Liverpool University Hospitals NHS Foundation Trust

New Royal Liverpool University

Inspection report

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Date of inspection visit: 28 and 29 October 2020
Date of publication: 29/01/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at New Royal Liverpool University

Inspected but not rated

Key facts and figures

Services at Royal Liverpool Hospital are provided by Liverpool University Hospitals NHS Foundation Trust. The trust was created on 01 October 2019 following a process of acquisition, in which Aintree University Hospital NHS Foundation Trust acquired Royal Liverpool and Broadgreen Hospitals NHS Trust.

Liverpool University Hospitals NHS Foundation Trust is a major city centre acute NHS trust. During the week this inspection took place, Merseyside was in a tier 3 COVID-19 area, and therefor facing higher community infection rates, which would impact on the activity of the trust.

We carried out a focused, responsive inspection at Royal Liverpool University Hospitals on 28 and 29 October 2020 to review the processes, procedures and practices within the medical care core service. We looked at parts of the safe, effective, caring and well-led key questions. We did not rate services because this was a focused, short notice inspection in response to specific areas of concern.

We observed care and treatment and specific documentation in 12 patient records, including do not attempt cardiopulmonary resuscitation (DNACPR), mental capacity assessment, care plans and intentional rounding documentation. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with 14 members of staff and 13 patients.

We observed patient care, the environment within wards and safety briefings.

Why we inspected

Over a three-week period in October 2020, CQC had received a number of enquiries from patients, relatives and staff which related to poor patient care and experience. These concerns related to nutrition and hydration, hygiene needs; staff being unable to provide care; infection prevention and control and staffing concerns.

There were continuing concerns about patient care and safety at the trust's two main hospital sites. We heard from patients, relatives and staff that:

- COVID-19 and non COVID-19 patients were mixed in ward areas, that there were increasing infection transmission rates within the trust and staff were not complying with requirements for use of appropriate personal protective equipment (PPE).

- Ward 9Y had opened at the Royal Liverpool University Hospital site with no staff, no equipment including resuscitation equipment, and this was highlighted as being dangerous to patients and staff. This was raised immediately with the Trust to ensure appropriate emergency equipment was available.

Our findings

- we received whistleblowing concerns about safe staffing, particularly with regard to wards 3a and 9Y at Royal Liverpool Hospital

Immediately prior to the inspection CQC received further concerns from patients and relatives that: - Staff did not appear to be adhering to social distancing at all and that some staff were walking around wearing their masks under their chin and not covering their nose.

- Basic care needs were not being met and patient care plans were lacking. Some patients did not receive pressure care resulting in their acquiring pressure sores and patient's hygiene and nutritional needs were not always being met adequately.

The concerns also included allegations of neglect, mismanagement and miscommunication.

These concerns were mainly related to medical wards at both Royal Liverpool Hospital and University Hospital Aintree and specifically to wards 3A and 9Y at Royal Liverpool Hospital. In accordance with CQC procedures, due to the significant concerns raised, enquiries were also referred to local authority safeguarding services.

What we did

We initially raised the concerns with senior leaders at the trust and asked for information of how the trust was assured of patient safety at the point of care delivery. The trust provided information to confirm that ward 9Y had since been safely staffed and that emergency resuscitation equipment was available, in line with their established escalation processes.

They also gave some assurance about senior nurse review of clinical areas, including the environment, patient experience, and infection prevention and control, in relation to the other concerns that had been raised. However, there was no specific evidence or information provided that patients had their health needs assessed, appropriate risk assessments were completed, or that care plans reflected the patient's needs.

There was a lack of clarity regarding any continued actions to ensure risk assessments were completed and reviewed in a timely way, particularly in response to changing patient needs. In addition, there was no detail of how any concerns identified from matrons' weekly checks would be monitored, actions taken and followed up to ensure these actions had resolved the issues.

We carried out a focused, short notice inspection in response to the specific areas of concern. We inspected medical care core services at Royal Liverpool Hospital on 28 and 29 October 2020 and our findings are summarised below. We did not inspect all the key lines of enquiry or domains and therefore have insufficient evidence to rate the service.

What we found

We found evidence to support the serious concerns that had been raised regarding patient care, as follows:

The service did not always control infection risk well. The systems in place to manage infection prevention and control were not always followed by staff. There was no evidence of leaders taking action to ensure compliance and mitigate these risks, which meant patients could be exposed to the risk of harm.

