence and to advise the A&E staff on any treatment that may be required. The team also facilitated early discharge for medically fit patients who could be seen at home or from an outreach team. We observed one interaction between the alcohol nurse and a patient and saw she gave appropriate information, support and was very caring with the patient.

We spoke with a hospital outreach worker for homeless people who told us the team worked with people with no fixed abode and the service was available in the A&E department most of the time. The service tried to ensure that no one was discharged back onto the street and offered referral to various shelters throughout Liverpool.

All the staff we spoke with were fully aware of the services that were being offered and knew the people to contact. We saw positive relationships between the services and saw this enhanced patient care.

Staff who we spoke with told us there were nurses who were specially trained in dealing with patients with learning difficulties who were referred to as "Learning Disability Champions". The nursing staff told us they would ask for a "Passport to health", which is a document which captures the patients care needs, and if one wasn't available, they would complete one. We saw signage and posters to encourage staff to adhere to this system.

The department had a team in place to treat patients with mental health issues. We saw a dedicated team in place who were part of the Mersey Care NHS Trust. There were a number of support staff as well as a mental health nurse specialist who assessed any potential patients.

We spoke with the safeguarding lead for A&E who told us he worked with all the specific teams to ensure patients were not at harm. Staff we spoke with confirmed they knew about the safeguarding lead. The outreach worker for homeless people confirmed he worked closely with the safeguarding lead on a routine basis.

### Discharge planning
We saw an operational policy for a GP referral pilot from November 2013 to March 2014. The aim of the service was to support the emergency department with the management of patients presenting with medical conditions that could be dealt with by a GP. The staff we spoke with told us the initiative saw between 10 to 20 patients daily which reduced the pressure on the A&E beds.

# Accident and emergency

## Are accident and emergency services well-led?

### Leadership and vision

Senior staff in the department provided visible leadership particularly at times when the department was stretched.

### Training

We spoke with a number of clinical staff including, consultants, nurses, junior doctors, student nurses and domestic staff. All the staff we spoke with were very positive about the support they had received. All the staff confirmed they had received mandatory training, and told us there were opportunities for continuing professional development for them to enhance their skills.

There was evidence of regular teaching sessions for junior doctors. This included weekly teaching and one-to-one teaching with a consultant. Every doctor was supported by a clinical supervisor. Doctors we spoke with confirmed they felt well supported and were able to approach their seniors if they had any concerns. The nurses we spoke with felt supported in their roles and told us they had good access to training.

On the first day of inspection we saw the A&E department was extremely busy and a red status was in place. The sister in charge told us that when the status was escalated all training would be cancelled and all staff would be expected to work their respective shifts. The training figures supplied by the trust current to October 2013 showed that 83% of the training had been completed.

### Risk management

The concerns regarding the achievement of the national four hour wait target were recognised at all levels and actions were being taken to address these.

# Medical care (including older people's care)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Information about the service

The acute medical care services at the Royal Liverpool and Broadgreen University Hospitals NHS Trust are provided on wards 3A, 3X, 3Y, 5X, 5Y, 7A, 7B and 9B. Wards 2A, 2B and 2X provide care for the frail elderly. We visited all these wards during the inspection in addition to the Heart Emergency Centre, Coronary Care Unit, Medical Admissions Unit and Stroke Unit (2Y). Over the course of the three-day inspection we observed care, looked at records and spoke with patients, relatives and staff at all levels and across all disciplines.

## Summary of findings

We were impressed by the acute medical unit which was well staffed and showed close integration with the emergency department and were. Ward areas were clean and patients we talked to spoke positively about the general level of cleanliness throughout the hospital. Essential equipment was available on most wards and most of the patients and relatives we talked to commented on the kindness, professionalism and patience of staff at all levels. We observed the staff to be hardworking and patient.

We noted that patients were not always admitted to an appropriate specialist ward affecting the timeliness of medical review and risking some patients not being reviewed on a daily basis. We also found concerns around the management of medicines. Most of the ward managers told us they were short of staff with most of the wards being supported by bank staff and permanent staff working overtime. In addition, there was no system in place to establish the dependency levels of patients and amend the staffing rotas accordingly. The trust had recognised this and had plans to implement one in the near future.

# Medical care (including older people's care)

## Are medical care services safe?

### Staffing

Most of the patients and relatives we talked to commented on the kindness, professionalism and patience of staff at all levels involved in their care. We observed the staff were hardworking and patient. Most of the ward managers told us they were short of staff. The fact that most of the wards we inspected had vacancies which were filled by bank staff and permanent staff working overtime corroborated this. Senior staff informed us that sometimes bank staff were not available and the ward was short of staff. This meant that there were delays in the time taken to respond to the needs of patients, which staff found concerning. Some comments made were, "We rush around doing our best but if we are short we can only deliver the basics to people" and "I feel exhausted all the time, there are never enough of us".

There was no system in place to establish the dependency levels of patients and amend the staffing rotas accordingly. The trust had recognised this and had plans to implement one in the near future. Until this system is implemented, staffing levels within the hospital may not reflect the dependency levels of the patients in their care.

### Environment and equipment

We saw the space between beds was very limited in some ward areas, particularly in the Heart Emergency Centre where there was a distance of 800 millimetres between each bed. Health Building Note (04-01) Adult in-patient facilities states,"…most activities carried out at the bedside can be accommodated within the dimensions 3600mm (width)…". This lack of space meant that it was not possible to put an armchair at the side of the bed for patients to sit in and it was difficult for staff to carry out routine daily tasks or to maintain patient privacy. This also raised concern should emergency equipment be required at the bedside.

Essential equipment, such as commodes and hoists, was available on all wards and was clean and well-maintained. However, one ward caring for older people shared the use of a hoist with an adjoining ward which had been relocated seven floors away for redecoration. Suitable arrangements had not been made for the availability of the hoist. This was considered to be a risk in view of the potential for a significant number of patients to require manual handling transfers using a hoist.

### Medicines management

We found there were some concerns around the management of medicines.

Three patients, on different wards, informed us that they had been without at least one item of medication for more than a day during their stay as the item was not available on the ward.

Nursing staff on all the medical wards we inspected informed us that the system for obtaining medication for patients to take home once they had been discharged did not work efficiently, particularly at weekends. This resulted in patients waiting for long periods of time on the wards or in the discharge lounge awaiting their discharge medication. Staff informed us that occasionally patients would become frustrated and leave without their medication, or family members would collect it later in the day.

Some patients were able to administer their own medicines safely. These medicines were stored securely but, when questioned, both junior and senior nursing staff were either not aware of where to find the appropriate documentation regarding the self-administration of medicines, were not aware that it should be completed, or had not completed it. We found only one patient for whom the appropriate risk assessment and documentation regarding self-administration of medicines had been completed. This had been initiated and completed by the ward pharmacist.

### Cleanliness

Ward areas we visited were clean and tidy and there was hand hygiene gel in all areas. Patients we talked to spoke positively about the general level of cleanliness throughout the hospital.

Most staff followed the trust's policies and procedures for infection prevention and control. Ward areas we visited were clean and tidy and there was hand hygiene gel in all areas. Patients we talked to spoke positively about the general level of cleanliness throughout the hospital. One patient told us, "this ward is very clean, the commodes are always spotless." However, on several occasions we observed poor practice whereby staff delivered care without cleaning their hands, walked through clinical areas without using the appropriate hand gel or wore

inappropriate clothing, such as jackets and long sleeved shirts. We removed mattress covers from beds on two wards and found the mattress to be clean and in a good state of repair.

### Learning from incidents

Staff at all levels and within all disciplines were familiar with the incident reporting system and told us they were encouraged to report incidents. Feedback from the incident and any action taken was reported back effectively to the nursing staff, but the medical staff told us they did not often receive feedback from reported incidents. All staff told us they found the incident reporting system "cumbersome" and "time consuming" and some staff reported they could only report incidents in their own time as there was no time during their shift to do so. Nursing staff told us they rarely reported "near misses". It is important that near misses are reported as risks can be identified as a result of a near miss and action taken to mitigate the risk.

