Kettering General Hospital NHS Foundation Trust

Kettering General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Not sufficient evidence to rate
Urgent and emergency services	Not sufficient evidence to rate
Medical care (including older people's care)	Not sufficient evidence to rate

Summary of findings

Letter from the Chief Inspector of Hospitals

Kettering General Hospital is an established 576 bed general hospital, which provides healthcare services to North Northamptonshire, South Leicestershire and Rutland. The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust also provides regional cardiology services to the wider Northamptonshire and surrounding areas.

The Care Quality Commission (CQC) previously carried out a comprehensive inspection between the 2 and 4 September 2014 which found that overall, the trust had a rating of 'requires improvement'.

We carried out a focused inspection on 10 February 2016 due to information of concern regarding the hospital's emergency department (ED) and also the use of escalation areas. These escalation areas are reported in the medical care section of this report. These are clinical areas in the hospital not normally used for caring for patients overnight however are opened to accommodate patients due to high demand for beds and patient flow pressures across the hospital. Concerns had been raised regarding the quality and safety of patients being cared for in the corridor area of the ED and also in some of the escalation areas being used at times of peak demand for beds in the hospital. During the past year, attendances at the ED had risen by 6%. The inspection was conducted during the evening of one of the days of the junior doctors' strikes which had run from 8am on 10 February 2016 to 8am the next day.

Our key findings were as follows:

- Staff were caring and considerate towards patients and their families during our inspection.
- Patients who required prioritisation of treatment in the emergency department (ED) were not always identified in a timely way, leading to delays in care. We escalated this immediately to the executive on call, who took immediate actions to address this on the day of the visit and the trust then took a series of actions following the visit to put systems in place to maintain oversight of this concern.
- Patient records lacked sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage assessments, were not always completed and there was a lack of recording of the care and treatment given whilst patients were within the ED.
- Patient records within the paediatric area of ED were not always stored securely and were accessible to anyone who entered.
- Staffing within the paediatric ED was not always sufficient to ensure a paediatric trained nurse was present to care for children. We escalated this immediately to the executive on call, who took immediate action to ensure a qualified nurse was present in the paediatric ED whenever it was open. Following the inspection, the trust put in place a series of actions to address this concern.
- The entrance to the paediatric ED was not restricted and could be accessed by all hospital staff, patients and the public. We escalated this immediately to the executive on call, who took immediate action to ensure a qualified nurse was present in the paediatric ED whenever it was open. Following the inspection, the trust put in place a series of actions to address this concern.
- Patients' privacy and dignity was not always respected whilst being cared for in the corridor of the ED.
- The department was not meeting the national performance measure to admit, transfer or discharge 95% of patients within four hours, with performance consistently below the national average since October 2014.
- There was a lack of effective risk management oversight governing the use of the corridor area in the adult ED, with a lack of clear policies and effective risk assessments for this area being used to provide care and treatment for patients. During our inspection, the trust took immediate actions to ensure the safety of patients in ED and immediately following the inspection provided a detailed action plan to deliver a programme of actions designed to sustain and embed the required improvements.
- Escalation areas in medical care areas and wards were being used at peak times of demand for beds to facilitate patient flow through the hospital.

Summary of findings

- Nurse staffing levels and skill mix had been managed to meet the needs of the patients in these escalation areas. Extra nurses were booked for each shift to manage patients in escalation areas.
- Clinical operations managers reviewed every patient in an escalation area at the start of each night shift to ensure the placement was appropriate.
- Patients in escalation areas were reviewed by a consultant-delivered ward round, at least once every 24 hours, seven days a week.
- Emergency equipment, including equipment used for resuscitation was checked daily in escalation areas.
- Assessments for patients in escalation areas were generally comprehensive, covering all patients' health needs.
- Patients' pain was assessed and reviewed regularly. Appropriate pain relief was given as prescribed when required.
- The trust had been working with Commissioners and external providers to determine new ways of working to reduce demands upon the trust. At the time of the inspection these measures had not yet delivered improvements.
- Numbers of patients with a delayed transfer of care had remained high over the past two months, however, the number of patients outlying on other speciality wards had reduced in the past two months, due to change in bed management processes.
- Generally, effective systems were in place regarding the use of escalation areas in the hospital and senior staff had an effective oversight of the risks to patient safety.
- Most staff had an understanding of the escalation area usage and admission criteria. They understood the need to move staff to meet patient needs, but some staff felt under pressure due to this.

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

Importantly, the trust must:

- Ensure effective systems are in place to monitor and address risks to the safety and quality of patient care in the ED.
- Ensure that all patients presenting to ED receive appropriate and timely assessments of needs and that effective care and treatment is provided in a timely way.
- Review nurse staffing within the paediatric ED to ensure a paediatric trained nurse is present to care for children.

In addition the trust should:

- Ensure patient records including risk assessments in ED contain sufficient detail to ensure all aspects of their care is clear.
- Ensure all records in the paediatric ED are always stored securely.
- Ensure patients' privacy and dignity is respected whilst being cared for in all areas of the ED.
- Review and monitor the security and access to the paediatric area to ensure risks of unauthorised entry are addressed.
- Ensure effective systems are in place to monitor the risks to the quality and safety of patient care in the ED and fully embedded throughout the whole staff team to ensure effective oversight and management of risks.
- Ensure data is collected and monitored regarding patients transferred under the 'Early Flow Discharge policy' to maintain an oversight of potential risks.
- Review the storage patients' records in escalation areas to ensure they are stored securely.
- Ensure medicine fridge temperatures are checked regularly in all escalation areas.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Not sufficient evidence to rate	Patients who required prioritisation of treatment were not always identified in a timely way, leading to delays in care. Patient records lacked sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage assessments, were not always completed and there was a lack of recording of the care and treatment given whilst patients were within the ED. Patient records within the paediatric area of ED were not always stored securely and were accessible to anyone who entered. Staffing within the paediatric ED was not always sufficient to ensure a paediatric trained nurse was present to care for children. Paediatric patients were often left alone within the department, some being vulnerable children with no accompanying adult. The entrance to the paediatric area was not restricted and could be accessed by all hospital staff, patients and the public. Patients' privacy and dignity was not always respected whilst being cared for in the corridor. The department was not meeting the national target to admit, transfer or discharge 95% of patients within four hours, with worsening performance against the national average in December 2015. There were not robust systems in place to monitor the quality and safety of care and treatment and a lack of effective oversight of risks in the corridor area of the adult ED. Whilst the trust was in the process of implementing new policies regarding the use of the corridor area, these were not fully embedded throughout the whole ED staff team. During our inspection, the trust took immediate actions to ensure the safety of

Summary of findings

patients in ED and immediately following the inspection provided a detailed action plan to deliver a programme of actions designed to sustain and embed the required improvements.