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always have access to enough suitable equipment.

Our findings

Staff completed but did not always update risk assessments to safely manage and mitigate the risks to patients. Staff did not always follow all the systems that were in place to identify and take action where patients were at risk of deterioration.

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Frequent staffing shortages meant there were occasions when staff were unable to meet the basic care needs of patients.

Staff kept records of patients' care and treatment. Although records were clear and easily available to all staff providing care, they were not always up-to-date or stored securely.

The service used systems and processes to prescribe, administer and store medicines but staff did not always follow processes for recording medicines administration. Agency staff did not always have access to the electronic patient medication system.

Staff recognised but did not always report incidents and near misses.

Not all patients requiring dietetic review received this in a timely way, including some with significant nutritional needs. Through our review of the information, we were not assured the trust had a robust system in place to manage patients' nutritional and hydration needs. This meant patients may or will be exposed to the risk of harm. However, from our observations on the days of inspection we saw staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Staff treated patients with compassion and kindness, respected their privacy and dignity, but did not always take account of their individual needs in a timely way. Staff did not always provide emotional support to patients to minimise their distress.

Leaders were not always visible and approachable in the service for staff.

Culture in the service was mixed and not all staff said they felt respected, supported and valued, or able to raise concerns without fear.

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Ward quality audits had been commenced but were not fully embedded. Although the trust was facing a surge of demand, leaders had taken a decision not to escalate their status through the NHS Operational Pressures Escalation Framework. However, we were informed that local arrangements were in place with system partners and being co-ordinated through NHS E/I's specific COVID-19 incident control function using the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework.

Leaders did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However local teams used systems to manage performance effectively.

However:

We observed staff working extremely hard to provide treatment and care under difficult circumstances during the current COVID 19 pandemic, which had impacted on the numbers of patients and their acuity. During October 2020

Our findings

the North West region saw an increase in COVID-19 patient activity and through October this trust had the highest levels of COVID-19 activity across the region. As of 19 October 2020, the percentage of beds occupied by COVID-19 patients was 24% (34% including suspected COVID-19 patients), compared to 15.4% in the previous week. The percentage of beds occupied by non-COVID patients was 50% as of 19 October. The number of beds available overall had been below expected since September and numbers decreased further in October.

We spoke with senior leaders on the day of inspection for the trust's action to ensure immediate patient safety. The trust identified immediate actions in response to the concerns identified.

Following the inspection, we reviewed information the trust had provided to CQC before the inspection and our evidence gathered during our onsite inspection. We found there was a lack of robust systems and processes to monitor the quality of the care patients received at both hospital sites in the medical core service.

We formally wrote to the trust following our inspection and clearly identified the significant patient safety concerns we had found with regards to nutrition and hydration; infection prevention and control; staffing; assessment of health needs, implementation of care and documentation and operational oversight and governance. We asked the trust to take urgent action and provide a detailed response with action plans to mitigate the risks to patients.

Provider response

The trust provided a detailed response with immediate actions they had taken to mitigate the risks to patients. These included: -

- Identification of additional senior leadership capacity and support for the Specialist Medicine Division.

- A briefing with the Matrons and Ward Managers from the Chief Nurse, focusing on infection prevention and control, staffing, risk assessments and nutrition and hydration.

- Establishment of an overview and scrutiny meeting with the Divisional Director of Nursing and matrons, for review of staffing and quality metrics related to falls, pressure ulcers, nutrition and hydration and the matrons' checklist.

- Development of a "Safe Nursing" strategy as part of the trust's approach to quality and safety.

In addition to their assurances of the immediate improvement actions taken, the trust provided further details of their continuing actions to improve the safety and quality of medical care services.

Following the inspection, we issued the trust with seven requirement notices with actions they must complete.

We will continue to monitor the trust through our engagement to ensure that the risks to patient safety have improved, that there is evidence of continuing and sustained improvements and that these improvements are embedded across the service.