Staff told us that following analysis of incidents in which people had fallen footwear with anti-slip soles had been introduced throughout the hospital to reduce number of falls. We saw patients wearing this footwear throughout our visit.

Each ward displayed their progress against the national patient safety thermometer, which included instances such as pressure ulcers and falls with harm. Also displayed was the number of some healthcare acquired infections, such as Clostridium Difficile, contracted by patients on each ward. Ways in which the ward could improve their scores were discussed with staff at ward meetings.

## Are medical care services effective?
(for example, treatment is effective)

### Evidence-based treatment

Patients' needs were assessed on admission and re-assessed throughout their stay. Care was planned to meet those needs. Records were appropriately completed and risks, such as falls, malnutrition and breakdown of the skin were clearly identified. Each patient, where appropriate, had a comprehensive plan of care in place to manage their individual risks.

People were provided with a choice of suitable and nutritious food and drink. During our inspection we spent time observing the lunch time meal and saw that people were offered a choice of food and drinks. The food was served hot and assistance was given where necessary. We spoke with patients who needed a special diet due to their religious or cultural backgrounds and were told that their needs had been met. One patient commented, "The food has really improved here recently". We noted that the MUST (Malnutrition Universal Screening Tool) was used to assess patients on admission so that appropriate action could be taken if the person was at risk of malnutrition.

There was a formal, structured and effective method of nursing handovers (where staff change shifts and communicate information about patient care) on all the wards we inspected. There was no formal process for a medical handover on the Acute Medical Unit, with medical staff relying on the nursing handover for the less acutely ill patients. This meant that there was a risk that essential information regarding patient care was not communicated effectively.

We saw examples of a memory café session as a joint initiative for dementia patients organised between a number of agencies. We recognised this as a highly positive initiative.

### Working with others

We saw several examples of good co-operation with other providers, which included the prompt acquisition of a breast pump for a nursing mother on one ward and an efficient transfer of care for one patient from another hospital. There was a consultant-led GP advice line which was provided by the cardiology department each lunchtime. However, we were informed by the consultants that, due to a recent restructuring of the administrative staff, letters to GPs and patients following outpatients' appointments were subject to delays of up to four weeks. This meant that there was a significant delay in information which may have an effect on the way in which a patient's care is managed from returning to their GP.

### Clinical Audits

We were provided with their clinical audit report which demonstrated regular auditing (and reporting back) of services throughout the medical directorate.

There was evidence of regular audit meetings and they were able to demonstrate specific improvements to the quality of care provided for patients. For example, the gerontology department implemented a project to reduce

their pressure ulcers following a fractured neck of femur and demonstrated a drop from 7% to 2.6%. This was recognised by the National Hip Fracture Database and they were awarded a national prize as a result of this work.

The trust contributes to most of the National Clinical Audits it is eligible to. In the most recently published SSNAP report, the Royal Liverpool had the third highest overall SSNAP performance scores in the country and the highest scores outside London at 72.5 and 72.4. The audit rates each trust's performance from 'A' to 'E'. The trust was also one of only three trusts outside London to be awarded an overall level of 'B' in the pilot report (both for patient and team centred care). No trust has been awarded an overall level of 'A' to date.

## Are medical care services caring?

### Patient experience

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment. 15 of the 19 wards that scored less that the trust average were those providing medical care.

Most of the patients and relatives we talked to commented on the kindness, professionalism and patience of staff at all levels involved in their care. Comments included, "we are so well-cared for", "the staff have been wonderful" and "you can't fault the girls, they're brilliant". The only time we received negative feedback from patients was on the wards where staffing levels were poor. These patients commented, "I feel the staff are just about coping" and "they are doing their best but there aren't enough of them".

### Patient centred care

Some care records were not personalised and did not contain evidence that patients had been involved in planning their care. However, patients we talked to told us they knew what was happening and that staff listened to them and explained their care. Patients commented, "Care staff explain what they are doing" and "the consultant has explained everything and I understand and I am happy with that".

### Patient involvement

The patients we spoke to had received all the information they needed about their care and treatment. This had been provided in a way that they could understand. A welcome pack was available on all the wards and contained information about the hospital including visiting times and how to make a complaint, should they wish to do so. However, some of the welcome packs were in an old format and contained out-of-date information which included an advertisement for care homes within Liverpool which the Care Quality Commission had recently taken enforcement action against.

One ward had a comment board where patients could attach notes containing their views and thoughts while on the ward. This gave patients an opportunity to express their feelings anonymously and enabled staff to understand how patients were feeling while they were delivering care.

A variety of information leaflets were available on all wards. Copies of the leaflets were available in many languages on the trust intranet and could be downloaded by staff when needed. Interpreter services were available on all wards, either by the use of a telephone or face-to-face interpreting service.

### Observation

Staff treated patients in a discreet and dignified manner. Suitable arrangements were in place for single sex accommodation, with separate male and female bays on wards which had designated bathroom and toilet facilities. All the patients we talked to gave us positive feedback about the ways in which staff showed them respect and ensured their dignity was maintained. One person described the staff to us as "polite, calm and respectful". We saw that notices were pinned to the curtains in wards while staff were delivering personal care in order to preserve patient dignity.

## Are medical care services responsive to people's needs?
(for example, to feedback?)

### Access

We noted that due to an increasing number of emergency medical admissions, patients were not always admitted to an appropriate specialist ward and were sometimes nursed on other specialist wards. This meant that these patients were being looked after by nursing staff who were not as experienced at caring for their medical conditions as those on the appropriate specialist wards. In addition, doctors spent longer caring for these patients as they had to visit

several wards throughout the hospital in order to see these patients. There was a risk that some patients would be forgotten about and we were informed that patients were misplaced regularly though "not quite weekly". All the patients identified by the hospital as not being cared for on the appropriate specialist ward at the time of the unannounced inspection were reviewed. This showed us the hospital did not have accurate information regarding all these patients for example the names of two patients on the list were misspelt, there was no unique identifier used on the list and of the 26 patients on the list nine did not have a consultant identified. We found these patients did not receive the same level of medical review as those patients on the appropriate specialist ward. One person had not been reviewed by the specialist medical team for three days and another had been delayed in their discharge because of the lack of specialist review.

All the patients identified by the hospital as not being cared for on the appropriate specialist ward at the time of the unannounced inspection were reviewed. This showed us the hospital did not have accurate information regarding all these patients and they did not receive the same level of medical review as those patients on the appropriate specialist ward.

In the case of cardiology patients, people were nursed in an acute environment for longer than was necessary when a rehabilitation ward would have been more appropriate for their needs. This led to a shortage of beds on the cardiology ward.

On one ward staff could not locate a patient whose family had come to take them home. A nurse on another ward did not know what was wrong with a patient who had been admitted there temporarily, or which doctor was responsible for their care. This nurse was telephoning around the hospital in order to find this information. Another patient had been admitted to a ward without a bed being available and had to sit for approximately four hours in a chair in a narrow gap between another patient's bed and the window. Family members were not given a seat. This poor quality care, showed lack of respect for the needs of the person and their family and also compromised the privacy and dignity of the person in the bed.

### Treatment of vulnerable adults

Safeguarding policies for adults and children were in place and safeguarding training was included in the mandatory training for new members of staff at the hospital. We saw evidence of good partnership working across both sites with regard to the hospital safeguarding team, the local authority and the Care Quality Commission. Patients we spoke to told us they felt safe within the hospital.

### Discharge planning

The hospital had systems in place to manage the discharge of patients from hospital. However, staff on most of the wards we visited told us that patient discharges were not always managed as efficiently as they could be, particularly for the elderly patients with complex needs. This was because co-ordination of services provided by health and social care could be difficult and time consuming, particularly when the funding of the care need to be established. This meant patients were staying in hospital longer than necessary, which had an impact on the availability of beds for other people within the hospital. The introduction of case managers to proactively manage patient discharge from the time of their admission had speeded up the discharge process, but staff were aware that some discharges were still subject to avoidable delays.

