

Southport and Ormskirk Hospital NHS Trust

Southport & Formby District 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

Urgent and emergency services	
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Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the emergency department as an unannounced responsive inspection on 7 March 2018 in response to concerns regarding patient safety and how responsive the department were to people's needs. We had previously inspected the urgent and emergency care service in November 2017, when we rated the service overall as requires improvement and inadequate in terms of patient safety. At this inspection we looked at specific areas of concern including: patient safety, medicines, staffing levels, the environment, infection prevention and control, record keeping, mandatory training of staff, how services were planned, whether services met patients' individual needs and how the flow of patient through the department was managed. We wanted to make sure patients were receiving safe care that was responsive to their needs.

We did not re-rate urgent and emergency care at the time of this inspection. We found the following areas for improvement:

- We had concerns about the safety of patients in the department. This was for a number of reasons. The department did not have enough capacity to accommodate all the patients requiring treatment.
- Patients waited a long time to receive medicines such as pain relief. Handover, initial assessment and responsibility for patients was not happening in a timely manner. Ambulance staff were waiting with patients for excessively long times in the department.
- Records were not completed in a comprehensive way and risk assessments were not documented as being carried out.
- Infection prevention and control practices were not following national guidance: staff were not always washing their hands, using gloves appropriately or arms bare below the elbow. The department was not always as clean as it should be with dirty rooms and smears of bodily fluids on walls.
- There were insufficient staff deployed to the department and from the evidence we looked at, this had been a long-term issue.
- Staff were not up to date with their mandatory training.
- We had concerns about the responsiveness of the department. It was not able to meet the demand from the number of patients attending. The department had severe problems with capacity.
- The hospital was also full to capacity and as a result, emergency department patients were waiting for long periods of time in corridors before being admitted to wards. There was poor flow through the department on to wards and from wards to home. From what we saw and what staff told us, the whole flow of the system did not appear to be working well.
- The department was performing poorly against national government performance indicators such as waiting time targets. This meant patients did not have access to treatment and care in a timely manner.
- There was no system of data validation in place to ensure waiting time information was accurately reflecting the time patients spent in the department.
- Escalation processes in place were not effective and patients were waiting excessive time in the department as a result.

However:

- Staff were working extremely hard to deliver care that was caring and compassionate under very difficult circumstances.

Summary of findings

- We observed staff helping patients and supporting them as best they could.
- Nursing and medical staff worked well together and were doing the best they could for patients.

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

Importantly, the trust must:

- Ensure sufficient medical and nursing staff are deployed in the department to meet the need of patients.
- Prescribe and administer pain relief in a timely way to ensure patients are not left in pain for long periods of time.
- Improve the triage process and take responsibility for patients brought to the department by ambulance and as soon as handover has been carried out, administer their medicines and manage their needs.
- Improve the quality of record keeping and storage of paper records to ensure no information is lost or misfiled. This includes completion of risk assessments, safeguarding, mental capacity assessments and National Early Warning Scores (NEWS).
- Adhere to infection prevention and control standards including cleaning of rooms, and following hand hygiene and other infection control processes.
- Improve data validation oversight.
- Improve the escalation process to ensure senior decision makers are involved in the process as soon as possible.
- Make sure processes for the management of medicines is robust; that expired drugs are removed and replaced and oral medicines are dated and disposed of once expired.
- Ensure all staff follow the same triage process and assess patients in order of urgency and not chronology.
- Ensure patients receiving treatment have privacy and their dignity respected.
- Work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department.
- Work collaboratively with other departments around the hospital to improve the length of time patients wait to see specialist medical staff and reduce the length of time before a decision whether to admit or not is made.