Medical care (including older people's care)

Inspected but not rated

Key facts and figures

The medical care core services at the Royal Liverpool University Hospital span across three divisions (acute and emergency medicine, specialist medicine and diagnostic and support services). Medical care is provided 24 hours a day, seven days per week and primarily serves the population of Liverpool and the wider Merseyside area

Between 28 and 29 October 2020 we carried out a focused inspection at Royal Liverpool University Hospital that covered elements of the four key questions: is the service safe, effective, caring and well-led? In a three-week period prior to inspection, serious concerns about patient safety and care had been raised to us. These included concerns regarding the provision of adequate nutrition and hydration, the meeting of people's hygiene needs, staff being unable to provide care, the effectiveness of infection prevention and control practices, and staffing concerns. In response to the concerns, we carried out a focused inspection to review the processes, procedures and practices within the medical division at Royal Liverpool hospital. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We visited wards 2B (Elderly Medicine), 3A (Cardiology), 3X (Step-up ward for high dependency care), 5A (Cardiology), 7A (General Medical) and 9Y (Escalation ward).

We observed care and treatment and documentation in 12 patient records, including do not attempt cardiopulmonary resuscitation (DNACPR), mental capacity assessment, care plans and intentional rounding documentation. We also interviewed key members of staff and the senior management team who were responsible for leadership and oversight of the service. During the inspection we spoke with a matron and 13 members of staff of differing grades, including consultants, doctors, nurses, healthcare assistants and administrative staff.

We completed a short observational framework for inspection (SOFI) to assist our inspection surrounding patient and staff interaction and communication. SOFI is a tool developed between the Centre for Applied Dementia Studies and the Care Quality Commission (CQC) and is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves.

We spoke with 13 patients during this focused inspection with regards to key questions in safe, effective, and caring.

The inspection was carried out by a CQC inspection manager, and two CQC inspectors.

Overall summary

We found the following issues needed improvement:

The service did not always control infection risk well. The systems in place to manage infection prevention and control were not always followed by staff. There was no evidence of leaders taking action to ensure compliance and mitigate these risks, which meant patients could be exposed to the risk of harm.

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always have access to enough suitable equipment.

Medical care (including older people's care)

Staff completed but did not always update risk assessments for each patient and removed or minimised risks. Staff did not always follow all the systems that were in place to identify and take action where patients were at risk of deterioration.

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Frequent staffing shortages meant there were occasions when staff were unable to meet the basic care needs of patients.

Staff kept records of patients' care and treatment. Although records were clear and easily available to all staff providing care, they were not always up-to-date or stored securely.

The service used systems and processes to prescribe, administer and store medicines but staff did not always follow processes for recording medicines administration. Agency staff did not always have access to the electronic patient medication system.

Staff recognised but did not always report incidents and near misses.

Not all patients requiring dietetic review received this in a timely way, including some with significant nutritional needs. Through our review of the information, we were not assured the trust had a robust system in place to manage patients' nutritional and hydration needs. This meant patients may or will be exposed to the risk of harm. However, from our observations on inspection we saw staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Staff treated patients with compassion and kindness, respected their privacy and dignity, but did not always take account of their individual needs in a timely way. Staff did not always provide emotional support to patients to minimise their distress.

Leaders were not always visible and approachable in the service for staff.

Culture in the service was mixed and not all staff said they felt respected, supported and valued, or able to raise concerns without fear.

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Ward quality audits had been commenced but were not fully embedded. Although the trust was facing a surge of demand, leaders had taken a decision not to escalate their status through the NHS Operational Pressures Escalation Framework. However, we were informed that local arrangements were in place with system partners and being co-ordinated through NHS E/I's specific COVID-19 incident control function using the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework..

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However:

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Medical care (including older people's care)

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Is the service safe?

Inspected but not rated

Infection Prevention and Control

The service did not always control infection risk well. The systems in place to manage infection prevention and control were not always followed by staff. There was no evidence of leaders taking action to ensure compliance and mitigate these risks, which meant patients could be exposed to the risk of harm.

The hospital had designated areas for COVID-19 positive and negative patients and had a one-way system signposted at entrances and exits to wards. All areas we visited were visibly clean but cluttered. Where we observed cleaning practices during inspection, these were to a reasonable standard, however cleanliness checks across equipment and areas such as sluices, bathrooms and other patient and staff areas, were inconsistently completed and were on some shifts were completely missed.

We saw that doors to side rooms and bays on some wards were not consistently kept closed and that staff did not always follow national guidance in relation to COVID-19, including infection control principles, and correct use of personal protective equipment (PPE). On ward 7A we saw a door remained open to a ward bay area where patients who had tested positive for COVID-19 were being treated. We spoke to the ward manager who confirmed it should be closed but did not take immediate action to correct this. On ward 2B we saw staff left the door open to a bay, where patients were being treated who had tested positive for COVID-19, whilst staff sat outside to complete the patients' notes.