We visited the discharge lounge, an area where some patients waited for transport to take them home. We found that the area was not well staffed with one nurse unable to take their meal break until one hour before the end of their shift. Some patients we talked to had used the discharge lounge before and although they had waited for up to three hours they were happy with the care they received. They had been provided with appropriate food and hot drinks while they waited. When patients leave the ward they are recorded as discharged on the hospital computer system even though they are still on the premises awaiting transport. This means that if an enquiry is made, inaccurate information could be given regarding the whereabouts of the patient.

### Complaints

Copies of the complaints procedure were available throughout the wards we visited. There were also details of how to complain and how to give feedback in the hospital's welcome pack. Patients we spoke with were aware of the Patient Advice and Liaison Service and how to access their services should this be necessary.

# Medical care (including older people's care)

## Are medical care services well-led?

### Leadership and vision

Staff told us they attended regular staff meetings and that they felt their suggestions and opinions were listened to and valued by their immediate line managers. However they told us they felt the executive management team did not fully appreciate their workload or the effect that low levels of staffing had on their morale. Two of the wards which had staff vacancies for several months were recording staff sickness levels significant higher than the trust average.

### Training

Most of the staff we spoke with had received an appraisal during 2013, which included a discussion regarding their learning and development needs. Senior staff informed us that the way in which the training for staff was organised did not work efficiently, as consideration was not given to the staff off-duty rotas prior to the Learning and Development staff booking them onto training courses. Details of bookings on training courses were given to staff after their duty rotas had been organised and meant that some staff were unable to attend as they were on night duty or annual leave.

### Risk management

We observed a variety of colour coding and symbols used throughout the hospital to alert staff when a person was vulnerable. These would be used around patients' beds if the person, for example, was at risk of falls or needed assistance with their meals. There was no common system throughout the hospital, which meant there was a risk of nurses who moved between wards, misinterpreting the colour coding. We spoke to one nurse, who was new to the hospital, who could not tell us what any of the symbols meant.

# Surgery

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Information about the service

The surgical care services at Royal Liverpool are provided on wards 4A, 4B, 5A, 5B, 8A, 8X, 8Y, 9A and 11Z. There is also an Emergency Surgical Admissions Unit (ESAU) within the emergency department on the ground floor as well as a large operating theatre suite that includes 12 theatres. The hospital provides a range of surgery including vascular surgery, orthopaedics, general surgery, urology and a renal transplant service.

During our inspections we visited eight wards, the ESAU and the theatre suite.

## Summary of findings

The staffing levels on the wards and in theatres were set at levels where they were able to meet patients' needs in a timely manner but this was supported by overtime, bank and agency shifts due to recruitment delays. The theatre suites had systems in place to improve patients' safety including team brief and the World Health Organization (WHO) theatre checklist. On all the surgical wards most of the patients we spoke were very complimentary about the care they had received.

We found theatre lists were regularly changed and operations were cancelled. At times surgeons were not able to operate as recovery areas were full. On one day during our inspection there were 30 vascular patients being cared for on other wards increasing the workload of the junior doctors. They felt they were understaffed as there had recently been a significant increase in the number of vascular patients. Most of the staff we spoke with told us that they felt supported by their immediate line manager but they felt that more senior staff within the organisation did not listen to their views. Some staff we spoke with were frustrated about the lack of their involvement in discussions about service developments.

# Surgery

## Are surgery services safe?

### Staffing

The nurse staffing levels on the wards that we visited were set at levels where they were able to meet patients' needs in a timely manner. The ward managers told us that they asked for bank staff if there were no staff members available for certain shifts. However, we were concerned that the ward staff did not know until the day if this request was going to be met.

In theatres there were several vacancies and senior staff were in the process of recruiting to these posts but this was taking many months to achieve. Agency nurses with relevant skills were used for this specialised area of care so patients were not at risk of inappropriate care.

Junior doctors working within the vascular teams felt they were understaffed due to the high numbers of patients who were being treated. Patients received the required care and we saw that their care was safe; we concluded that there was a risk as staff were not always able to attend to patients' needs in a timely manner.

We were told that there had been shortages of medical staff on the colorectal wards and this had led to some patients not being reviewed by a senior doctor as often as necessary. The Clinical Director for surgery told us that this had been issue but it had now been addressed on a temporary basis and there were plans in place for a permanent solution.

On one of the trauma and orthopaedic wards we saw that the manager had requested an extra staff member to care for a patient who also had dementia and required one-to-one nursing. This request had been granted and this person was being supported appropriately. The ward manger told us this situation had happened before with other patients and it had always been possible to have an extra staff member. This showed that mangers were responsive to changing needs within the wards.

Within the surgical service we saw that staff were sometimes moved from Broadgreen Hospital to Royal Liverpool Hospital to cover shifts. We were told that this was happening less frequently than it used to but that staff were concerned that it was still happening. It was important that all wards and departments were appropriately staffed at all times and on occasions it had been necessary to move staff.

### Environment and equipment

On some of the surgical wards, patients who had returned from theatre were cared for together in a separate part of the ward. This helped to increase patient safety as changes in patients' conditions can be recognised earlier because nursing staff remained in a smaller area for longer periods of time.

### Medicines management

Patients with diabetes told us that they were able to manage their own insulin while they were being cared for on the surgical wards. This was an example of good practice but we were concerned that on at least one of the wards (8Y) there were no lockable areas where patients could store their own medication. We were told by ward staff that this would be rectified when the new hospital was built but this was not expected to happen until 2017.

### Cleanliness

The ward environments were clean and well organised. The patients we spoke with told us that they had no concerns about the cleanliness of the hospital or the frequency with which staff washed their hands. We saw that there were plenty of dispensers for hand gel around the surgical wards although we did find that a significant number of them were empty.

### Learning from incidents

We were concerned that some clinical incidents that were not reported to senior staff. Some nursing staff told us that they were encouraged to report incidents but they said they did not always report incidents due to a lack of time. However, they were aware of the type of incidents that should be reported. Some of the junior doctors we spoke with were not aware of the type of incidents that should be reported and very few had ever reported an incident. When an incident occurred and was reported, we saw that it was followed up and action was taken to prevent the same incident from happening again.

The surgical wards had introduced and monitored a number of initiatives to increase patient safety. We saw that information for some incidents was recorded visually so that staff were reminded how many had occurred or how many days had passed since the last incident. This

included incidents such as pressure ulcers and falls. The system used to record the information is a nationally recognised method for collecting and presenting this information.

## Are surgery services effective?
(for example, treatment is effective)

### Evidence-based treatment
We found that staff were following best practice guidelines when treating and caring for patients who had undergone surgery. Their colorectal surgery is offered from within an Accelerated Colorectal Unit (ACRU), which promotes enhanced recovery in line with best practice and early discharge. It offers a wide range of trauma and orthopaedic services, and has a large number of specialist nurses and specialist physiotherapists. It also offers one stop assessment and diagnostic clinics.

Regular MDT meetings were held throughout the surgical division.

### Clinical Audit
The annual clinical audit report demonstrated that regular audit was a priority. The urology department audits itself against NICE guidelines and develops action plans for any areas of concern. They introduced a standardised approach to their mortality and morbidity meetings, and after identifying an area of concern changed practice. Following their tonsillitis audit, the ENT department changed the hospital antibiotic prescribing policy and developed a new patient pathway. In line with cancer peer review practices, the Breast team hold quarterly half day meeting to discuss audit and best practice. All routine clinical commitments are cancelled that day to ensure widespread attendance.

## Are surgery services caring?

### Patient experience
On the surgical wards we spoke with 12 patients and most of them were very complimentary about the care they had received. The comments we heard included, “The staff are fantastic”, “they are really friendly” and “the staff are absolutely brilliant”. We spoke with a patient on one ward who was not satisfied with their care when they had been in another part of the hospital (11Z).

We spoke with a patient and their relatives at a listening event as a part of our inspection. They told us that the renal (kidney) transplant service was very good and they had received good support from the specialist nurses. They felt they were given very good information and praised the counselling service that was a part of the transplant service.