In addition, the trust should:

- Work towards a system, such as a patient group direction, that allows simple medicines such as pain relief to be given by nurses without the need for a doctor's prescription.
- Continue the work being carried out to ensure staff attend their mandatory training in a timely manner.
- Consider having a robust process in place to ensure cannulas are checked for early signs of infection.
- Have a robust system in place to support patients who are self-medicating in the department whilst waiting for treatment.
- Monitor ambient temperature in clinic rooms to ensure medicines are stored within their recommended temperature ranges.
- Have a process for monitoring the compliance of staff against the hospital policy of prescribing all oxygen.
- Have a robust process for making sure all appropriate sepsis patients are started on the sepsis pathway.
- Have a robust process to make sure controlled drugs are routinely checked in line with trust policy.

Summary of findings

- Ensure 'corridor' nurses are fully aware of the 'tag' process should they need to leave their designated corridor area.
- Consider raising the profile of patients living with dementia or a learning disability, or others with additional needs to improve the support they receive in the department.
- Explore alternative ways of discharging patients waiting for social care packages to improve flow through the emergency department.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating Why have we given this rating?

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Southport & Formby District General Hospital

Detailed findings

Services we looked at

Urgent and emergency services

Detailed findings

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Detailed findings from this inspection

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Background to Southport & Formby District General Hospital

Southport and Ormskirk Hospital NHS Trust provides both inpatient and community healthcare to approximately 258,000 people across Southport, Formby and West Lancashire. Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk and District General Hospital. The trust also provides sexual health services for the metropolitan

borough of Sefton. The North West Regional Spinal Injuries Centre is at Southport and Formby District General Hospital and provides specialist care for spinal patients across the North West and the Isle of Man. Services at the trust are commissioned by West Lancashire and Southport and Formby Clinical Commissioning Groups.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Nicholas Smith, Care Quality Commission

The team consisted of two CQC inspectors, one inspection manager and a variety of specialist advisors.

How we carried out this inspection

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse. We previously inspected urgent and emergency services in November 2017 and rated them as requires improvement. At this inspection we did not change our ratings.

We inspected the department as an unannounced responsive inspection on 7 March 2018. We looked at specific areas of concern during this inspection, including: patient safety, medicines, staffing levels, the environment, infection prevention and control, record keeping, mandatory training of staff, how services were

planned, whether services met patients' individual needs and how the flow of patient through the department was managed. We wanted to make sure patients were receiving safe care that was responsive to their needs.

During the inspection we reviewed information from the trust and other stakeholders, spoke with staff and patients and carried out observations of practice and behaviours. We looked at the recent performance of the trust.

We visited:

- the triage areas,
- resuscitation,

Detailed findings

- majors,
- the observation ward,
- escalation wards and the waiting room.

We spoke with 26 staff of different grades and disciplines, including nurses, doctors and the management team. We also spoke with three staff from other organisations who attended the department during our inspection and were regular visitors to the department.

We spoke with seven patients and four relatives and carers in the department at the time of our inspection.

We reviewed 21 sets of patient records including emergency department records, prescription charts and observation charts.

We observed the waiting room and saw direct care and treatment being delivered throughout the department.

Facts and data about Southport & Formby District General Hospital

Southport and Formby District General Hospital provides acute healthcare for patients in the local area. This includes an adults urgent and emergency care service, intensive care and a range of medical and surgical specialities. The North West Regional Spinal Injuries Centre provides specialist care for spinal patients from across the North West, North Wales and the Isle of Man. Across the hospital there were 403 beds including 13 intensive care beds. From April 2016 to March 2017 Southport and Formby District General Hospital had 29,115 inpatient admissions, 48,669 urgent and emergency care attendances and 187,501 outpatient attendances.

The trust employs approximately 2,500 staff.

The urgent and emergency care services at Southport and Formby District General Hospital serves the population of Southport and the surrounding area. The department sees patients over the age of 18. Children and young people attend Ormskirk and District General Hospital for emergency care.

They provide emergency care services including the treatment of minor injuries, urgent medical and surgical presentations and emergency presentations. The department saw 48,669 patients between April 2016 and March 2017. This equated to approximately 133 patients per day.