Personal protective equipment was available for staff outside most bays and side rooms on wards. However, we found on ward 2B there were no aprons available outside two bays used to care for patients who had tested positive for COVID-19. We saw a member of staff leave a bay and walk down the ward before they remove all items of PPE; on ward 7A we observed another member of staff removing PPE outside a COVID positive bay. These actions were not in accordance with the trust's infection prevention and control procedures.

On another ward we also saw a box with no lid utilised as a bin for used PPE, which would not meet expected standards for hygiene.

Staff did not always support patients to follow infection prevention and control measures to limit the spread of infection. We saw a patient leave a bay which was used to care for COVID-19 positive patients; the patient had their mask under their chin and was walking up and down the corridor, using shared patient facilities, therefore putting other patients and staff at risk of transmission. We observed that staff did not challenge or assist the patient.

Environment and equipment

Medical care (including older people's care)

The design maintenance and use of facilities, premises and equipment kept people safe. However, safe storage of oxygen cylinders required improvement.

On one ward we saw full and empty oxygen cylinders were stored together in an unlocked storeroom. On ward 9Y the lock to the medicines room was broken allowing open access. We raised this to the ward manager at the time of inspection who said this was being followed up immediately. The trust confirmed this work was completed as part of the initial inspection feedback.

Assessing and responding to risk

Staff completed but did not always update risk assessments for each patient or take action to remove or minimised risks. Staff did not always follow all the systems that were in place to identify and take action where patients were at risk of deterioration.

We found most initial patient risk assessments were completed; however, risk assessment reviews and associated care plans were not always fully completed. This meant that changes in a patient's condition may not have been recognised and appropriate and timely intervention to maintain patient safety may not have been implemented.

Whilst staff completed initial falls risk assessments for patients in line with trust policy, which stated all patients over 65 years old should have a falls risk assessment, not all patients had completed associated falls care plans and not all risk assessments were fully reviewed and updated. On ward 2B, we saw a patient had not had a vision assessment completed as part of their falls risk assessment and an overall risk score was not completed.

We found inconsistencies and gaps in the documentation of specific patient care interventions, in relation to wound care, diabetes monitoring and comfort checks.

For example, for one patient on ward 3A we saw a wound assessment and care plan was completed on 23/10/2020 but there was no further wound care documented on the care plan until 28/10/2020.

We reviewed paper records for an insulin dependent diabetic patient with complex needs and found there were several gaps evident in the recording of blood glucose recordings between 22 October 2020 and 29 October 2020. On 23 and 24 October 2020 there were no entries documented on the paper record until 24 October 2020 at 23:10. Following inspection the trust provided information which stated the ICE system for recording investigations requested, the date blood samples are collected and received, and the date and time they are reported, demonstrates that 37 blood glucose checks were undertaken for this patient between the times noted from 24 to 27 October 2020.However,the use of two systems for recording the same information, demonstrated the potential for discrepancies in recording blood sugar levels. Therefore, there was a potential risk to appropriate timely response, and safe management of diabetic patients.

We found gaps in the recording of IV insulin infusion rates. We reviewed paper records for an insulin dependent diabetic patient with complex needs and found there were gaps evident in the recording of infusion rates. We saw IV insulin rates had not been recorded consistently or signed for on seven occasions on 27 October 2020 and three occasions on 28 October 2020. Following inspection, the trust informed us that IV Insulin rates are recorded on a paper chart and entered on electronic systems. The use of two systems for recording the same information, demonstrated the potential for discrepancies in recording IV insulin infusion rates. Therefore, there was a potential risk to appropriate timely response,

and safe management of diabetic patients.

We saw another patient's peripheral vascular catheter (PVC) care plan which was completed on 24/10/2020. However, it was also documented that the PVC was removed on 23/10/2020.

We found staff recorded comfort checks or patient 'rounding' in different ways on each ward visited. This made it difficult for staff to confirm whether patient comfort checks had been completed or not. This was further compounded by the high usage of agency staff in the service. Patient 'rounding' is a process of regular nursing checks to ensure patient's fundamental care needs are being met.

Staff used the National Early Warning Scores (NEWS2) nationally recognised tool to identify deteriorating patients. Records we reviewed showed scores were correctly calculated, with isolated exceptions, and that patients were escalated for medical review from this.