Medical care (including older people's care)	**Not sufficient evidence to rate**		Patients were treated with respect and compassion. Nurse staffing levels and skill mix had been managed to meet the needs of the patients in the escalation areas. Extra nurses were booked for each shift to manage patients in escalation areas. Clinical operations managers reviewed every patient in an escalation area at the start of each night shift to ensure the placement was appropriate. Patients were reviewed by a consultant-delivered ward round, at least once every 24 hours, seven days a week. Assessments for patients were generally comprehensive, covering all patients' health needs. Patients' pain was assessed and reviewed regularly. Appropriate pain relief was given as prescribed when required. The trust's management team was actively working with commissioners and external stakeholders to address the longstanding increase in the demand for beds at the hospital, and implement a range of contingency measures to manage the rising demand for beds. This work was also focusing on the requirement to reduce levels of delayed transfers of care. At the time of the inspection, this work had however not yet delivered improvements. Escalation areas were being used at peak times of demand for beds to facilitate patient flow through the hospital. The trust was planning a bed reconfiguration initiative designed to increase the numbers of beds available. Numbers of patients with a delayed transfer of care had remained high over the past two

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months, however, the number of patients outlying on other speciality wards had reduced in the past two months, due to change in bed management processes.
Generally, effective systems were in place regarding the use of escalation areas in the hospital and senior staff had an effective oversight of the risks to patient safety.
Most staff had an understanding of the escalation area usage and admission criteria. They understood the need to flex staff to meet patient needs, but some staff felt under pressure due to this.
Not all medical records were securely stored in either a locked cabinet or dedicated rooms.
Medicine fridge temperatures were not being checked regularly in all areas.
Effective monitoring of average waits for those patients transferred under the 'Early Flow Discharge policy' was not yet available. The trust was planning to monitor this data for these patients.

Kettering General Hospital

Detailed findings

Services we looked at
Urgent and emergency services and Medical care (including older people's care

Detailed findings

Contents

Background to Kettering General Hospital

Kettering General Hospital is an established 576 bed general hospital which provides healthcare services to North Northamptonshire, South Leicestershire and Rutland. The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust also provides regional cardiology services to the wider Northamptonshire and surrounding areas.

The average proportion of Black, Asian and Minority Ethnic (BAME) residents in Kettering (6.1%) is lower than that of England (14.6%). The deprivation index is lower than the national average implying that this is not a deprived area.

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 2 and 4 September 2014. That inspection was undertaken as part of our comprehensive inspection methodology. Overall, the trust was rated as 'requires improvement'.

Our inspection team

Our inspection team was led by:

Inspection Manager: Phil Terry

The team included four CQC inspectors and a consultant in urgent and emergency care.

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?

This unannounced inspection took place on 10 February 2016 following information of concern being received regarding risks in the Emergency Department and also some of the hospital's escalation areas. As this was a focused inspection, we did not gather evidence across all of the five key questions.

Before visiting, we reviewed a range of information we held as well as information provided by the trust regarding the emergency department's performance.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, senior managers and

patients and their relatives. We visited the adult and children's emergency department as well as three clinical areas that were being used as escalation areas at the time of the inspection.

Facts and data about Kettering General Hospital

At the time of the inspection, Kettering General Hospital:

- Had 576 beds - 524 Acute Inpatient, 40 Maternity and 12 Critical Care
- Served 330,000 people
- Employed 3,100 staff
- Had an annual turnover of approximately £203 million
- Achieved Foundation Trust status in 2008
- The trust ended 2014/15 with a deficit of -£6.3m

Between April 2014 and March 2015 the trust had:

- 39,387 inpatient admissions
- 233,160 outpatient attendances
- 76,269 A&E attendances
- 3,537 deliveries

Data Source: Trust Medway Patient Administration System

Four requirement notices were put in place following the comprehensive inspection were in respect of:

- Regulation 10 Heath and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers: for the end of life care service.
- Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines: in medical care, surgery, and outpatients services.
- Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises: in maternity and outpatients services, and lack of oversight of hot water temps
- Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing: in maternity, critical care services and for junior doctor cover out of hours for surgery.

This inspection did not include a review of these.

Urgent and emergency services

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

The emergency department (ED) at Kettering General Hospital provides a 24 hour service, seven days a week to the local population.

The emergency department saw 61,606 patients between April 2015 and December 2015; this is an increase of 7% in comparison to the same time period in 2014.

There are four areas in which patients can be cared for within the ED this includes minors, majors, children's ED and resuscitation. Minors consists of a waiting area and five side rooms for patient assessments and treatments. Majors is formed of a red bay for up to seven patients and a separate further five cubicles. The resuscitation area consists of five beds where patients with life threatening conditions are cared for. The department's co-located children's ED has its own waiting area and four assessment bays; this is not open 24 hours a day.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance only entrance. Patients, who self-presented to the department, reported to the reception area where they were booked in and directed to the waiting area. A hospital ambulance liaison officer (a member of staff from the local ambulance trust) worked within the department to assist with ambulance handovers and manging ambulance flow during times of high demand. The member of staff worked for an NHS ambulance trust and was not employed by the hospital.

During our inspection we spoke with six members of nursing and medical staff, eight patients, six family members and two members of the senior management team within the trust. We also reviewed records and associated care plans of 10 patients (eight adults and two children's records).

Urgent and emergency services

Summary of findings

This was a focused inspection and we did not give the service an overall rating. We found that:

- Patients who required prioritisation of treatment whilst awaiting handover from ambulance crews were not always identified in a timely way, leading to delays in care. We escalated this immediately to the executive on call, who took immediate actions to address this on the day of the visit and the trust then took a series of actions following the visit to put systems in place to maintain oversight of this concern.
- Patient records lacked sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage assessments, were not always completed and there was a lack of recording of the care and treatment given whilst patients were within the ED.
- Patient records within the paediatric area of ED were not always stored securely and were accessible to anyone who entered.
- Staffing within the paediatric ED was not always sufficient to ensure a paediatric trained nurse was present to care for children.
- Paediatric patients were often left alone within the department during our evening inspection, some being vulnerable children with no accompanying adult. We escalated this immediately to the executive on call, who took immediate action to ensure a qualified nurse was present in the paediatric ED whenever it was open. Following the inspection, the trust put in place a series of actions to address this concern.
- Patients' privacy and dignity was not always respected whilst being cared for in the corridor.
- The entrance to the paediatric area was not restricted and could be accessed by all hospital staff, patients and the public. Following the inspection, the trust put in place a series of actions to address this concern to ensure this area was secure.
- The department was not meeting the national performance measure to admit, transfer or discharge 95% of patients within four hours, with worsening performance against the national average in December 2015.
- There were not robust systems in place to monitor the quality and safety of care and treatment and there was a lack of effective oversight of risks in the corridor area of the adult ED.
- Whilst the trust was in the process of implementing new policies regarding the use of the corridor area, these were not fully embedded throughout the whole ED staff team.
- During our inspection, the trust took immediate actions to ensure the safety of patients in ED and immediately following the inspection provided a detailed action plan to deliver a programme of actions designed to sustain and embed the required improvements.

Urgent and emergency services

Are urgent and emergency services safe?

Not sufficient evidence to rate

We have not rated the service for safe. This was a focused inspection and elements of this key question were not inspected. We found that:

- Patients who required prioritisation of treatment were not always identified in a timely way, leading to delays in care. We escalated this immediately to the executive on call, who took immediate actions to address this on the day of the visit and the trust then took a series of actions following the visit to put systems in place to maintain oversight of this concern.
- Patient records lacked sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage assessments, were not always completed and there was a lack of recording of the care and treatment given whilst patients were within the ED.
- Patient records were not stored securely in the paediatric area of ED; records were left out on the side or in open trays attached to the wall.
- There were often delays in transfer of patient from ambulance to hospital staff, patients in care of ambulance crews were not assessed for priority by hospital staff.
- Lead nursing and medical staff did not regularly assess the safety of patients within the corridor to ensure they had a full oversight of any patients requiring priority treatment.
- Staffing within the paediatric ED was not always sufficient to ensure a paediatric trained nurse was present to care for children and paediatric patients were left unsupervised at times. We escalated this immediately to the executive on call, who took immediate action to ensure a paediatric trained nurse was present whenever it was open. Following the inspection, the trust put in place a series of actions to address this concern.
- The entrance to the paediatric area was not restricted and could be accessed by staff, patients and the public. Following the inspection, the trust put in place a series of actions to address this concern to ensure this area was secure.
- Staff carried out infection control practices in line with trust policy but there were not always sufficient facilities for staff and visitors to wash their hands.