Urgent and emergency services

Safe

Responsive

Overall

Information about the service

We carried out this unannounced responsive inspection because we received information of concern about the department from stakeholders about staffing levels and overall performance in the department. We also wanted to return to make sure concerns identified at our inspection in November 2017 were being addressed.

The emergency department at Southport and Formby District General Hospital provides urgent and emergency care for patients over the age of 18 who self-present or are brought in by ambulance. They are equipped to treat trauma patients. However, more seriously ill or injured patients are taken to the closest major trauma unit. The department does not have the facilities to treat patients under the age of 18 unless in an extreme emergency if the patient self presents. Patients under 18 requiring urgent or emergency care are taken by ambulance and attended to by Ormskirk and District General Hospital emergency department.

The department has a majors area with 11 cubicles to accommodate patients with more serious conditions; three of these are side rooms used to isolate patients with infections or to give patients more privacy. There is also a resuscitation room with four trolley spaces used to accommodate patients presenting with life threatening conditions. There are eight informal corridor spaces marked with numbers used to accommodate patients. Next to the emergency department there is an observation ward which is designed to accommodate patients who need short term additional observation prior to discharge from the department. There are two designated triage areas within the department; one for patients who self-present to the department and one for patients who present by ambulance.

Summary of findings

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Urgent and emergency services

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- Records were not completed in a comprehensive way and risk assessments were not documented as being carried out.
- Infection prevention and control practices were not following national guidance, staff were not always washing their hands, using gloves appropriately or arms bare below the elbow. The department was not always as clean as it should be with dirty rooms and smears of bodily fluids on walls.
- There were insufficient staff deployed to the department and from the evidence we looked at, this had been a long-term issue.
- Staff were not up to date with their mandatory training.

However:

- The room used to see and support patients living with a mental health condition had two exits, sturdy furniture and was free from ligature points thus providing a safe environment for patients.
- Medicines were stored safely in locked cupboards and fridges.
- The department had a plan in place to address poor mandatory training compliance.

Are urgent and emergency services safe?

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Cleanliness, infection control and hygiene

- At our last inspection we had concerns regarding cleanliness in the department. At this inspection when we visited the department we still found cleanliness to be a concern. We saw bodily fluids on the floor and the wall, an unclean mental health room with a dirty toilet, cups and other rubbish lying around.

Urgent and emergency services

- We observed a patient sitting in the corridor covered in their own blood. We observed that they were still bleeding.
- We spoke with staff about the cleaning cover in the department. They told us that although there was supposed to be a cleaner on duty in the department overnight, they were often moved away from the department to other areas in the hospital. The impact of this was that when the day shift cleaner came to the department, not all of the night shift duties had been completed. Staff acknowledged that the cleaning staff worked hard and did as much as they could in the department. However, they also told us about the impact that moving the cleaning staff away from the department overnight had. We escalated this to the trust at the time of our inspection.
- We observed staff as they carried out their routine duties. We saw that hand washing did not always take place as it should. We saw one member of staff wearing gloves, wash and clean a bed then carry out clinical care of a patient wearing the same gloves. One senior member of medical staff was not arms bare below the elbows. We escalated this to the trust at the time of our inspection.
- We spoke with staff about how they monitored cannulas (small devices inserted in to patient's vein and left in place to make taking blood or giving medicines direct in to the blood stream quicker, easier and less uncomfortable for patients). Best practice states that cannulas should be monitored regularly after insertion to check for site infection. Three staff told us that cannulas were not routinely monitored in the department.

Environment and equipment

- The department had a waiting room next to the entrance to the main department. Reception staff could see the department. If there was a nurse in the triage room, they could see the waiting room. At our inspection, the waiting room was full most of the day and some people had to stand. We noted that two of the seats fixed to the wall were broken and unsafe to sit on. However, they had not been labelled as such. There was a risk of harm to patients if the seats were sat on. We escalated this to the trust at the time of our inspection.
- The department had four resuscitation bays, one of which had equipment to cater for children and young people. However, the department would only treat

children in an extreme emergency as all children who needed emergency treatment were treated at the children's emergency department in Ormskirk and District General Hospital.