We observed a nursing handover meeting on ward 7A and saw it contained all relevant information needed to keep patients safe. We also saw the meeting was interrupted several times and held in an open, noisy area, with the risk important patient information was not fully and effectively shared.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Frequent staffing shortages meant there were occasions when staff were unable to meet the basic care needs of patients.

Ward staffing, absence and nurse deployment was monitored by matrons at regular bed meetings held three times daily.

Senior nursing staff were not always supernumerary and needed to work in the daily staffing numbers due to staff shortages, particularly on ward 7A. There were delays in redeployment of staff to support areas with staffing shortages and staff told us this meant they could not always meet the basic personal care needs of patients.

Some staff we spoke with said they had worked shifts where staffing numbers were not sufficient to safely care for patients. We were given examples where staff were left on their own for some time before additional staff were deployed. Several staff told us they had been working extra hours and moved from other wards due to the staffing shortages.

Ward managers we spoke with told us all bank and agency staff received a full induction onto the ward.

There were mixed views on staffing from the patients we spoke with they told us 'the staff are run ragged, but they check on you. I've no complaints" and "Plenty of staff when we need them"

Total staff absence for nursing and midwifery staff between the 6 and 12 October 2020 was 12.6%. This was the second highest rate of staff absence for NHS Trusts in the northwest region. Of this total, 7.7% were COVID related absences.

There was evidence of incident reporting of staff shortages, with 102 incidents reported across two particular wards in the six months prior to inspection.

Medical care (including older people's care)

We reviewed incident data on the national reporting and learning system (NRLS) for the trust covering the time period 01 April 2020 - 14 October 2020 and found that between 01 April 2020 and 14 October 2020, the below incidents were reported through the NRLS system in relation to staffing issues at the Royal Liverpool Hospital site:

■ 59 incidents with ward 3 mentioned

■ 43 incidents with ward 9 mentioned

Through our review of the information and our onsite inspection we could not be assured that patients were always being cared for by sufficient numbers of suitably skilled, qualified and experienced staff.

Records

Staff kept records of patients' care and treatment. Although records were clear and easily available to all staff providing care, they were not always up-to-date or stored securely.

Staff recorded a summary of comfort checks and activity for each patient for each shift in an electronic patient record system called PENS. We found records of care and treatment, as outlined in the patient's care plan, were not always completed for every shift.

We saw staff did not always fully complete care records, with dates and signatures. For example, we saw one patient's pressure ulcer care plan and associated notes were not dated so staff could not be sure when pressure ulcer care had been given. However, we saw fluid balance charts had been completed in records we reviewed.

Electronic records were not always stored in a confidential way. At each nursing station, we frequently saw screens displaying patient details, were left visible on unlocked computers. These displayed patient identifiable information, including their name, current early warning score and time when observations were due.

From our review of national reporting and learning system (NRLS) information, we found between 01 April and 07 October 2020 there were four incidents of records being returned from offsite scanning due to wrong patient information in the record, and another incident of documents for three different patients being filed in a patient's folder.

Medicines

The service used systems and processes to prescribe, administer and store medicines but staff did not always follow processes for recording medicines administration. Agency staff did not always have access to the electronic patient medication system.

We saw in one case that IV insulin rates had not been recorded consistently or signed for on seven occasions on 27 October 2020 and three occasions on 28 October 2020.

We were told that many agency staff were unable to access the electronic patient medication system, which impacted on the delivery of timely medicines.

Incidents

Medical care (including older people's care)

Staff recognised but did not always report incidents and near misses.

‘Whilst we saw there was evidence of incident reporting in relation to staffing, several staff we spoke with during inspection. told us they were discouraged from reporting incidents, especially those relating to staffing shortages.

Is the service effective?

Inspected but not rated

Nutrition and hydration

Not all patients requiring dietetic review received this in a timely way, including some with significant nutritional needs. Through our review of the information, we were not assured the trust had a robust system in place to manage patients’ nutritional and hydration needs. However, from our observations on the days of inspection we saw staff gave patients enough food and drink to meet their needs. The service made adjustments for patients’ religious, cultural and other needs.

During the inspection we saw food and drink record charts were completed in patient care records. Some patients we spoke with confirmed they were given enough to eat and drink. However, we also heard less positive experiences, such as "I'm lucky to get a drink, my mouth gets really dry as I'm on steroids.", and another patient agreed saying "Yes, only if you press the button". We saw occasions where staff prompted patients to eat and drink and offered help, where needed. Catering staff explained how they could order meals for different dietary requirements including religious requirements.