Incidents

- As part of our ongoing relationship with the trust, it had provided information for January 2016, which showed that eight incidents had been reported; all highlighted the operational pressures within the department due to high demand and patient flow issues with no patient harms reported.

Cleanliness, infection control and hygiene

- We observed nursing and medical staff carrying out hand hygiene procedures in between seeing patients in accordance with trust policy.
- There were not appropriate hand washing facilities for hospital or ambulance staff when caring for patients in the corridor of ED, so staff had to go into other areas of the department to wash their hands increasing the risk of cross contamination. ED staff were aware of this concern and took action following the inspection to review the risk assessment in place for the corridor area of the ED.
- Hand sanitiser was available within all areas of the department for staff, patient and public use.
- In January 2016, an infection control audit showed that hand hygiene had been highlighted as an area that required further work in the department. This audit reported that not all staff followed appropriate hand hygiene at all times. The trust provided an action plan following the inspection detailing a series of actions to continue to monitor compliance in this area.

Environment and equipment

- During our inspection, the corridor area of the main adult ED was being used to provide care and treatment for up to seven patients, either under hospital or ambulance staff care. This corridor was not designed and did not have appropriate facilities to provide patient care and so there was a risk to the quality and safety of the care and treatment being provided.
- Within the corridor, there was one observation machine (enabling staff to assess patients' blood pressure, pulse and oxygen levels). This meant that not all patients

could be monitored regularly. Ambulance staff told us they often had to bring in their own equipment from the ambulance to monitor patients within the corridor as hospital equipment was not always available.

- There was a separate paediatric area within ED which was co-located next to the adult ED. Some paediatric patients were treated in this area and others were treated in the main adult area of ED. The entrance to the paediatric area was not restricted and could be accessed by staff, patients and the public without any challenge by staff. Access was via a touch pad that any staff member or visitor could open. During our inspection, we observed medical and nursing staff, who were not working in the paediatric area, enter the unit for various reasons, including borrowing equipment or to use a reference book as well as seeking advice from medical staff about patients in the main ED. We also observed one adult patient being brought into the unit to be weighed by a staff member whilst younger patients were in the room without being supervised by a nurse. This was not in accordance with trust policy regarding the security and access of the children's ED. We raised these concerns to the trust's executive on call, who took immediate action to address the concerns and arranged for a dedicated nurse to be in this area whenever used.
- Immediately following the inspection, the trust provided a detailed action plan regarding the urgent actions being taken in the paediatric ED. These actions included the installation of a card swipe mechanism to provide secure access to the area, assurance that a dedicated named nurse would be present in this area whenever in use, confirmation that all staff in adult ED had been instructed not to enter or use equipment in the paediatric ED to follow trust security policy for this area.

Medicines

- We did not gather evidence for this as part of the inspection.

Records

- We reviewed eight sets of adult patient nursing records and found that they lacked sufficient detail to ensure all aspects of their care was clear. Basic entries such as "observations taken" were recorded, but further interactions with the patient were not recorded. We saw one patient who had been in the department for six hours and had two minimal nursing entries within their notes.
- We saw two examples of patients with skin damage risks being repositioned in line with national guidance; however this was not documented within their record so other staff could not be sure when or how often a patient was being repositioned to avoid further skin damage.
- Patient records were not stored securely in the paediatric area of ED. Records were left out on the workstations or in open trays attached to the wall. The paediatric unit in ED was not locked and we observed at times that there were patients and their relatives on the unit, but there was no member of staff. Therefore, confidential patients' notes were left unsecured when no staff were present presenting a risk that unauthorised staff or visitors could access patient confidential information.

Safeguarding

- We did not gather evidence for this as part of the inspection.

Mandatory training

- The Royal College of Nursing (RCN), Defining staffing levels for children and young people's services guidance, states that there must be at least one nurse with a valid advanced paediatric life support (APLS) or European paediatric life support on duty within paediatric ED at all times. We were told that nursing staff were trained to an intermediate level and not advanced life support, therefore the hospital were not following RCN guidance.
- We found that not all adult nurses working within the paediatric ED or treating paediatric patients in the adult ED had received any specific training to provide paediatric care. Following the inspection, the trust provided an action plan detailing how all ED staff would receive urgent training regarding children's nursing competencies. We were provided with evidence of a competency framework in place and a timescale for actions.

Assessing and responding to patient risk

- There was insufficient pressure ulcer assessment and care within the ED. We saw that the majority of patients

had not had pressure ulcer risk assessments or care plans completed. Four patients that had been in the department for between two and six hours had not had the pressure ulcer scoring tool completed: two of these patients had a history of pressure ulcers and were receiving pressure area care. One patient had been in the department for eight hours and had a documented grade four pressure ulcer but no pressure area care had been implemented or documented. We raised this urgently with the nursing staff caring for this patient who informed us they had ordered a specialist mattress for the patient within her seventh hour in the department. Therefore the patient was on a standard ED trolley not suitable for protecting further skin damage. We raised this concern with the trust's on call executive, who took immediate action to ensure the patient was assessed and appropriate care and treatment provided.

- Nursing staff we spoke with showed a good understanding of skin damage and pressure area care but felt they did not have enough time to carry out full assessments due to demands in the department. Also when they were caring for patients alone they couldn't fully assess a patients' skin as it required two members of staff to move the patient and allow this. We raised this with the on call executive during the inspection who took immediate action to ensure no patients were at risk.
- A registered nurse was allocated to the corridor who cared for up to six patients whilst they were waiting for a bed within the majors department. During our inspection, a student paramedic was assisting this nurse in caring for patients. We saw one example of the student paramedic carrying out basic observations on a patient, this patient was found to have an elevated heart rate and a higher than normal National Early Warning Score (NEWS) however this was not escalated to the registered nurse by the student paramedic. This lack of escalation meant the patient waited 90 minutes until an electrocardiograph (ECG) was carried out to assess their high heart rate. We were informed that student nurses and paramedics regularly carried out placements in the department and there was no specific structure to ensure they followed escalation processes for deteriorating patients. This was raised with the trust's executive on call during the inspection who took immediate actions to address this concern.
- Ambulance staff and the Hospital Ambulance Liaison Officer (HALO) told us they often had delays in handing over patients and had to queue in the corridor. During our inspection the wait for ambulance crews to handover their patient was between 15-30 minutes. We were told that when delays occurred observations and basic interventions were carried out on patients by the ambulance staff, however ED staff did not risk assess these patients awaiting handover to determine those patients that needed to be seen as a priority by ED doctors. ED staff relied on the ambulance crews alerting hospital staff to patients that deteriorated whilst waiting in the corridor. This was not safe practice as not all ambulance crews contained qualified staff and therefore may not have recognised a deteriorating patient. We saw no evidence of impact of this on patients during our inspection.
- During our inspection we did not see the nurse in charge or the lead doctor of the department assess the level of risk within the corridor; this meant they did not have a full oversight of any patients requiring priority treatment unless the corridor nurse had escalated this. We raised this with the trust during the inspection and were told that the department were in the process of sharing learning from a neighbouring trust to develop a robust assessment of safety within the department at regular points in each shift.
- Immediately following the inspection, the trust provided a detailed action plan regarding the urgent actions being taken in the adult ED. These actions included the introduction of two hourly ED safety rounds with immediate effect and a process for a formal, documented senior clinical review for all patients waiting in the corridor to ensure that there was effective review and oversight of all patients' condition whilst in the ED.
- The department used a Paediatric Early Warning Score (PEWS) to monitor vital observations of children which was linked to their age. We reviewed a sample of notes and found that one child's observations had been recorded on a NEWS form (designed for adult patients) and therefore an age appropriate tool had not been used which could produce different results. Neither of the PEWS and NEWS charts we reviewed for paediatric patients contained all relevant observations. One of the PEWS charts indicated that hourly observations were required but these had not taken place hourly and it had taken five hours for the second set of observations to be recorded. PEWS scores were not always totalled and where they had been totalled, there was missing