- There was a mental health room that was specially designed to support people with mental health concerns. It had no ligature points, solid furniture and two exits for staff and patient safety. There was also a panic alarm system in place.
- The department had a good supply of trolleys and beds. At our last inspection we were concerned that there were insufficient cubicles and beds resulting in patients being cared for on the corridor. At this inspection, there were insufficient cubicles or bays to house the number of patients in the department. As a result, laminated signs had been placed on the corridor to indicate designated spaces. Staff told us that it was usual for patients to be located in the corridor, even overnight. We had concerns about the privacy and dignity of patients because the corridor space was not conducive to preserving these.
- At the inspection patients told us they had been nursed on the corridor overnight. We found evidence that six patients had been nursed on the corridor overnight.
- Cubicles and treatment rooms were an appropriate size and contained the necessary equipment to treat patients safely.
- We carried out a random check of equipment in the department to make sure it had been cleaned and maintained appropriately. There were sufficient supplies and we found no concerns.
- The department had a room that could be used in the event of chemical, biological, radiation or nuclear (CBRN) contamination.
- The escalation area in the department had three beds, oxygen and call bells. It was away from the main department. At the time of our inspection this area was not in use as senior staff had taken the decision due to staffing resource available that it was safer for patients to be cared for within the department and on the corridor.
- We checked resuscitation equipment during our inspection. All trolleys were ready to be used in an emergency and there were records in place to show that trolleys were checked regularly in line with the hospital policy.

Medicines

Urgent and emergency services

- The department did not use patient group directions. These are procedures that qualified nurses can follow to administer patients fitting specific criteria medicines such as pain relief or antibiotics. The impact of this was that only medical staff could prescribe pain relief for patients. Due to the department being very busy, we saw four occasions when patients with high pain scores were left in pain, waiting for medical staff to prescribe pain relief for over an hour. We saw one example of a terminally ill patient who had requested pain relief numerous times for over an hour. The patient had not been provided with pain relief and had decided to self-medicate in the corridor.
 - At the time of the inspection we found no evidence of a policy for self-administration of medicines within the emergency department. We observed that patients held their medicines with them on their bed or trolley. We observed that patients were self-medicating on an informal basis. This represented a patient safety risk as nursing and medical staff did not have oversight of medicines administered.
 - The trust policy for prescribing oxygen stated that all oxygen should be prescribed for patients who require it. We noted three patients with oxygen who had no prescription for it on their medicines chart. This was a breach of the trust policy.
 - We checked the recording for fridge and room temperatures. This is because some medicines must be stored below a specified temperature otherwise they may lose their efficacy. This meant they may have to be destroyed in line with the trusts medicines policy. We found that on the whole, fridge temperatures were recorded consistently. However, we found that the maximum temperature had been exceeded on three consecutive days with no evidence of further action being taken, such as reporting the issue to the hospital pharmacy, or consulting them for advice.
 - When we looked for evidence of room temperature checks, we found that these were not carried out. Medicines room temperatures must also be regularly checked to make sure medicines are being stored at the correct temperature.
 - At the last inspection we had concerns regarding medicines. At this inspection we did a random check of medicines stored in the medicines cupboard to make sure they were within their expiry date. We found that all tablets were within their expiry date. However, we found four opened oral medicines bottles with no date of opening marked. This meant that it was unclear whether they were still safe to use as opened bottles often have expiry dates. When we brought these to the attention of staff, they were disposed of immediately.
 - We checked the controlled drugs cupboards, fridges and documentation. Controlled drugs are specific type of drug that need to be stored and dispensed within strict rules and regulations. We found that most of documentation to show controlled drug totals had been completed.
 - We found one controlled drug item that was out of date with an expiry of January 2018. We brought this to the attention of staff who removed it. They told us that the department often experienced delays in collections of expired controlled drugs by pharmacy. However, the department was not left with any of the same medicines that was in date once this medicine was removed.
 - The department was storing intravenous fluid bags safely and securely in a locked keypad access only cupboard. We checked and found all intravenous fluid bags to be in date.
 - The department were able to access medicines to support patients with addictions, to help them with withdrawal symptoms.
- ## Records
- The department used an electronic system to record patient attendances. Staff used a combination of electronic and paper record keeping tools to record care and treatment
 - We noted that the paper notes for patients in the corridor were loose leaf. There was a risk that documentation could be misfiled or lost. We saw an example of this during the inspection when a test, completed by ambulance crew, showing abnormalities was lost and the patient had to be admitted for further monitoring.
 - The electronic system was displayed on monitors around the nursing station. The monitors were only accessible using a smart card. However, we saw that staff left their cards in machines and machines were unattended on a regular basis. The department was busy and this posed a risk that other patients or the people they attended the emergency department with could have accessed the information on the screen.
 - Once a patient was discharged from the department, all paper records were scanned and archived.