In the records we reviewed the Malnutrition Universal Screening Tool (MUST) was not always fully completed in line with trust guidance for weekly reviews. This meant there were delays in appropriate referrals to dietetics services. Within the MUST documentation, there was no evidence of clinical goal setting or actions recorded, such as referral to dietetics, or identified feeding plans for those with high-risk scores. Following our inspection, the trust reviewed patient records and told us the patients identified had received adequate dietetic reviews'.

We reviewed incident data on the national reporting and learning system (NRLS) for the time period 01 April 2020 - 07 October 2020 in relation to nutrition and hydration and found that:

- There were seven incidents which included parenteral feeds not received as prescribed; the trusts’ standard operating procedures were not followed.
- For one patient to meet their nutritional and hydration needs there was a two-day delay in referral to speech and language therapy.
- There were 42 incidents which included one patient who had a 10% weight loss whilst waiting for percutaneous endoscopic gastrostomy (PEG), a 17-day delay in receiving feed via nasogastric tube, one patient was nil by mouth for five days before a PEG was inserted and there had been no referral for assessment before feed was commenced.

In this time period there were two incidents reported by the dietetics team who were concerned about the significant reduction in the number of referrals. These incident reports detail that in the five-week period from 20 April 2020 to 22

Medical care (including older people's care)

May 2020 the dietetic team had identified 140 patients needing a referral to a dietitian based on their MUST scores. This was an average of 28 patient referrals a week, who should have been referred to a dietitian and who otherwise would not have been identified. It was not clear at the time of our inspection that the trust had put in place actions as a result of these incidents been identified.

Through our review of the information and our onsite inspection we were not assured that that the trust had robust systems in place to manage patients nutritional and hydration needs. Following the inspection, the trust informed us that following their review of dietetic referrals for October 2020, these had met expected levels.

Is the service caring?

Inspected but not rated

Compassionate care and emotional support

Staff treated patients with compassion and kindness, respected their privacy and dignity, but did not always take account of their individual needs in a timely way. Staff did not always provide emotional support to patients to minimise their distress.

During our observations we saw staff were discreet and respectful when caring for patients, respecting their privacy. We observed staff drawing curtains round the bed space when delivering personal care, explaining clearly to patients the reason for their intervention and asking permission.

We saw most staff respond to patients' requests in a kind and caring manner although on occasions we saw staff did not take time to interact with patients and those close to them in a respectful and considerate way. We observed there was a 20-minute delay before any staff member responded to one patient calling for assistance. We observed another patient who was distressed and agitated within the view of staff, and staff did not respond for a period of time.

As part of the inspection, we carried out observations using the Short Observational Framework for Inspection (SOFI) method during our inspections on wards 2B, 7A and 9Y. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the patients, the type of activity or non-activity they were engaged with and the style and number of staff interactions with patients. In each time frame there may be more than one type of engagement and multiple interactions with staff. Staff interactions are categorised as positive, neutral or poor. Some examples of positive interactions would include displaying respect, warmth and providing enablement for patients. Negative interactions may include withholding behaviour, such as refusing to give asked for attention, or not meeting an evident need; or failing to acknowledge the reality of a patient.

The observations took place in bays at a mealtime. The observations lasted between 10 and 20 minutes. We observed 17 patients and six members of staff.

- The general mood state for patients throughout the observations was neutral for 91.5% of the period, 3.5% of the time it was positive and 5% of the time it was negative.

Medical care (including older people's care)

- In 15.8% of the time frames the patients were engaged with a task such as eating their meal. In 54% of the time frames there was engagement between patients and staff or visitors.
- There was some interaction with staff in 52% of the time frames. There were 55% of staff interactions that were neutral, 45% were positive and none were poor.

Most patients told us they could reach call bells and staff responded quickly when called. Patients we spoke with said staff treated them well and with kindness.

Is the service well-led?

Inspected but not rated

Leadership

Leaders did not always understand and manage the priorities and issues the service faced. Leaders were not always visible and approachable in the service for staff.