### Patient centred care
The staff we spoke with on the wards were aware of their responsibilities to ensure that patients’ care was safe. Most of the patients’ records that we checked had been completed in a way that promoted safe practice. For example, risk assessments regarding the use of bed rails had been completed and updated when required. However, we found that some records were not fully completed. An example of this was that transfer documents were not always completed when patients were transferred from one ward to another or from the high dependency unit to a ward. Staff told us that the required information was always given verbally but there was not always a written record to confirm this. It was important that the correct information was passed from area to another to ensure that care was appropriately continued. Patients could be at risk of receiving inappropriate care because information was not available.

We also saw that nursing staff were using abbreviations that were not included on the trust’s approved list of abbreviations. This was a risk as it was possible that the abbreviation could be misunderstood by staff reading the records and this could affect the safety of the care that patients received.

### Observation
When we visited the wards we found that they were well organised and had appropriate patient information on display. We observed that call bells were answered quickly and patients’ care was delivered in a calm and dignified manner. We noted that there was a calm and relaxed atmosphere on the wards that we visited and staff were cheerful and positive with patients. The patients who we asked told us that they were treated with dignity and respect at all times. We saw from records that nursing staff completed patient safety and comfort checks every hour during the day and every two hours from midnight until 6am. The patients we asked told us they appreciated these checks and that they helped them to safe and secure.

# Surgery

## Are surgery services responsive to people's needs?
(for example, to feedback?)

### Access

The staff we spoke with in theatres told us they were concerned about the pressures they were under to move patients through the theatre suite. There were systems and process in place to help to manage the volume of patients that were treated. However, during our inspection we found that theatre lists were regularly changed and operations were cancelled so patients were not operated on in the order that had been originally planned. The theatre staff told us that they often had difficulty in finding the patients on the wards as they were often not on the wards where they should have gone to. At times, surgeons had to stop operating as the recovery area was full and there was nowhere for the patients to go. Some staff we spoke with appeared to deal with constant changes better than others but it was clear that it was a stressful environment for staff.

Theatre staff told us that the vascular surgery lists often over run and this impacted on the work and finishing times of theatre staff

The vascular services had been redesigned to include a much larger geographical area. This resulted in many more patients within the vascular service than there were beds, so patients were given beds on other wards. On one day during our inspection there were 30 vascular patients on other wards because all of the beds on the vascular unit were full. This increased the workload of the junior doctors and it meant that they were consistently working around four hours extra each day. The junior doctors thought that they were gaining excellent experience within the surgical rotation but were obviously concerned about their working hours. The vascular patients were often placed on medical wards and some of the doctors we spoke with expressed concern about the nurses' ability to care for these patients as this was not their area of expertise.

We were concerned that from 1 September 2013, 250 patients were kept in the recovery area for longer than required. The vast majority of these delays occurred because beds were not available either in the Post-Operative Critical Care Unit (POCCU) or on the wards. Staff told us that they spent a lot of time trying to secure beds on the wards for patients. Most of delays that occurred were longer than an hour but were less than six hours. It was clear that this was not effective use of the recovery area; however we were most concerned about the privacy and dignity of the patients.

Since September 2013 the theatre records showed that 11 patients had stayed in the recovery area overnight. When we visited for the unannounced inspection we found that one person had stayed overnight in the theatre recovery area as there was no bed in the POCCU for them.

We were concerned about the availability of toilets for patients. There were toilets available in another part of theatre a short walk away. However, this would not have been an easy walk for many patients who had just undergone surgery. There were no showers available as theatre areas were not designed for patients staying more than a few hours. We were also concerned about some patients eating meals while other patients were recovering from the effects of having had surgery and anaesthetic drugs. This was not acceptable care for either group of patients. It was also a concern that three of the 11 patients had stayed for two nights. We were told that visitors had been allowed only for a short period of time as it was not a suitable area for visitors. On some occasions it had not been possible to allow visitors into the area because of the activity that was happening at that particular time.

The staff we spoke with were not clear about how they would obtain medicines for the patients who had extended stays in the recovery area. This was a concern patients may have required medicines for conditions such as heart problems where it was important that they should not miss any doses.

It was clear that staff working in theatres were also concerned about this and had raised it with managers. It was not recorded on the risk register that we were shown. The Clinical Director for theatres told us that they asked the commissioners of the service if they could open the extra beds in the Intensive Care Unit and High Dependency Units to try to relieve some of the pressure but this request had been declined. This was because the commissioners believed that there were sufficient numbers of critical care beds across all of the neighbouring hospitals. It was not clear from the information that we were given if the trust Board were aware of issues with patients being kept in the recovery area for extended periods of time.

# Surgery

### Treatment of vulnerable adults

We saw that staff were aware of the Mental Capacity Act and it's implication for patients in their care. On one of the wards we saw that the correct procedures had been followed for a patient who was not able to consent to the treatment themself. A "best interest" meeting had also been held and appropriate staff had been involved. This meant that the rights of person who could not make some of their own decisions had been protected.

### Discharge planning

On each of the surgical wards we found that there was a case manager and it was a part of their duties to ensure that patients' discharge from hospital was planned effectively. One patient told us that their case manager had been working really hard in liaising with social services to ensure that their discharge was safe. However, we found that patients often experienced delays in obtaining their medicines to take home and this had a knock-on effect within the surgical wards and theatres. We noted that there was not a pharmacy service after 12 mid-day on a Saturday until 9am on Monday. This resulted in some patients going home without their medicines or in delayed discharges when there was a very high demand for beds.

## Are surgery services well-led?

### Leadership and vision

We saw that the surgical areas, including theatres had taken steps to monitor the quality of the service that was being delivered. On the vascular wards we saw that a nursing quality audit had been completed and an action plan was in progress to address the concerns that had been raised. Within theatres we saw that an audit had recently been completed on compliance with the WHO checklist. The staff within theatres at Royal Liverpool site told us that there were regular meetings that included the quality of care. The matron for theatres fed back about incidents that had occurred so that staff were aware of and could learn from the action that had been taken to resolve this issue. While this was good practice, it did not include the theatre staff from Broadgreen.

Most of the staff we spoke with on the Royal Liverpool site told us that they felt supported by their immediate line manager but they felt that more senior staff within the organisation did not listen to their views. Some staff we spoke with were frustrated about the lack of their involvement in discussions about service developments. The reconfiguration of the vascular service was an example of this where staff had put forward solutions for dealing with the increased numbers of patients but they felt that their suggestions had not been heard as they had not seen that any action had been taken.

Staff within theatres were also concerned that they were reporting the number of patients who stayed overnight in the recovery area but that no action was being taken to prevent this from reoccurring. The frustration was increased as this had been happening on a more regular basis since October 2013.

### Training

The staff told us they had received appropriate training for their roles and the patients we asked told us that they thought staff were knowledgeable about their care.

### Risk management

When we visited the theatre suites we found that there were systems in place to improve patients' safety. A team brief for theatre took place prior to the beginning of each theatre list. We observed team briefs and found these to be satisfactory on both sites. The staff told us that attendance at team briefs had improved over the last 12 months. We saw that an internationally recommended theatre checklist was completed on most occasions. The checklist had been developed by the World Health Organization (WHO) in response to patient safety concerns within operating theatres in many different countries. We spoke with the Clinical Director of theatres as we were told that they we aware of two senior staff at Broadgreen Hospital who were not following with the required procedures with regard to the team brief. We were told that this was being addressed with the staff concerned. It was important that these guidelines were followed to ensure that patients were fully protected from known risks of having surgery.

# Intensive/critical care

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|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Information about the service

The critical care service at the Royal Liverpool Hospital was divided into three units. The Intensive Care Unit (ICU) had 15 beds (with spaces for four more beds). The High Dependency Unit had 10 beds and the Post-Operative Critical Care Unit (POCCU) had four beds. The three units, although situated in different areas and on different floors within the hospital, worked well together.

## Summary of findings

The critical care service was well-managed locally and it was clear that it worked well with other departments within the hospital to ensure the best possible outcomes for patients. On all three units there were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care.