Urgent and emergency services

- Reception staff ensured discharge letters were sent once the patient had left the department.
- We looked at the records of 21 patients who had been in the department in previous days and had since been moved to a ward or been discharged. We wanted to make sure that there was sufficient detailed information within the records to ensure that patients received safe, appropriate and effective care and treatment.
- We had concerns about the standard of record keeping in the department. We found that pain scores were not consistently recorded (12 out of 21 missing). This meant that there was not always evidence that patients' pain levels had been considered. However, three patients who did not have a pain score recorded had been given analgesia.
- Records did not always document whether patients had allergies. Of the 21 records, 14 had no entry, four patients had allergies recorded and four stated that the patient had no allergies. We had concerns about this as there was an increased risk to patients if allergies are not recorded correctly. The records review suggested that patients were not always being asked whether they had allergies.
- There was poor evidence of comfort rounds being carried out. Comfort rounds are regular rounds where patients are asked if they have any needs such as pain relief, food or drinks, or assistance to the toilet. Only six of 21 records showed evidence of a comfort round. However, as we carried out our inspection we saw nursing staff assisting patients.
- Of the 21 sets of records we looked at, only two sets were fully signed and dated
- We looked at the standard of other records kept in the department such as cleaning logs, medicines fridge checks and resuscitation trolley checks. We found that these were completed
- Staff told us that record keeping quality audits did not take place in the department therefore there was no assurance that clinical records were of a good standard or met the Royal College of Nursing standards for record keeping.

Mandatory training

- On the inspection senior staff gave us the most up to date training information which had recently been presented to a board meeting
- This was only an overall figure and was not split by the different modules of mandatory training. The

information showed that as of February 2018 emergency department staff had improved from 71.8% in November 2017 to 78% compliance in February 2018. This was against an overall target of 85%. The departments performance was worse than the trusts performance overall.

- We spoke with the newly appointed practice education facilitator, matron and major trauma nurse coordinator about training levels within the department. They showed us evidence of their training plans for the department. They had a clear plan for improving attendance at mandatory training and improving overall mandatory training.
- The department had carried out some work to look at why mandatory training levels were low. They found that staff could not always be released for training due to patient demand in the department, challenging patient flow throughout the hospital impacting on the emergency department and high staff sickness absence rates. We spoke with staff who told us the same reasons why they were not always able to attend mandatory training.
- We had concerns that not all medical and nursing staff were up to date with mandatory training. There was a risk to patients of out of date or inappropriate care and treatment if staff are not up to date with mandatory training.

Assessing and responding to patient risk

- The department used the Manchester triage system. This is a well-known and established triage system used by many emergency departments across the country. Triage allows staff to establish initial symptoms, identify the most poorly patients and ensure that these patients are treated as a priority.
- We discussed triage with a number of staff both clinical and non- clinical. Clinical staff told us there were triage guidelines, however; we did not see them. Some staff told us that the triage system worked differently depending upon who was carrying out triage. For example, some would assess the pile of patient records quickly to see who needed to be seen most urgently, looking for key phrases such as chest pain. However, other staff worked through the pile of patient records in strict chronological order. We had some concerns about the latter method as this could mean that sicker patients were not being identified as quickly as they should be.