1. We received concerns about patient care and safety at both sites prior to the inspection. We raised these with the trust and asked for assurance of how they were assuring patient safety at the point of delivery. We received information from the trust which provided some assurance about senior nurse review of clinical areas such as environment, patient experience and infection prevention and control. However, there was no evidence or information provided that patients had their health needs assessed, appropriate risk assessments were completed, and care plans reflected that person's needs.
2. The trust provided details of matron reviews which indicated some concerns regarding infection prevention and control and social distancing of patients in five bedded bays, provision of hand wipes/ gel for patients and cleaning of equipment between uses. However, there was no information provided on the actions taken to mitigate these risks.

During the inspection, most staff told us senior leaders did not visit the ward areas during COVID-19; some felt the senior leaders were not visible otherwise.

CQC formally wrote to the trust to notify them of the serious patient safety concerns that had been identified and to provide further information on the immediate actions put in place to mitigate the risks to patients. Following the inspection, the trust told us of the immediate actions they had taken, which included additional senior leadership capacity and support for Specialist Medicine Division; circulation of communications to all staff how they value their staff and encouraging them to raise concerns.

In addition, the trust informed us that to ensure a level of independent scrutiny, an additional regulatory compliance meeting would be held every two weeks to seek assurance and ensure progress was achieved. This would be reported through to the Quality Committee in due course. The Director of Operations for Specialist Medicine would be chairing an overview and scrutiny meeting with the Divisional Director of Nursing and Matrons to provide enhanced oversight and scrutiny. The forward plan for staffing and quality metrics related to falls, pressure ulcers, nutrition and hydration and the matrons' checklist would be reviewed at this meeting. The Chief Nurse and the Director of Patient Safety were developing an overarching "Safe Nursing" Strategy which would form part of the Trust approach to Quality and Safety.

Culture

Medical care (including older people's care)

Culture in the service was mixed and not all staff said they felt respected, supported and valued, or able to raise concerns without fear. However, we observed staff working extremely hard to provide treatment and care under difficult circumstances during the current COVID-19 pandemic.

Some staff we spoke with during inspection told us they did not feel able to raise patient safety concerns regarding incidents or staffing and were not supported by managers when doing this. They told us they felt that managers adopted a 'just get on with it' attitude. We were told they were not supported when they raised potential issues of bullying. However, we also heard mixed views from staff with some saying they did feel supported and confident to raise concerns.

We observed staff working extremely hard to provide treatment and care under difficult circumstances during the current COVID-19 pandemic. During October 2020 the North West region saw an increase in COVID-19 patient activity and through October this trust had the highest levels of COVID-19 activity across the region. As of 19 October 2020, the percentage of beds occupied by COVID-19 patients was 24% (34% including suspected COVID-19 patients), compared to 15.4% in the previous week. The percentage of beds occupied by non-COVID patients was 50% as of 19 October 2020 and 15% of beds were unoccupied (compared to 12% in the previous week up to 12 October 2020). The number of beds available overall has been below expected since September and numbers decreased further in October (over a hundred beds were still unoccupied in the week up to 14 October 2020).

Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Ward quality audits had been commenced but were not fully embedded.

Although the trust was facing a surge of demand, leaders had taken a decision not to escalate their status through the NHS Operational Pressures Escalation Framework. However, we were informed that local arrangements were in place with system partners and being co-ordinated through NHS E/I's specific COVID-19 incident control function using the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework.

The service had recently introduced the Liverpool Quality Audit (LQA) on wards to assess each areas performance against CQC key lines of enquiry. This was a rolling quality assurance process with each area given a score and reassessed at regular intervals based on the last assessment score. These had been carried out on some of the wards we visited such as 7A.

Matrons conducted monthly audits and did ward walk rounds regularly. They fed back the results of the audits through meetings with ward managers and escalated any immediate concerns on the day of the audit.

During the inspection we met with senior leaders who told us of the trust's response and latest planning during COVID-19. Prior to the second surge in demand, the trust had begun to implement reset plans following the first wave of COVID-19. During COVID-19 the trust reviewed information in dashboards to monitor overall activity, including bed occupancy; critical care bed availability; staff absence and community prevalence. From this monitoring, a building picture of demand was identified during September 2020. The trust's senior leaders met three times a week to agree decisions in response to the changing needs, including transfer of surgical beds for medical care; use of the elective care facility for patients requiring level 2 critical care; and redeployment of theatre staff to critical care and high dependency areas. Leaders described the support through 'mutual aid' working, which was continuing from across the wider health

care system, in agreement with other stakeholder organisations. Although the trust was facing a surge of demand, leaders had not taken a decision to escalate their status through the NHS Operational Pressures Escalation Framework, to provide additional system support for the emergency response using the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework.