Patients' care needs were assessed and plans were in place to meet those needs. There was a formal critical care network in place with other local trusts to ensure the needs of patients were met effectively.

We found that the Post Operative Critical Care Unit (POCCU) functioned more like an Intensive Care Unit (ICU) with the range of care and treatment that was undertaken there. We found that the four beds with the POCCU were close together raising a potential infection risk as well as a safety hazard.

Senior nursing and medical staff told us that the overall bed availability across the hospitals often resulted in people staying in the unit longer than planned or required. We saw that there was an effective Critical Care Outreach Team (CCOT). Staff from the CCOT followed up patients on the wards who had been cared for on ICU or High Dependency Unit (HDU) for more than four days. The CCOT also supported ward staff when patients' conditions were deteriorating. As well as the CCOT, there was an Acute Response Team which responded to concerns from ward staff about individual patients which was confusing for ward staff and resulted in different approaches to accessing support to care for patients with deteriorating conditions.

# Intensive/critical care

## Are intensive/critical services safe?

### Staffing

On all three units there were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas provided a balanced skill mix and allocation of staff. We saw that there was one nurse to one patient on the ICU, as well as another nurse who had a co-ordinating role. However, we were told that 14 staff members from within the three units at the Royal Liverpool site were due to take maternity leave before the end of 2013 and we were concerned about the length of time that it was taking from interviewing staff to having them in post. We heard two examples where this had taken six months to achieve.

We saw that there were sufficient numbers of staff to meet the needs of people being cared for within the ICU, HDU and POCCU. We also saw that agency nursing staff were used to cover shifts when required. The senior staff within the units told us that they had presented a business case to reduce the numbers of agency staff used on the units as this was expensive. The business case had originally been rejected by managers but we were told that this was being looked at again to see if costs could be reduced by using staff already working within the units.

### Equipment and environment

We found that the four beds with the POCCU were close together and there was not much space for staff to move around as well as the equipment that was required for each patient. This was a potential infection risk as well as a safety hazard.

### Learning from incidents

Each month within the ICU there was a meeting to discuss the critical incidents that had occurred in the last month. This was usually led by one of the consultants (senior doctors). The evidence we saw showed that staff were learning from the incidents that were reported and were taking steps to prevent the same incidents from happening again, where possible. However, some staff told us that incidents were not always reported due to the length of time it took to report the incident on the electronic system.

We found that staff were aware of the increase in patients who were transferred from the hospital for non-clinical reasons and the slight increase in unit acquired infections. We saw these issues were being taken seriously and actions had been identified to address the issues raised.

### Clinical Audit

There was a process in place to investigate grade 2 and 3 pressure ulcers that developed while a patient was treated on the unit.

## Are intensive/critical services effective? (for example, treatment is effective)

### Evidence-based treatment

We saw that there were nationally recognised guidelines in place for patients who were receiving care within a critical care environment. These guidelines ensured that patients were receiving up to date and evidenced based care.

We observed one of the consultant ward rounds on the ICU. These rounds were conducted twice a day and were led by a consultant. This involved members of the multi-disciplinary team including a pharmacist and a microbiologist. We saw that the consultant ensured that of all the team members were included and that their opinions were asked for and respected. It was clear that staff respected each other and that everyone worked well as a team. One staff member told us, "It's like a family." However, we noted that a microbiologist (a person who studies organisms that cause infections and advises on the best treatments available for the infections) only attended the wards rounds three times a week. The current Core Standards for Intensive Care Units suggest that a microbiologist attend the wards round five days a week. This meant that there may be some delays in patients receiving the most effective and/or appropriate care.

### Working with others

There was a formal critical network in place with other local trusts to ensure that the needs of patients were met effectively. For example, patients who required neurological (conditions affecting the brain and the nervous system) care were transferred to another local hospital. Staff also contacted the network when they had a patient who required ICU or HDU care and there were no beds available at the Royal Liverpool Hospital. This ensured that patients received the most appropriate level of care, although it may not have been at their local hospital.

# Intensive/critical care

### Clinical Audit

The units submitted the required data to the Intensive Care National Audit and Research Centre (ICNARC), which aims to foster improvements in the organisation and practice of critical care (intensive and high-dependency care) in the UK. The data from this was on display on the units and it was clear that staff members were fully aware of their results in comparison to other ICUs and HDUs around the UK. However, it was not clear how much of this information was sent to the Board for review. The review of the data is important to monitor the effectiveness of the unit and allow comparison with other intensive care units nationally.

## Are intensive/critical services caring?

### Patient experience

Most of the patients we spoke with about their critical care experience were unable to give us much information about their care during that time. We spoke with one patient who had been discharged from ICU and they stated that they were happy with the care they had received and they told us the staff had been "great".

### Patient centred care

Patients' care needs were assessed and plans were in place to meet those needs. We saw evidence that patients' fundamental care needs were met, for example, through pressure ulcer prevention and management. This was important to ensure that all patients received appropriate preventative care and care at the appropriate time.

The staff we spoke with told us that case conferences were arranged for patients when this was required and that the relevant people from the multi-disciplinary team were invited to attend. Case conferences were in place for patients with very complex care requirements to ensure that the best possible outcome for them was achieved.

We saw that there was an effective Critical Care Outreach Team (CCOT). This was a team of three senior nurses who were very experienced in dealing with patients whose condition was deteriorating and/or critical. They saw patients on the wards to ensure that all relevant care was being carried out and if required, the patients would be moved to HDU or ICU. One of the main aims of this service was to ensure that the appropriate patients received the correct care and treatment as early as possible in order to prevent admission to ICU or HDU. They also followed up all patients who had been discharged from ICU and HDU. The staff worked from 7.30am to 7pm on Mondays to Fridays and were kept busy seeing patients so many aspects of their role were neglected such as service improvements. Staff had recognised that this was an issue and they had written a business case to increase the number of staff in the team but at the time of our inspection, they had not received any feedback from this.

Staff from the CCOT followed up patients on the wards who had been cared for on ICU or HDU for more than four days. This gave patients the opportunity to discuss their experience of critical care and we were told that the patients appreciated this opportunity to discuss and understand the care that they had received. This also gave the nurses the opportunity to identify any physical and psychological issues that required further care, treatment or support. This was an example of good practice as it helped to ensure that both physical and psychological issues were identified and addressed at an early stage by staff with the most appropriate skills to do this.

### Patient involvement

The staff also told us about a support group for patients who had received care within the ICU. Staff gave patients information about this group and patients decided for themselves if they wanted to attend the meeting.

### Observation

When we visited the units we saw that curtains were used to ensure patients' privacy and dignity were maintained. We heard staff speaking respectfully to patients and treating patients in a calm and respectful manner.

## Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

### Access

Senior nursing and medical staff told us that the overall bed availability across the hospitals often resulted in people staying in the unit longer than planned or required. We saw that some patients went straight to the ward from ICU as there were no beds available in HDU. It also resulted in patients being transferred from this hospital to other critical care units when there were no beds available.

We noted that there were no defined areas for male and female patients on the units. When male and female

patients are cared for next to one another, NHS guidelines state that this has to be reported (because in most circumstances it should be avoided) and we saw that this had been done.

### Treatment of vulnerable adults

The staff members we spoke with were aware of their responsibility to ensure that they protected the rights of patients who may not be able to make certain decisions for themselves. These rights are included within an Act of Parliament called the Mental Capacity Act 2005 (MCA). The MCA sets out legal requirements that must be followed to ensure that decisions made about people who do not have capacity are made in their best interests. They are designed to ensure that people who are unable to give consent for certain aspects of their care and welfare receive the right type of support to make a decision in their best interest. The staff told us that there were other staff available within the hospital to support them when it was required.

As well as the CCOT, there was an Acute Response Team who responded to concerns from ward staff about individual patients. We found that the pathway that staff followed for patients' whose condition was deteriorating unexpectedly was not clear as there were two teams with similar but not identical roles. This meant that that there was a not a well-co-ordinated response to this group of patients and there was potential for there to be delays in patients receiving the most appropriate care.