Urgent and emergency services

- Staff told us that to undertake triage they had to have undergone specific triage training and be assessed as competent before working in the triage area. Staff told us that triage was only suitable for more experienced staff and newly qualified staff would not be expected to work in triage until they were fully competent and had experience.
- Patients had to wait for triage, particularly patients brought in by ambulance. Patients queued in the corridor for long periods of time both before and after triage. Even after formal handover, when patients had been booked on to the emergency department's records system, ambulance staff were expected to stay with patients. We were told that ambulance crews were left waiting with patients for hours before being able to leave and be ready to respond to other emergency calls. Handover times we reviewed confirmed this information. We escalated this issue to the trust at the time of our inspection.
- The Royal College of Emergency Medicine recommends that patients should wait no more than 15 minutes from arrival to initial assessment. The median time to initial assessment for patients brought by ambulance in January 2018 to March 2018 was zero. This was compared to the England median time of nine minutes. During our inspection we identified that there had been a data collection error that the trust had failed to identify prior to submitting data to NHS England for national statistics. As a result of this error, there was no accurate measure of time to initial assessment available for this department. We escalated this issue to the trust at the time of our inspection.
- We carried out observations of the waiting room during our inspection. We observed patients waiting up to 35 minutes for initial assessment.
- The department had an adult sepsis pathway. At previous inspections we had concerns that patients were not always being recognised as needing to be on the pathway. At this inspection we looked at the pathway and patients in the department to ensure that all patients at risk of sepsis had been appropriately identified. We saw one patient brought to the department with a provisional diagnosis of sepsis. They were assessed in a timely way and appropriately placed on the pathway. We identified one patient with a sepsis diagnosis who had not been started on the sepsis pathway. From the evidence we found, patients were not consistently being started on the sepsis pathway.
- Whilst looking at historic records, we found evidence of a patient on the sepsis pathway who waited 50 minutes from arrival to initial assessment when they were started on the pathway. This meant that there was a delay in the patient receiving their first antibiotic medicine for their condition. Patients should receive initial assessment within 15 minutes and The National Institute for Health and Care Excellence (NICE) guidance states patients should receive intravenous antibiotics within 60 minutes.
- The department had a designated sepsis lead and there was a keypad activated cupboard containing specific equipment and drugs for patients with sepsis. This meant that medicines were easily accessible when required.
- The department used the national early warning score (NEWS) for patients to assist in monitoring patients and identifying when a patient's condition was deteriorating. Staff were aware of the action they should take if a patient deteriorated and there was a process in place for staff to follow. We looked at the records of 21 patients in the department and found that NEWS had been completed regularly for 10 patients. This meant that patients were at risk of not being identified as deteriorating in a timely manner.
- We saw NEWS being used at board rounds between medical staff. Board rounds were held every two hours. Patients were presented to the consultant in charge to discuss concerns or future management (treatment) plans and for advice if required.
- During the inspection we observed a patient being moved from the resuscitation area to the corridor area. However, they quickly deteriorated. We pointed this out to the nurse in charge who arranged for the patient to be moved back to the resuscitation area. We also observed a 20 minute period when the corridor had no nurse to oversee patients. This was against trust policy which states there should be a nurse on the corridor at all times and if they had to leave, they should 'tag' another nurse to take over responsibility for patients. We had some concerns that the processes for identifying deteriorating patients were not as robust as they should be. We escalated these issues to the trust at the time of our inspection as we observed staff were not responding to deterioration in patients. It was unclear whether missed deteriorating patients were reported as incidents and we did not look at incident reporting as part of our responsive inspection.