Leaders reflected the differences in attendance at emergency departments between the first wave of COVID-19 compared with the current surge in demand; with the continuing high rates of attendance having additional impact on patient access and flow through the hospital. This was also adding to delayed transfers of care and patient discharges. Although there were some plans in development with community partners and other initiatives, including NHS 111, the impact of these was not anticipated to begin until early 2021.

During the call leaders shared examples of collaborative system working in areas, such as maintaining cancer services to meet targets, effective transfer of patients by the NHS ambulance service and working with the local mental health provider to secure services for patients with mental health needs.

Management of risk, issues and performance

Leaders did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However local teams used systems to manage performance effectively.

On 12 October 2020 we received an enquiry which indicated that a ward opened at the Royal Liverpool university hospital site with no staff, no equipment including resuscitation equipment, and this was highlighted as being dangerous to patients and staff. This was raised immediately with the Trust to ensure appropriate emergency equipment was available. The trust provided information to confirm that ward 9Y had since been safely staffed and that emergency resuscitation equipment was available, and this was reviewed and confirmed on inspection.

We also received concerns about patient care and safety at both sites prior to the inspection. We raised these with the trust and asked for assurance of how they were assuring patient safety at the point of delivery. We received information from the trust which provided some assurance about senior nurse review of clinical areas- such as environment, patient experience and infection prevention and control. However, there was no evidence or information provided, that patients had their health needs assessed, appropriate risk assessments were completed, and care plans reflected that person's needs.

Following the inspection, we formally wrote to the trust and raised significant concerns regarding the oversight and management of safe nurse staffing. The trust provided details of actions they had taken, including the establishment of a virtual nurse control centre (VNCC) in October 2020 to manage the nursing, AHP and Healthcare Assistant workforce and related matters during the second in-patient COVID-19 surge. The divisional triumvirate lead on the re-allocation of resource following clinically assessed reduction in activity. The VNCC supported any cross divisional actions ensuring appropriate re-deployment of staff. The VNCC also provided appropriate routes for rapid escalation of key issues.

In response to concerns about staff adherence to infection prevention and control practices, the trust provided a specific improvement plan for the medical wards at the Aintree and Royal Liverpool sites. This identified actions including completion of a daily COVID checklist; peer matron spot checks on a daily basis; frequency of monthly matron audits increased to weekly; and increased frequency of senior nurse walkabouts across medical wards.

Medical care (including older people's care)

In response to concerns about access and flow through the hospital, the trust provided details of a range of meetings and reports to monitor access and flow across the organisation. These included a meeting to support the flow of non-elective and elective admissions whist maintaining safe and effective care within their pathway. There were patient level meetings, unit, divisional and trust wide governance systems to oversee and respond to patient capacity, demand and activity.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure risk assessments and care plans are reviewed and updated for patients to ensure they mitigate risks to patient safety. This includes ensuring tools to identify patients at risk of deterioration are used in an accurate and timely manner by staff (Regulation 12: Safe Care and Treatment).
- The service must ensure the proper and safe management of medicines particularly in relation to timely administration and recording of medicines. (Regulation 12: Safe Care and Treatment).
- The service must ensure they are detecting and controlling the spread of infections, including those that are health care associated. (Regulation 12: Safe Care and Treatment).
- The service must ensure Malnutrition Universal Screening Tool (MUST) risk assessments are completed correctly and reviewed in accordance with national guidance. The service must ensure patients are referred for assessment of nutritional needs as indicated. The service must review and act on the 42 incidents relating to nutrition and hydration, to ensure patients receive timely nutrition and hydration. (Regulation 14: Meeting Nutritional and Hydration Needs)
- The service must ensure paper and electronic records of care and treatment for patients are accurate, complete and contemporaneous and that patient records are stored securely. Records must be accessible to all authorised staff as necessary in order to deliver people’s care and treatment (Regulation 17: Good governance)
- The service must ensure they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. (Regulation 17: Good governance)
- The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed (Regulation 18: Staffing).

Action the service SHOULD take to improve:

- The service should improve care and treatment to meet the needs of service users and that patient call bells are responded to in a timely way.

Our inspection team

The inspection was carried out by a CQC inspection manager, and two CQC inspectors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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

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