### Discharge planning

There were systems in place to ensure that patients were moved to the most appropriate areas of care. However, senior staff on the units within the critical care service told us that it was a time-consuming part of their role when patients were suitable to be moved but there were no available beds for them to be moved into. Delayed transfers from a critical care unit may not have a detrimental effect on patients' care but it is potentially not an effective use of the facilities. It also results in a lack of availability of beds for those patients who do require high dependency care.

## Are intensive/critical services well-led?

### Leadership and vision

The critical care service was well-managed and it was clear that they worked well with other departments within the hospital to ensure the best possible outcomes for patients. The only concerns that we heard about the critical care service were about the lack of availability of beds.

We found that the POCCU functioned more like an ICU with the range of care and treatment that was undertaken there. We noted that the POCCU was led by consultant anaesthetist rather than a consultant who was a specialist in intensive care medicine (intensivist). At the time of our visit there was no system in place to check that the consultant anaesthetists kept up to date with changes in intensive care medicine.

### Training

We found that the nurses working on the units were suitably qualified for their roles. The senior nurses on the units had all completed formal training courses for staff working in critical care units. The more junior nurses were currently in the process of completing training and we were told that 60% of them had completed a recognised qualification for this type of nursing.

The staff in the CCOT told us that there were more acutely ill patients being cared for on the wards and they ran training courses for staff in recognising deteriorations in patients' conditions and appropriate care and treatment for patients who were acutely unwell. They told us these were poorly attended as staff could not be released from the wards to attend. This resulted in some ward staff not being able to develop the appropriate skills and therefore increasing the workload of the CCOT. There were no plans in place to resolve this situation.

We were also told by staff that there was an issue in how patients with tracheostomies (patients who have a surgical opening in their neck at the front of the windpipe) were managed within the hospital. Many patients had to be kept in ICU or HDU because many staff were not fully trained to look after these patients. Managers were in the process of trying to address the issues but the impact of the lacking of training meant that patients were kept on the on the units for longer than necessary.

# Intensive/critical care

### Risk management

The staff we spoke with were clear about issues within their service and we saw that they had taken action where this was required. For example they had submitted two business cases: one to reduce the amount of money spent on agency staff and another to increase the number of critical care beds on the Royal Liverpool site. At the time of our visit, neither of these business cases had been approved but they demonstrated that staff had a clear idea of where improvements could be made.

The three units on the Royal Liverpool site were under the nursing leadership of a matron and there were clear lines of accountability in place. The staff who we asked told us that they felt supported and they had appraisals completed on an annual basis. Staff were encouraged to undertake further training to improve and increase their skills. One of the senior nurses was responsible for completing audits (checks) in a number of areas that included hand hygiene. We saw that action had been taken when it was required. This showed that staff were taking appropriate action to improve the quality of the care and treatment provided within the critical care service.

# End of life care

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| Safe | |
| Effective | |
| Caring | |
| Responsive | |
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## Information about the service

The Royal Liverpool Hospital has a dedicated palliative care team led by a multi-professional team. Palliative care is the holistic care of patients towards the end of their lives whose illness is incurable. The palliative care team offer advice on pain and symptom control, support families and provide practical advice to other healthcare professionals. The service is provided seven days a week and currently engages with approximately 30% of people who die at the Royal Liverpool Hospital and the Broadgreen Hospital. There is a network of nurses across both sites that have been given extra training in palliative care who help to ensure that patients receive appropriate care when they are near death. The hospital has a dedicated bereavement team which provide care and support to relatives following the death of their loved ones. There is also a large and well-organised multi-faith spiritual support network.

## Summary of findings

The hospital had a multi-professional approach to end of life care and worked in partnership with the Marie Curie Palliative Care Institute Liverpool (MCPCIL). This meant that good research based practice was shared across the trust and MCPCIL.

The hospital no longer used the Liverpool Care Pathway for people in the last few days of their lives. However, it had implemented a care of the dying guidance document, based on the Integrated Care Pathway methodology. This was seen to be working well at the time of our inspection. We saw the care of the dying guidance was being followed from diagnosis until after death and that patients were receiving appropriate support and compassionate care.

The palliative care team focused on ensuring the provision of high-quality services that met the needs of the patients who used their service and their families. They underpinned their practices with the belief that care for the dying is part of the core business of their organisation. If care was necessary within the hospital environment the palliative care team provided support and information to the patient, their families and the care team working on the ward.

People told us that they were satisfied with the care they received from the palliative care team. For patients who remained in hospital plans were put in place to ensure that their wishes were respected.

# End of life care

## Are end of life care services safe?

### Staffing

The hospital had a multi-professional approach to end of life care that consisted of palliative care nurses, end of life care case managers, a complementary therapist, a clinical nurse specialist, a specialist social worker, a dedicated consultant, medics and volunteers.

For patients who remained in hospital plans were put in place to ensure that their wishes were respected. We spoke with two of the palliative care team's case managers whose role was to support patients in their final days.

### Learning from incidents

The palliative care team monitored all end of life care concerns and complaints and made relevant changes to the service in light of these.

## Are end of life care services effective? (for example, treatment is effective)

### Evidence-based treatment

We spoke with senior managers who confirmed that the hospital was no longer using the Liverpool Care Pathway (LCP). Senior managers informed us that immediately after the announcement of the withdrawal of the LCP nationally, there were concerns that only 11% of patients who died were supported by care that followed existing documentation (which could potentially affect the quality of care provided). This figure had fallen from a more satisfactory 40%. However, since the trust introduced its Best Care for the Dying guidance for staff, this figure had risen again to 30% in the last month. These figures had been reported to the board and were classed as amber on the trust's risk register.

It is worth noting that, in order to improve their service and embed the new care of the dying guidance document, the palliative care team had engaged with 98% of people who had died expectedly at the trust's two hospitals in the month before our visit. This meant that though the trust had had some problems following the withdrawal of the LCP they were now ensuring that patients received safe care towards the end of their lives.

The trust worked in partnership with the Marie Curie Palliative Care Institute Liverpool (MCPCIL). The clinical director and the directorate manager sat on the board of the MCPCIL as a director and associate director respectively. We also found evidence that medical staff rotated between the palliative care team and the MCPCIL. This meant that good practice was shared across the trust and MCPCIL.

### Clinical Audit

The palliative care team monitored ward referrals. A coding system of red green and amber was in place to prioritise urgent cases and trigger additional reviews. A regular sample audit was carried out around deaths within the hospitals and the information gathered was used to direct which wards required additional support or extra training. The trust also participated in the National Care for the Dying Audit which looks at appropriate and compassionate care for patients who are dying. We found that end of life care data was recorded monthly as part of the trust's quality performance report and was therefore included in the trusts mainstream reporting and mitigating action planning process. This demonstrated that the trust had systems in place to ensure the end of life care guidance document was effective.

## Are end of life care services caring?

### Patient experience

We spoke to patients who were using the palliative care service in the hospitals. They told us that they were satisfied with the care they received from the palliative care team though some of them did have concerns about their overall care. One person told us, "Staff have been brilliant organising medication and everything." Another told us, "No problems, I'm involved in my own care and able to make my own decisions."

### Patient centred care

We spoke with nursing staff on various wards throughout the hospitals. We asked some nurses to describe how patients who were dying were identified and looked after. One nurse told us that initially medical staff made a diagnosis of an illness. If the patient's prognosis was poor and indicated that they were going to live for less than the next three months a referral would be made to the palliative care team. Following that referral a decision would be made in conjunction with the patient and their

# End of life care

family as to where the patient was going to be looked after, for example at home, in a hospice or in hospital. This reflected the information we found in the care of the dying guidance document.

The case managers told us that they had systems in place to ensure that patient's wants and needs were met efficiently and in a timely manner. For example if an inpatient identified a desire to go home to die the case managers would organise their transport and a care package and have the patient at home within six hours. The case managers also told us that it was not uncommon for them to be involved in organising things like weddings and naming ceremonies on behalf of patients that were dying.