information, which may have altered the patient's PEWS score. One patient had a high respiratory rate which meant they should have been on a 'red' care plan, but documentation for the red care plan had not been completed.

Nursing staffing

- The Royal College of Nursing, Safer Staffing guidelines 2013, state that all registered nurses within a separate and dedicated children's emergency department must be registered children's nurses and that in mixed emergency departments (Kettering General was mixed for some patients when the paediatric area was closed), a minimum of one registered children's nurse.
- There were two registered children's nurses employed by the trust who worked in the ED. This meant that the paediatric ED could not be operational at all times. During our inspection there were no registered children's nurses on shift.
- We were told that when the paediatric nurses were not on duty that the paediatric ED area was closed and children were seen in the main ED. During our inspection the paediatric area was in operation and the paediatric nurse had finished an hour before our arrival (which was at 9pm). The paediatric area remained open until 12 midnight with patients being treated at the end of our inspection approximately four hours after the registered paediatric nurse had completed their shift.
- The Royal College of Nursing (RCN) guidance on Defining staffing levels for children and young people's services recommends, 'All registered nurses within a separate and dedicated children's emergency department must be registered children's nurses'. And that, there must be at least one nurse with valid Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) skills on duty at all times. By keeping the paediatric ED open and run by adult nurses, the hospital were failing to comply with the RCN guidance.
- RCN guidance also states that in mixed emergency departments, a minimum of one registered children's nurse with trauma experience and valid EPLS/APLS training must be available at all times. We were told that when the paediatric nurses were not on duty an adult nurse was on occasions allocated to work in the paediatric area when it was open. At other times when the paediatric area was open, the area was covered by adult nurses who were also seeing and treating patients in the minor injury area of ED. The adult nurses used to cover paediatric ED did not have training specifically for caring for paediatric patients and were not trained in Advanced Paediatric Life Support.
- We reviewed the staffing allocations over an eight day period and found that on seven days, there was paediatric nursing cover during the day; times varied and two of the seven days cover was provided either in the morning or afternoon only. One of the eight shifts was covered by an ED nurse, at night there was no allocated cover.
- The trust's policy was for a nurse to be in this paediatric area whenever patients were in the room: we found this did not happen frequently during our inspection as the nurse was also attending to patients in the minors' area of adult ED. We observed periods of time when either there were no members of staff in the paediatric area or there was no nurse on the unit who was responsible for caring for the patients. There were times when a doctor entered the unit to assess a specific patient.
- We observed one paediatric patient was having intravenous treatment (IV) but the nurse providing this care treatment did not have paediatric IV competencies.
- We raised these concerns about appropriate nurse staffing in the paediatric areas of the ED with trust's executive on call. Immediately following the inspection, the trust provided a detailed action plan regarding the urgent actions being taken in the paediatric ED, including the delivery of staff training programme to ensure staff with the required competencies would be available for all shifts. The trust told us immediately after the inspection that paediatric trained staff from another ward in the hospital would be deployed into the paediatric ED when required to ensure there was always a paediatric trained nurse in this area.
- The department had also prepared a business case to be presented to the trust's board on 16 February 2016 to increase the number of registered nurses in ED from nine to 11 (during the day) and from seven to nine (at night). This plan also included the recruitment of nurses with paediatric skills and competencies. The trust told us that actions to be taken included the introduction of a paediatric competency framework for all nurses working in the ED. Whilst this staff training programme was being completed, the ED lead nurses were to hold daily specific paediatric safety meetings to ensure effective clinical oversight was maintained for all paediatric patients.

Urgent and emergency services

Medical staffing

- Medical staffing met patient's needs at the time of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We have not rated the service for effective. This was a responsive inspection and this key question was not inspected.

Evidence-based care and treatment

- We did not gather evidence for this as part of the inspection.

Pain relief

- We did not gather evidence for this as part of the inspection.

Nutrition and hydration

- We did not gather evidence for this as part of the inspection.

Patient outcomes

- We did not gather evidence for this as part of the inspection.

Competent staff

- We did not gather evidence for this as part of the inspection.

Multidisciplinary working

- We did not gather evidence for this as part of the inspection.

Seven-day services

- We did not gather evidence for this as part of the inspection.

Access to information

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not gather evidence for this as part of the inspection.

Are urgent and emergency services caring?

Not sufficient evidence to rate

We have not rated the service for caring. This was a focused inspection and elements of this key question were not inspected. We found that:

- Staff were caring and considerate towards patients and their families during our inspection.
- Feedback from patients was positive.

However, we also found that:

- Patients' privacy and dignity was not always respected by staff whilst being cared for in the corridor.

Compassionate care

- We saw patients being cared for within the ED corridor and staff told us this occurred regularly and sometimes daily. The corridor space within the ED did not allow any privacy for patients and we regularly heard discussions between nursing/medical staff and patients being carried out within the corridor where they could be overheard by other patients and their families.
- Within a risk assessment in place at the time of the inspection, it stated that privacy screens were used in the corridor, however we saw only one screen was available but not being used. Staff told us screens could not be used as they would obstruct the entire corridor. We did not see staff actively using privacy screens during the inspection.
- Interactions between nursing staff and patients were caring and considerate. Patients commented that all staff they had spoken to whilst in the hospital were polite and apologetic when they had had to wait for treatment or assessment.

Urgent and emergency services

- Patients and their families told us they felt the ED staff were doing the best they could during periods of high demand.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

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

Not sufficient evidence to rate

We have not rated the service for responsive. This was a focused inspection and elements of this key question were not inspected. We found that:

- The department was not meeting the national target to admit, transfer or discharge 95% of patients within four hours, with worsening performance against the national average in December 2015.
- There was a significant problem with ambulance staff being unable to hand over their patients to staff in the ED due to problems with patient flow.
- Feedback from patients during inspection was mixed in relation to nutrition and hydration, however we saw corridor patients being offered fluids where they were able to drink.

Service planning and delivery to meet the needs of local people

- The trust had embarked on an Emergency Care Recovery plan as of 18 January 2016, with ongoing engagement with commissioners, which included the planned provision of additional extra 12 ED cubicles via the installation of a temporary building and also provision of additional staff in the department to meet the rising demands. This was planned to be implemented within six weeks. This was due to long standing issue with the ED not having the capacity to meet the rise in demand and due to increased attendances at the ED.

Meeting people's individual needs

- We saw two examples of patients in the corridor area of the adult ED asking to use toilet facilities; due to the patients being immobile or requiring assistance, this meant they had to wait for an appropriate private area to be free before they could use facilities. Family members we spoke with were unhappy about this and felt that it was not pleasant for the patient to have to wait for long periods of time to use a toilet.
- Feedback from patients during inspection was mixed in relation to nutrition and hydration, however we saw corridor patients being offered fluids where they were able to drink.
- We observed patients in the corridor being offered water where they were able to drink, with the corridor nurse having a good knowledge of which patients were nil by mouth due to their presenting complaint.
- Vending and hot drinks machines were available in the main entrance of the ED.

Access and flow

- There was a significant problem with ambulance staff being unable to hand over their patients to staff in the ED and the number of patients on trolleys in the ED exceeded the number of cubicle spaces available. We saw two patients in the department who had been waiting for more than two hours for an inpatient bed after a decision to admit to a ward.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. The department had failed to meet this standard since 2014. The average performance between April 2015 and December 2015 was 87% against this standard and was generally performing worse than the England average.
- The data for December 2015 showed worsening performance on the four hour waiting time standard with 83% performance compared to the England average of 91%. Performance worsened again for January and February 2016, at 77% and 81% respectively. Between December 2015 and February 2016, the ED saw an increase in attendances by 6% compared to the previous year.

- An escalation plan was in place to enable staff to raise acuity and capacity issues with senior staff. The escalation levels of the EDs were discussed during the hospital's operations meetings. During our inspection, the department was on "amber" escalation and this was known by the nurse in charge along with the operational team. We saw that appropriate actions were being taken in line with the trust's escalation plan.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are urgent and emergency services well-led?

Not sufficient evidence to rate

We have not rated the service for being well led. This was a focused inspection and elements of this key question were not inspected. We found that:

- There was a lack of effective risk management oversight governing the use of the corridor area in the adult ED area.
- There were not robust systems in place to monitor the quality and safety of care and treatment in the corridor area of the adult ED.
- Whilst the trust was in the process of implementing new policies regarding the use of the corridor area, these were not fully embedded throughout the whole ED staff team.
- The trust senior managers took immediate actions during the inspection to minimise risks to patient safety.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- From information provided by the trust prior to the inspection, the trust had no records of the number of times patients have been cared for in the corridor area of the Emergency Department (ED) as they had not been recording this. The trust were not able to say how many patients had been cared for in this area of ED and had not been recording how long the average wait was for patients in this area.
- We visited the clinical operations managers (senior nurses acting as site supervisors) and saw evidence that Standard Operating Policies for corridor care in adult ED had been ratified and implemented the day before the inspection but we found they had not yet been embedded throughout the staff team in ED. A documentation log for patients in the corridor area of ED had commenced two days prior to the inspection. The trust was not yet able to provide monitoring data for these patients but we saw plans were in place to record this data and to carry out audits.
- The trust had provided information before we inspected that a Standard Operating Procedure for 'Ambulance Streaming', governing the use of the corridor area of ED to care of patients arriving to the ED at times of high demand, had only just been introduced. On inspection, we saw that this policy was dated and had been ratified by the trust's board in February 2016. The trust had also introduced a Standard Operating Procedure for 'Queuing Out' governing the use of the corridor area in ED to care for patients awaiting a bed in the hospital. This policy was also dated and ratified February 2016. However, these policies did not have a recorded actual date of ratification on them.
- We saw that the ED had a 'Risk Assessment for Corridor Nursing' with the date of the initial assessment as 23 December 2015. This risk assessment had been reviewed on 4 February 2016 but was quite limited in terms of mitigating actions that had been taken to maintain an effective oversight of the care and treatment of patients and stated that a business case for additional staffing was to be presented to the trust management committee week commencing 8 February 2016.
- Whilst there was some evidence that the trust was taking actions to ensure an effective oversight and management of the risks to patients being cared for in the corridor area of the ED, further work was required to fully embed the new governance processes and management of risks throughout the whole staff team. There was a lack of accurate data regarding the frequency of use of the corridor area to provide safe care for patients and a robust quality assurance process to

monitor the risks and safety of patients in this area had not been established. This meant there were still risks that patients would not receive safe and high quality care and treatment in this area.

- Following our inspection, the trust shared the existing urgent and emergency care action plan that was in the process of being delivered. The trust had reviewed this plan to ensure all issues raised by the inspection were included with necessary actions being documented.

Leadership of service

- During our inspection, the trust took immediate actions to ensure the safety of patients in ED and immediately following the inspection provided a detailed action plan to deliver a programme of actions designed to sustain and embed the required improvements.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

Medical care (including older people's care)

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

Kettering General Hospital's medical care service has 12 wards, including cardiology, haematology, gastroenterology, stroke care, respiratory care, care of the elderly, an ambulatory care unit and a discharge lounge. The trust had commenced a new and innovative programme to become an Academy of Gerontology Excellence (AGE), with the introduction of the trust's AGE programme. The trust has recently opened the new cardiology unit, comprising of the cardiology ward and the coronary care unit (CCU). The cardiac ward has 14 beds and CCU has 12 beds. The cardiac centre also provides three catheter laboratories, to provide a 24 hour primary percutaneous coronary intervention service (PPCI). There are four wards for the care of the elderly, each having 20 beds. The two gastroenterology wards (one male and one female) both have 22 beds. The trust has an acute stoke unit (ASU) within the stroke care ward, and an added stoke rehabilitation ward.

We carried out a focused inspection in the evening of 10 February 2016 and inspected three escalation areas in use: Fotheringhay ward (also known as the discharge lounge) which had ten bed spaces for both male and female patients; Poplar Ward which had eight beds in two separate bays for female patients only; and the Surgical Day Case Unit, which had capacity for six patients. We also visited the chest pain assessment unit.

We spoke with the executive on call, the clinical operations managers, and seven nurses. We reviewed eight sets of medical and nursing notes. We carried out pathway tracking of six patients from their arrival in the hospital to their transfer to the escalation areas.

Medical care (including older people's care)

Summary of findings

This was a focused inspection and we did not give the service an overall rating as we did not inspect all elements of each key question. We found that:

- Patients were treated with respect and compassion.
- Nurse staffing levels and skill mix had been managed to meet the needs of the patients in the escalation areas. Extra nurses were booked for each shift to manage patients in escalation areas.
- Clinical operations managers (senior nurses) reviewed every patient in an escalation area at the start of each night shift to ensure the placement was appropriate.
- Patients were reviewed by a consultant-delivered ward round, at least once every 24 hours, seven days a week.
- Emergency equipment, including equipment used for resuscitation was checked daily on Poplar ward.
- Assessments for patients were generally comprehensive, covering all patients' health needs.
- Patients' pain was assessed and reviewed regularly. Appropriate pain relief was given as prescribed when required.
- The trust's management team were actively working with commissioners and external stakeholders to address the longstanding increase in the demand for beds at the hospital, and implement a range of contingency measures to manage the rising demand for beds. This work was also focusing on the requirement to reduce levels of delayed transfers of care. At the time of the inspection, this work had however not yet delivered improvements.
- Escalation areas were being used at peak times of demand for beds to facilitate patient flow through the hospital.
- The trust was planning a bed reconfiguration initiative designed to increase the numbers of beds available.
- Numbers of patients with a delayed transfer of care had remained high over the past two months, however, the number of patients outlying on other speciality wards had reduced in the past two months, due to change in bed management processes.
- Generally, effective systems were in place regarding the use of escalation areas in the hospital and senior staff had an effective oversight of the risks to patient safety.
- Most staff had an understanding of the escalation area usage and admission criteria. They understood the need to move staff to meet patient needs, but some staff felt under pressure due to this.