We spoke with staff and volunteers from the trust's chaplaincy service. They explained that patients of any particular faith had the option of being visited and supported by people of the same faith. We spoke with the staff and a volunteer from the Catholic Church. They told us that they were given a list of all Catholic patients admitted to the hospital. Each person was visited by a volunteer and asked if they required spiritual support. If they did not their wishes were respected. They also told us that as they travelled around the hospital patients often spoke with them and requested that a prayer be said or some time spent with them. We were informed that other faiths offered similar support and that the trust helped ensure that people were properly trained and that pre-employment checks, such as disclosure and barring had been carried out, this included volunteer staff. The physical environment of the Christian chapel was very good, although the multi-faith prayer room was situated somewhat away from that, next to a busy medical records department and which also required a security code to access the room, unlike for the former chapel area.

Some volunteers were attached to the palliative care team and did not represent any particular faith or church. We spoke with one of the volunteers and they explained that they often spent time with people who were dying if they had no immediate family or if their family required a break or a rest. They explained that they would sit with people, who were often unconscious, and talk with them and provide a comforting presence. They also ensured that they had a good understanding of the patient's history before they spoke to them in order to ensure that their conversations were relevant and valuable. This part of the care of the dying service ensured that patients were less likely to die alone in the hospitals.

We visited the mortuary and spoke with the bereavement staff. They explained that there were processes in place to support relatives once their loved one had died. This included help with death certificates, how to stop unwanted mail and how to collect personal belongings. The mortuary staff had created a pleasant environment to speak with people and had two rooms where relatives could view the deceased. Staff also told us that they worked closely with spiritual leaders to make sure that people's wishes and traditions were observed after death. For example they were able to give us examples of rabbi's attending post mortem examinations to ensure that religious practices were followed.

The trust had produced an end of life guidance document to help and support staff in caring for people in the last few days of their life. Senior ward nurses confirmed that they were aware of this new document. This demonstrated that the service was well led.

### Patient involvement

If care was necessary within the hospital environment the palliative care team provided support and information to the patient, their families and the care team working on the ward. This included information on pain relief and discussing and documenting the patient's and their families wishes about their death. If the palliative care team were not directly involved with the patient they still provided support to the care team responsible for that persons care. A network of 86 ward-based nurses had been set up. These "network" nurses received extra training and spent time with the palliative care team. Their role was to ensure that good practice was followed on the wards when dealing with dying patients. Though some network nurses we spoke with did feel that their training required updating they were all very keen to ensure that the role continued to develop.

### Observation

The trust has produced Best Care for the Dying Guidance to support staff in caring for people in the last few days of their life and we saw evidence that this was being followed.

# End of life care

## Are end of life care services responsive to people's needs?
(for example, to feedback?)

### Access
The palliative care team operates seven days per week aims to see in patients within 24 hours of receiving the initial referral. In the meantime they offer telephone support for both patients and professionals. According to the records we looked at patients had been seen and assessed promptly. We observed that the team also worked closely with ward staff to support them to deliver good end of life care. This showed that the team was responsive to the needs of patients.

### Treatment of vulnerable adults
Senior managers told us that in response to the national independent review of the Liverpool Care Pathway published in July 2013, the Department of Health asked all acute trusts to undertake an immediate clinical review of everybody who was on the Pathway. We saw a copy of the trust's briefing to its staff on interim measures to sustain good quality end of life care including pain management and their new end of life guidance document that was functioning well.

We found the trust had clear Do Not Resuscitate policies and guidance. We saw that decisions regarding the resuscitation of people were made following the processes outlined within the Mental Capacity Act guidance. However, the trust had identified that there were issues around using inpatient documentation when patients who were receiving palliative care wished to be transferred home to die. The trust had entered into negotiations with other service providers in the area to ensure this issue was resolved. When we visited the mortuary the staff told us that relatives had raised issues about being spoken to through the internal office window. They described this as being, "Talked to through a hole in the wall." Funding had been acquired and a family room had been set up that ensured that no relative had to deal with staff from behind a counter. These examples and the evidence we found demonstrated that the trust was responsive to the needs of the patients using its service.

## Are end of life care services well-led?

### Leadership and vision
Both senior managers and members of the palliative care team told us that end of life care was a priority for the trust. We saw a copy of the trust's briefing to its staff on interim measures to sustain good quality end of life care, including pain management and their new end of life guidance to support staff in caring for people in the last few days of their life, which was functioning well.The hospital had in a multi-professional team in place for end of life which was well supported and reporting structures and processes were in place. Staff were confident that they were listened to, and they felt able to voice any concerns or aspirations to improve the department. This demonstrated effective leadership.

The palliative care team focused on ensuring the provision of high-quality services that met the needs of the patients who used their service and their families. They underpinned their practices with the belief that care for the dying is part of the core business of their organisation. A senior manager told us, "Where we achieve good care we need to be consistent and when there are concerns or complaints or any evidence of poor care we welcome the opportunity to learn from this and demonstrate our learning as we strive to create where we can, a positive lasting memory for those who are left behind after a death."

There were clear reporting structures in place which included one to one time with the trust's Chief Executive Officer (CEO). Systems were in place to ensure that the service continually improved and concerns were correctly logged on the trust risk register.

# Outpatients

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Information about the service

The hospital runs a range of outpatient clinics. Around 640,000 outpatients are seen at the hospitals each year. We reviewed outpatients at both the Royal Liverpool and Broadgreen hospitals.

## Summary of findings

The outpatient areas were clean and well maintained. However, aspects of the physical environment were cramped and poorly laid out which may cause access problems for the physically disabled. We found that some outpatient areas did not respect patient's privacy and dignity in that people were seen in cubicles rather than rooms; this meant that consultations could be overheard. We also noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment. However, staff told us that this service was "hit and miss."

We found that there were a number of issues around the patient experience within the outpatient services. Patients told us that waiting times were still unacceptably long in some departments whereas other departments, for example x-ray, were seeing people quickly and efficiently. However, patients we spoke with told us that they were generally satisfied with the service they received.

We spoke to senior staff during our inspection who were aware of the issues with inconsistent service across different specialities. We saw evidence of improvement in some areas particularly around patient's appointment letters. It was acknowledged by the senior managers that there were still further improvements to be made.

We saw there were clear leadership structures in place and staff were aware of the issues around the outpatients department and were working proactively to address them.

# Outpatients

## Are outpatients services safe?

### Staffing

The outpatient departments appeared to have enough staff to manage people's needs at the time of our inspection. When we visited the x-ray department we found that they had several job vacancies and required more staff. Despite this they were still seeing up to 600 patients per day seven days a week. They showed us the feedback they received from patients which was very positive.

### Environment and equipment

Some aspects of the physical environment were cramped and poorly laid out which may cause access problems for the physically disabled.

We checked the resuscitation equipment within the outpatient clinics. We found that not all equipment had been regularly checked to see if it was in good working order. Some equipment was stored in poorly accessible areas which meant that it wasn't readily available in an emergency.

We found some confidential patient files had been left out in view of the public. This meant that there was a risk of someone removing paperwork without the correct authorisation. We also noted that many staff were not wearing identification badges which meant that patients were may have been unsure who they were approaching if they had a query.

We looked at hospitality arrangements for people using the outpatients departments. Though water was readily available only one of the hospitals offered a mobile shop service which was ran by the Women's Royal Voluntary Service. Both sites provided free hot beverages if patients had to wait a long time. Some areas provided pagers so patients could leave the waiting area to go to the hospital shop, for instance. However, we noted that these pagers were not in use, though this may have indicated that appointments were running on time.

We found that some outpatient areas did not respect patient's privacy and dignity in that people were seen in cubicles rather than rooms; this meant that consultations could be overheard. We also noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment. However, staff told us that this service was "hit and miss."

### Cleanliness

The outpatient areas were clean and well maintained. There were infection control measures in place. Staff were aware of their responsibilities in infection prevention and control. These ensured patients were protected from the risk of infection.