However, we found that:

- Not all medical records were securely stored in either a locked cabinet or dedicated rooms. Patients' notes were kept in a file outside the bedroom on Fotheringhay ward.
- Medicine fridge temperatures were not being checked regularly on Fotheringhay ward.
- Effective monitoring of average waits for those patients transferred under the 'Early Flow Discharge policy' was not yet available. The trust was planning to monitor this data for these patients.

Medical care (including older people's care)

Are medical care services safe?

Not sufficient evidence to rate

We have not rated the service for safe. This was a focused inspection and elements of this key question were not inspected. We found that:

- Ward areas were generally visibly clean and tidy.
- Nurse staffing levels and skill mix had been managed to meet the needs of the patients in the escalation areas. Extra nurses were booked for each shift to manage patients in these areas.
- There were appropriate systems in place for temporary staff to be inducted to ward areas.
- Clinical operations managers reviewed every patient in an escalation area at the start of each night shift to ensure the placement was appropriate.
- Patients were reviewed by a consultant-delivered ward round, at least once every 24 hours, seven days a week.
- Emergency equipment, including equipment used for resuscitation was checked daily on Poplar ward.
- Portable electric equipment had been tested regularly to ensure it was safe for use.
- Generally appropriate systems were in place for the storage, administration and recording of medicines.
- Staff used the National Early Warning System (NEWS) to record routine physiological observations, such as blood pressure, temperature and heart rate, and to monitor a patient's clinical condition.
- Staff we spoke with were able to describe how they escalated concerns about patients and that doctors responded in a timely manner for requests to review patients.

However, we also found that:

- Not all medical records were securely stored in either a locked cabinet or dedicated rooms. Patients' notes were kept in a file outside the bedroom on Fotheringhay ward.
- Medicine fridge temperatures were not being checked regularly on Fotheringhay ward.

Incidents

- In the month of January 2016, no patient harm incidents were reported in the Discharge Lounge, Day Case Surgical Ward or Poplar ward.
- In January 2016, nine incidents were reported on Fotheringhay ward including one incidence of pressure tissue damage and one patient fall with no harm reported by staff. There had been one incident reported of a patient deteriorating with medical staff reporting difficulty accessing the notes and one incident escalated by a nurse in relation to addressing the needs of all patients' safety; the outcome was that other patients had been moved to accommodate a patient with a dementia in a higher visibility room.
- In January 2016, the trust had introduced an 'Early Flow Discharge policy' designed to improve patient flow through the hospital and relieve operational pressure for beds in the Emergency Department. This process was used only to transfer patients into wards that had a definite or predicted discharge of another patient and patients were to be on the ward whilst awaiting the bed becoming available, usually for a short period of time. Seven incidents had been reported due to this process including two incidents where patients had been inappropriately placed; one resulting in a safeguarding adults' referral to the local safeguarding authority. This incident was under investigation at the time of the inspection. Senior staff told us that a learning log was being established from these incidents to share learning to reduce the risk of reoccurrence.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

- Ward areas were generally visibly clean and tidy and sanitising hand gel was available throughout the units.
- Equipment had 'I am clean' stickers on them, which were easily visible and documented the last date and time they had been cleaned.
- Staff worked in accordance with best practice for infection control; this included good hand hygiene and being bare below the elbows.
- Clinical waste bags on Fotheringhay ward were not always being managed or disposed of in a timely way. We raised this with staff, who took action to address this issue immediately.
- Prior to the inspection, the trust told us that the discharge lounge had reported no new hospital attributed infections (which was important due to this ward's proximity to the Oncology ward). There had been

one reported Clostridium difficile case when a patient's carrier status of this infection was found upon admission to the escalation area. The patient was placed into one of the side rooms and full isolation precautionary procedures were put in place. Infection control precautions and a risk assessment were in place for this area on our inspection.

Environment and equipment

- Emergency equipment, including equipment used for resuscitation, was checked every day on Poplar ward and records maintained in accordance with trust policy.
- Appropriate pressure relieving equipment was available for patients and staff reported no delays in obtaining equipment when required.
- All bed spaces in all escalation areas visited had appropriate facilities and equipment, including call bells and access to oxygen.
- There were sufficient toilet and washing facilities on the wards to meet the needs of patients of both sexes.
- Portable electric equipment had been tested regularly to ensure it was safe for use and had clear dates for the next test date on them.
- We noted that the sluice room on Fotheringhay ward was not lockable. There was a risk of non-authorised persons accessing the sluice. Senior staff told us that at least one member of staff was always present in this escalation area to oversee all patients on the ward so the risk of a non-authorised person going into the sluice was minimal.

Medicines

- Appropriate systems were in place for the storage, administration and recording of medicines.
- On Fotheringhay ward, patients' medication was kept in individual locked boxes outside each room. There was appropriate storage of controlled medicines in a locked clinic room.
- On this ward, there were locked cabinets in a locked clinic room for medicines for patients to take home.
- We saw some discarded medication for a discharged patient on a side table which was in the locked room on Fotheringhay ward; we raised this issue with the staff on duty and they took action to dispose of these medicines following the trust's procedure.
- The fridge temperatures were not being checked regularly on Fotheringhay ward. We raised this with senior staff who said that this concern would be addressed with all staff working in this area.
- On Poplar ward, patients' medication was kept in individual locked boxes beside each bed. There was appropriate storage of controlled medication on an adjoining ward (Maple).
- We observed nurses administer medicines on a drug round on Fotheringhay ward and all protocols were followed to ensure patients received the correct medicines at the correct time.
- We looked at two patients' drug charts and saw that records of prescription and administration were maintained.

Records

- During our inspection, we observed that not all medical records were securely stored in either a locked cabinet or dedicated rooms. All notes (nursing, medical, observation sheets) on Fotheringhay ward were kept in a file outside the side rooms in use on the ward. This presented a risk that unauthorised people could access these records.
- On Poplar ward, we were told that all patients' notes were kept in a lockable cabinet, when they were not being used by nursing staff. A lockable cabinet was available and in use for secure storage of these notes.
- We reviewed six sets of notes. All records we reviewed were well organised and information was easy to access. The majority of records were complete and up to date including biographical details and next of kin contact details.
- Records we reviewed were mostly maintained contemporaneously, however we observed in one set of notes that a care record summary had been written for a patient at 2:30pm for the care provided between 7:30am and 2:30pm, rather than a summary at the time of each intervention.

Safeguarding

- We did not gather evidence for this as part of the inspection.

Mandatory training

- We did not gather evidence for this area

Assessing and responding to patient risk

- Patients in the escalation areas that we visited had been appropriately placed. The trust's escalation procedure governing the use of these escalation areas had been followed and clinical risk assessments signed by a consultant were recorded in patients' notes to ensure patients would be appropriately cared for.
- The clinical operations managers oversaw this process and admission and exclusion criteria were in place for all escalation areas. Staff told us the main criteria for patients in escalations areas were that they were 'medically fit to discharge'.
- Clinical operations managers reviewed every patient in an escalation area at the start of each night shift to ensure the placement was appropriate.
- Staff used the National Early Warning System (NEWS) to record routine physiological observations, such as blood pressure, temperature and heart rate, and to monitor a patient's clinical condition to check for signs of deterioration. This system used a scoring scale to monitor patients' condition and an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient's observations to urgent review by a senior nurse or a doctor. The NEWS charts we reviewed were fully completed and up to date and we saw evidence that staff had used the escalation process when necessary and that medical reviews, when needed, were carried out in a timely manner.
- Staff were able to describe how they escalated concerns about patients. They told us that if they had a concern they contacted the on-call medical staff and could also escalate any concerns to the clinical operations managers. We saw that this had happened earlier in the evening when one patient had an increase in temperature picked up during routine observations. The nursing staff had contacted the on-call medical staff who had arranged for the patient to be transferred to the medical assessment unit for further tests.
- We saw that falls and venous thrombolytic embolism (VTE) assessments were carried out to identify those patients at risk and care plans were in place to minimise the risk.
- Pressure area assessments were completed and care plans were in place to minimise the risk of patients developing pressure ulcers. We saw evidence of patients being repositioned two hourly as per guidance and evidence that staff were using the SSKIN care bundle in line with national guidance. (This is a five step model for pressure ulcer prevention and related to Surface – making sure the patient has correct support such as repose mattresses, Skin inspection, Keeping the patient moving - 'repositioning', Incontinence/moisture – ensuring the patient was dry and Nutrition/hydration).
- We saw no evidence of patients waiting on trolleys in ward corridors or in general ward areas while they were waiting for patients to be discharged so that they could then be placed into the vacated bed space.

Nursing staffing

- At the time of inspection, nurse staffing levels and skill mix had been managed to meet the needs of the patients in the escalation areas.
- Fotheringhay ward was staffed with two registered nurses and two health care assistants. The trust told us they had planned that, as a minimum, one of the qualified staff members was a permanent member of staff (substantive). On the night of the inspection, both the qualified nurses were regular agency staff due to the demands elsewhere within the hospital that had required the substantive qualified nurse to move to the Emergency Department. A review of the staffing skill mix with a risk assessment had been carried out by senior managers to ensure the needs of patients in escalation areas could be met. This was in accordance with the trust escalation policy.
- Both registered nurses were responsible for up five patients each and at the time of our inspection there were eight patients on this ward.
- Poplar ward was staffed with two registered nurses; one permanent nurse and one agency nurse. The ward had seven patients and the nurse staffing levels met their needs at the time.
- The chest pain assessment unit had one patient admitted for assessment of their condition and two registered nurses were present in this area at the time of the inspection.
- We saw that bank and agency staff had received an appropriate induction to enable them to work in these escalation areas. On Fotheringhay ward, we saw an induction folder for agency staff and the agency nurses on duty had signed it that evening. In the front of this folder was a protocol related to the trust's new

escalation policy dated 9 February 2016 which the agency staff had read and signed for. This protocol laid out the criteria for admission and use of escalation areas processes.

- Given the demands on bed capacity prevalent at the time of the inspection, the trust had an extra six agency nurses booked each night and permanent staff were moved between wards to balance the skill mix across all wards.
- At the time of our inspection, there were nine registered nurses supporting the 17 patients being cared for overnight in escalation areas. They told us that they were given an effective handover of the patients' needs on their transfer to the escalation areas.
- There were two clinical operations managers on duty at the time of the inspection and staff were able to escalate any concerns about patient care to them as required. Staff confirmed that the clinical operations managers visited patients in the evenings to check the suitability of their placement in the escalation areas and that their needs were being met in these areas.

Medical staffing

- Records showed that patients were reviewed at consultant-delivered ward rounds, at least once every 24 hours, seven days a week.
- We saw that the nursing staff were aware of how to contact the on-call medical staff when necessary and that medical reviews were carried out effectively.
- Dedicated doctors were assigned to provide medical cover for all escalation areas and for those patients in outlying wards.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are medical care services effective?

Not sufficient evidence to rate

We have not rated the service for effectiveness. This was a focused inspection and elements of this key question were not inspected. We found that:

- Assessments for patients were generally comprehensive, covering all patients' health needs.
- Patients' pain was assessed and reviewed regularly. Appropriate pain relief was given as prescribed when required.
- Nursing staff obtained patients' verbal consent before carrying out care on both Fotheringhay and Poplar wards.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs.
- Patient's care and treatment was generally planned and delivered in line with evidence based guidelines. Care plans were in place that detailed how patients' needs were to be met.

Pain relief

- We saw that patients' pain was assessed on NEWS charts on the wards visited. Records reviewed showed that patients' pain relief was reviewed regularly and appropriate pain relief was given as prescribed when required.

Nutrition and hydration

- We saw records of patients' daily nutritional input and that patients' fluid balance charts had been completed in accordance with trust policy. Appropriate risk assessments were in place to minimise the risk of malnutrition or dehydration.

Patient outcomes

- We did not gather evidence for this as part of the inspection.

Competent staff

- We did not gather evidence for this as part of the inspection.

Multidisciplinary working

- We did not gather evidence for this as part of the inspection.

Seven-day services

- We saw evidence of a consultant-delivered ward round, at least once every 24 hours, seven days a week.

Access to information

Medical care (including older people's care)

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed nursing staff obtaining patients' verbal consent before carrying out care on both Fotheringhay and Poplar wards. Capacity assessments had been completed when required.

Are medical care services caring?

Not sufficient evidence to rate

We have not rated the service for caring. This was a focused inspection and elements of this key question were not inspected. We found that:

- Patients were treated with respect and compassion.
- Staff communicated with the patient and their relatives throughout the patient's care.

Compassionate care

- Patients were treated with respect. We observed positive interactions between patients and staff in all areas visited.
- Staff were friendly and kind in all interactions we observed.
- Feedback from patients was generally positive. However, we did witness a conversation between staff which compromised privacy. Staff discussed what support a patient required to use a commode that could have been overheard by other patients.

Understanding and involvement of patients and those close to them.

- Care records showed that communication with patients and their relatives was maintained throughout the patients' care.

Emotional support

- We saw evidence in the patients' notes that staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required.

Are medical care services responsive?

Not sufficient evidence to rate

We have not rated the service for responsiveness. This was a focused inspection and elements of this key question were not inspected. We found that:

- The trust was actively working with commissioners and external stakeholders to address the longstanding increase in the demand for beds at the hospital.
- Escalation areas were being used at peak times of demand for beds to facilitate patient flow through the hospital.
- The trust was planning a bed reconfiguration initiative designed to increase the numbers of beds available.
- Numbers of patients with a delayed transfer of care had remained high over the past two months, however, the number of patients outlying on other speciality wards had reduced in the past two months, due to change in bed management processes.