## Are outpatients services effective?
(for example, treatment is effective)

### Clinical Audit

Managers of each different clinic carried out regular audits that were introduced as part improving outpatient services. This included peer reviewing different areas once per month and meant that many issues that arose could be quickly addressed. There was an overall service quality assessment process that was undertaken in much more detail where all areas were assessed against the CQC essential standards. The trust informed us that there has been a sustained improvement in performance in the past 12-18 months.

## Are outpatients services caring?

### Patient experience

The patients we spoke with told us that waiting times were still unacceptably long in some departments whereas others departments, for example x-ray, were seeing people quickly and efficiently. We noted that information leaflets were not widely available and we could not find leaflets in other languages. This meant that the issues that the outpatient improvement group had set out to address three years ago were still occurring and may have caused the service to be less effective in particular areas.

We spoke with outpatients at the Royal Liverpool Hospital. They told us that overall they were satisfied with the service they received though they often experienced long waits. One patient told us, "Given the choice I would always come here even though it's further than my local hospital." Another told us, "The liver unit [day care] is excellent." Another added, "Staff are helpful and listen to my needs but waiting for over 30 minutes can be typical."

# Outpatients

### Patient centred care
Treatment reflected the needs, preferences and diversity of people using the service. The analysis of diagnostic tests and assessments were undertaken by qualified staff and advice was sought from other healthcare professionals, where necessary

### Patient involvement
Most patients told us that they felt that their consultations with staff were useful and informative. They told us that they felt their questions were answered and that they were satisfied with the outcome before they left. However, one person we spoke with told us that on one occasion they were left to contact their own GP to organise their medication.

We noted that there was some confusion around appointment times in some departments. One patient arrived to be told that their appointment had been cancelled. They were then told that they had not contacted the department to "opt in" to their appointment. However, on examination of these patients appointments letter it was not clear that the patient had to 'opt in' to their appointment.

## Are outpatients services responsive to people's needs?
(for example, to feedback?)

### Access
We spoke to senior staff during our inspection, they were aware of the issues with inconsistent service across different specialities. We saw evidence of improvement in some areas particularly around patient's appointment letters. However it was acknowledged by the senior managers that there were still further improvements to be made.

### Complaints
We saw that there were systems in place for the reporting of issues and concerns about the outpatient department.

## Are outpatients services well-led?

### Leadership and vision
The outpatients department was part of the hospital's core clinical support division which was led by the director of nursing. The director of nursing chaired the outpatient improvement group, which was linked patient experience committee. We spoke with staff who told us that they met representatives of the outpatient's improvement group regularly and that they understood who they were being led by. However we were told that "certain departments" did things "certain ways" which we observed caused inconsistencies with the delivery of outpatient services. We noted that the nursing director was relatively new in post and that many of the improvements that had been made were recent. The nursing director and their staff addressed some of our concerns during our inspection and provided us with further information about other improvements they had made, for example the new audit systems. This meant that there were clear leadership structures in place and they were aware of the issues around the outpatients department and were working proactively to address them.

### Risk management
We looked at clinical governance arrangements to assess whether there was staff engagement from board level and assurance processes were in place to monitor patient safety. We found there were systems in place for the reporting and management of risk. An outpatient improvement group had been set up in November 2010 following feedback from the national outpatient survey which indicated that there were issues around waiting times and information for patients.

# Good practice and areas for improvement

## Introduction

<Start text here...>

## Areas of good practice

Our inspection team highlighted the following areas of good practice:

- The end of life care service is of a high standard and provides care seven days a week. The hospital also has a dedicated bereavement team which provides care and support to relatives following the death of their loved ones. This is supported by a large and well organised multi-faith spiritual support network.
- In critical care, there was an effective Critical Care Outreach Team (CCOT), which is a support group for patients who had received care within the ICU.
- We were told of a recent initiative to improve the knowledge of all staff in the hospitals regarding the appropriate responses to support a person breathed via a tracheostomy ('neck breather') should they face a breathing problem when visiting the hospital. This initiative had resulted in raised awareness across the trust – not just in the specialist areas. It had also been delivered outside the hospital setting.
- The cohesive way in which the A&E and Acute medical unit worked.
- The stroke service, which had the third highest overall performance scores in the country and the highest scores outside London in the most recently published Sentinel Stroke National Audit Programme (SSNAP) report.

## Areas in need of improvement

### Action the hospital MUST take to improve

- Improve care received by 'outlier' patients
- Adhere to infection control procedures within the accident and emergency department
- Review the use of theatre recovery as an overnight facility for which it is not designed.
- Review the use of the observation room CDU6 as an overnight facility for which it is not designed.
- Clarify the roles of the Acute Response Team and the Critical Care Outreach Team
- Address the unsafe allocated space between beds in the Heart and Emergency Centre
- Ensure that the consultant leading the Post Operative Critical Care Unit has adequate experience and qualifications in intensive care medicine.
- Improve medical staffing in vascular and colorectal surgery.
- Improve the responsiveness of pharmacy to provide medicines on admission and discharge, and ensure that the emergency department has access to required medication at all times.

### Action the hospital SHOULD take to improve

<Start text here...>

### Action the hospital COULD take to improve

- Resolve the issue caused by two of the care of the elderly wards sharing a hoist, despite being located on different floors.
- Information about patients' whereabouts needs to be more robust, to make sure patients can be located while they remain within the hospital particularly when they are moved to the discharge lounge.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that service users, staff or others, in the accident and emergency department, are protected against identifiable risks of acquiring an infection by means of an effective operation of systems designed to assess the risks of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene relating to premises, equipment and reusable medical devices used for the purpose of carrying on the regulated activity.<br><br>Regulation 12 (1)(a)(b)(c); 12(2)(a) and (c)(i)(ii) |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that service users, staff or others, in the accident and emergency department, are protected against identifiable risks of acquiring an infection by means of an effective operation of systems designed to assess the risks of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene relating to premises, equipment and reusable medical devices used for the purpose of carrying on the regulated activity.<br><br>Regulation 12 (1)(a)(b)(c); 12(2)(a) and (c)(i)(ii) |

This section is primarily information for the provider

# Compliance actions

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that service users, staff or others, in the accident and emergency department, are protected against identifiable risks of acquiring an infection by means of an effective operation of systems designed to assess the risks of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene relating to premises, equipment and reusable medical devices used for the purpose of carrying on the regulated activity.<br><br>Regulation 12 (1)(a)(b)(c); 12(2)(a) and (c)(i)(ii) |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not always made suitable arrangements to ensure the dignity, privacy and independence of service users.<br><br>Regulation 17 (1)(a) |

| Regulated activity | Regulation |
| --- | --- |
| Surgical procedures | Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not always made suitable arrangements to ensure the dignity, privacy and independence of service users.<br><br>Regulation 17 (1)(a) |

This section is primarily information for the provider

# Compliance actions

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not always made suitable arrangements to ensure the dignity, privacy and independence of service users.<br><br>Regulation 17 (1)(a) |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that each service user is protected against the risk of receiving care or treatment that is inappropriate or unsafe through the planning and delivery of care and treatment to meet their individual needs or to ensure their safety and welfare.<br><br>Regulation 9(b)(i)(ii) |

| Regulated activity | Regulation |
| --- | --- |
| Surgical procedures | Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that each service user is protected against the risk of receiving care or treatment that is inappropriate or unsafe through the planning and delivery of care and treatment to meet their individual needs or to ensure their safety and welfare.<br><br>Regulation 9(b)(i)(ii) |

| Regulated activity | Regulation |
| --- | --- |

This section is primarily information for the provider

# Compliance actions

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| --- | --- |
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| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to patients having their medicines at the times they need them.<br><br>Regulation 13 |

| Regulated activity | Regulation |
| --- | --- |
| Surgical procedures | Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to patients having their medicines at the times they need them.<br><br>Regulation 13 |

| Regulated activity | Regulation |
| --- | --- |

This section is primarily information for the provider

# Compliance actions

| | |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to patients having their medicines at the times they need them.<br><br>Regulation 13 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.<br><br>Regulation 22 |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br><br>How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.<br><br>Regulation 22 |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. |

This section is primarily information for the provider

# Compliance actions

How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

Regulation 22