Service planning and delivery to meet the needs of local people

- The trust was actively working with commissioners and external stakeholders to address the longstanding increase in the demand for beds at the hospital. One strategy under consideration was to identify more appropriate community beds. The trust was using some commissioned beds at two local care homes at the time of the inspection.
- This work was also focusing on the requirement to reduce levels of delayed transfers of care. At the time of the inspection, this work had however not yet delivered improvements.
- Since January 2016, the trust had implemented an 'Early Flow Discharge policy' (referred to as 'boarding'). This process was used only to transfer patients into wards that had a definite or predicted discharge of another patient. This meant that at times, there would be an additional patient on the ward for a short period of time whilst the patient being discharged was transferred to the discharge lounge or to their home.
- The trust had implemented this approach at the beginning of January 2016 and was seeking examples of policies and procedures from other organisations undertaking this initiative.

Medical care (including older people's care)

- The discharge lounge (Fotheringhay ward) was scheduled to move to a new location in the trust at the end of February 2016 designed to provide more permanent bed capacity. By mid-March 2016, the trust was planning for this area to be opened and staffed appropriately to deliver care to those patients under a facilitated 'Early Discharge' initiative which was part of a wider ward reconfiguration programme to create further capacity. This was based upon a recent bed capacity review and bed modelling initiative. Staff told us this initiative was designed to increase the number of medical beds by an extra 30 or 40 beds.

Access and flow

- We spoke with the clinical operations managers and discussed what actions the trust had taken regarding the increased demand for beds and the pressures on effective patient flow through the hospital. The trust had reviewed and updated its escalation procedure and admission and exclusion criteria for all escalation areas in the week of the inspection.
- The 'Early Flow Discharge policy' was mainly used in the mornings to facilitate effective patient flow and was not used overnight, so wards did not have an additional patient bedded during the night time hours. It was only used when the hospital was experiencing a high demand with the potential for compromising patient safety and the quality of care and treatment in the emergency department. Staff told us that there had been only one occasion in the previous eight days when patients had had to be 'boarded'.
- The discharge lounge (Fotheringhay ward) had been used when needed as an escalation area since September 2015 and had on average eight or nine patients bedded overnight.
- Due to the need for additional bed capacity, Poplar ward was opened as a further escalation area on 19 January 2016 in the evening and closed again the next day. It had been opened on four further occasions since then with a maximum of eight same sex patients with an average length of stay of 72 hours.
- The day case surgical ward had been opened 15 times in January 2016 to the date of the inspection to accommodate up to six patients including medical and surgical patients.
- Staff told us the hospital had a 'perfect week' for early discharge of patients in December 2015, and the learning from this week was being used to inform the current 'Early Discharge' initiative.
- On the day of our inspection, there were 41 patients classified as having a delayed transfer of care, due mainly to difficulties in securing social care support packages in the community. The number of delayed discharges of care had remained high over the past two months.
- There were also 21 patients being cared for in outlying wards (wards that were not the dedicated medical or surgical speciality for the patients' condition). This had reduced from over 30 in previous weeks due to a change in bed management processes.

Meeting people's individual needs

- We did not gather evidence for this as part of the inspection.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are medical care services well-led?

Not sufficient evidence to rate

We have not rated the service for being well led. This was a focused inspection and elements of this key question were not inspected. We found that:

- Effective systems were in place regarding the use of escalation areas in the hospital and senior staff had an effective oversight of the risks to patient safety.
- The clinical operations managers maintained and reviewed daily staffing plans for the escalation areas to ensure appropriate nurse staffing levels and skill mix to meet patients' needs.
- The trust's management team were actively working with external partners and commissioners to review and implement a range of contingency measures to manage the rising demand for beds.
- Most staff had an understanding of the escalation area usage and admission criteria. They understood the need to flex staff to meet patient needs, but some staff felt under pressure due to this.

Medical care (including older people's care)

However, we found that:

- Effective monitoring of average waits for those patients transferred under the 'Early Flow Discharge policy' was not yet available. The trust was planning to monitor this data for these patients.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- Generally, effective systems were in place regarding the use of escalation areas in the hospital and senior staff had an effective oversight of the risks to patient safety. Procedures had been reviewed and updated prior to the inspection. Nurse staffing levels and skill mix were reviewed each shift and the clinical operations managers maintained an effective oversight of bed capacity pressures and the risks to the safety and quality of care and treatment for patients in the escalation areas.
- All admission and exclusion criteria for the escalation areas had been updated prior to the inspection. The clinical operations managers checked all patients in escalation areas had appropriate clinical decisions recorded regarding their suitability to be placed in an escalation area and that individual care plans for being bedded overnight were in place.
- A documentation log for those patients that were to be transferred under the 'Early Flow discharge policy' (or "boarded") had only been introduced in the days prior to the inspection so effective monitoring of average waits for available beds was not yet available. The trust was planning to monitor this data for these patients to allow audits of any risks to patient safety but this was a work in progress at the time of the inspection.
- The clinical operations managers maintained and reviewed daily staffing plans for the escalation areas to ensure appropriate nurse staffing levels and skill mix to meet patients' needs.
- The trust carried out detailed weekend planning for medical and nurse staffing levels based on predicted bed pressures to ensure an optimum level of cover to meet patients' needs.

Leadership of service

- The trust's management committee (with input from clinical leads in all areas of the trust) had reviewed and implemented a range of contingency measures to manage the rising demand for beds within internal resources and were in the process of a significant bed remodelling initiative to increase the bed base available and so improve patient flow throughout the hospital.
- The trust leadership had made representations to external partners and commissioners regarding the operational pressures and patient flow concerns.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We spoke with staff and most had an understanding of the escalation area usage and admission criteria. They understood the need to move staff to meet patient needs, but some staff felt under pressure due to this.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure effective systems are in place to monitor, address and document risks to the safety and quality of patient care in the emergency department.
- Ensure that all patients presenting to ED receive appropriate and timely assessments of needs and that effective care and treatment is provided in a timely way.
- Review nurse staffing within the paediatric ED to ensure a paediatric trained nurse is present to care for children

Action the hospital SHOULD take to improve

- Ensure patient records including risk assessments in ED contain sufficient detail to ensure all aspects of their care is clear.
- Ensure all records in the paediatric ED are always stored securely.
- Ensure patients' privacy and dignity is respected whilst being cared for in all areas of the ED.
- Review and monitor the security and access to the paediatric area to ensure risks of unauthorised entry are addressed.
- Ensure effective systems are in place to monitor the risks to the quality and safety of patient care in the ED are fully embedded throughout the whole staff team to ensure effective oversight and management of risks.
- Ensure data is collected and monitored regarding patients transferred under the 'Early Flow Discharge policy' to maintain an oversight of potential risks.
- Review the storage patients' records in escalation areas to ensure they are stored securely.
- Ensure medicine fridge temperatures are checked regularly in all escalation areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014).** How the regulation was not being met: The trust did not operate effective systems to ensure that patients had appropriate and timely assessments of need and delivery of safe care and treatment in the emergency department as not all patient risk assessments had been carried out and documented in accordance with trust policies.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014).** How the regulation was not being met: The trust did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients in the emergency department as there was not effective risk assessment and clinical oversight and management of the risks pertaining to the care and treatment of patients in the corridor area of the adult emergency department. Patients' records were not always completed to give a complete record of staff interventions.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014).** How the regulation was not being met: The trust did not have sufficient trained paediatric staff in the paediatric area of the emergency department at all times when it was open.