Urgent and emergency services

- We found that all patient assessments were not always carried out, or documented if not required. For example, pressure care, nutrition and hydration needs and falls assessments were not routinely completed for patients. This meant that patients were at an increased risk of harm from inappropriate or unsuitable care. Of the 21 records we looked at 15 had not been fully completed.
- Staff were not consistently completing safeguarding assessments. These should be carried out for every patient and when no risk is identified, this should be recorded as such. Of 21 records we saw, five had documented safeguarding concerns that had been considered. This meant that safeguarding was not being considered for every patient and represented a patient safety risk.
- Although all patients are assumed to have capacity to understand information and make decisions, some patients are at risk of fluctuating capacity and may not be able to make decisions or give consent for care or treatment. Of 21 records, five had completed assessments, three were recorded as not applicable and 13 had nothing recorded to give an indication either way.
- We saw one example of an older patient with mental health needs who should have undergone a mental capacity assessment but had not. This meant they were at risk of not understanding fully the implications of decisions they were being asked to make. We did however also see a further example of a patient who had fluctuating capacity where all appropriate documentation was completed. Our concern was that staff were not documenting mental capacity assessments and that some patients who lacked capacity may not be identified as such. This posed a risk that patients may not get the support they need and give valid consent.
- Clinical records were unable to assure us that patients were asked about any known allergies as 11 of 21 did not show whether the patient had been asked about allergies. Additionally, the department did not use a process, such as a wristband, to easily identify patients who had allergies. Therefore, staff relied on clinical records to identify patients with allergies. Because of this, there was a risk that patients could receive medicines they had sensitivities or were allergic to.
- Following the last inspection, we wanted to make sure that staff had undergone training about domestic violence and female genital mutilation (FGM). We spoke with staff about safeguarding vulnerable people.
- Staff told us that domestic violence and female genital mutilation were included in safeguarding vulnerable people training. The staff we spoke with could tell us about female genital mutilation and the action they would take if they came across a victim or someone they had concerns about.
- There were laminated flyers and leaflets in the majors department and resuscitation department to support staff and to give to patients.

Nurse staffing

- On the day of the inspection the department was short staffed. Senior staff told us there should be 12 qualified nurses on duty. However, the trust later told us the allocated staffing level for the department was 11 qualified nurses. At the start of our inspection there were eight staff on duty. This is a fill rate of 72%. This meant that the department was under significant staffing pressure. As a result, there were insufficient staff for the department to open the three-bedded escalation area. By 10am a further qualified nurse started working in the department.
- Staff told us the department was often short staffed and that there was a reliance on bank and agency staff to bolster staffing levels.
- During our inspection we overheard staff being asked to work there even though they had not worked in the department before.
- At the time of the inspection the department had a vacancy rate of five whole time equivalent (WTE) qualified nurses.
- Staffing levels were reviewed every six months. Just after our inspection, the trust carried out a review and agreed a further 10 WTE staff to support the expanding size of the department. The trust reported that recruitment to these posts had commenced.
- Trust guidance stated that there should be a nurse allocated to look after every four patients in the corridor. During the inspection there was one nurse allocated to look after eight patients. There was a period of 20 minutes when there was no nurse looking after patients in the corridor.

Safeguarding

Urgent and emergency services

- We had significant concerns about the staffing levels in the department. We looked at staffing rotas for December, January and February. We identified a number of concerns:
- Nurse practitioners and advanced nurse practitioners were being used during the day and over night to supplement the number of registered nurses in the department. However, nurse practitioners and advanced nurse practitioners are responsible for specialist duties such as treating minor injuries and illness.
- Only 17 of 91 night shifts had the actual planned number of qualified nursing staff (not supplemented by nurse practitioners or advanced nurse practitioners) on duty however 37 further night shifts were supplemented by advanced nurse practitioners and nurse practitioners. Of the nights, 12 had agency staff working. On five of 12 occasions there were three agency staff working a night shift.
- On 61 of 91 day shifts the department had less than their planned staffing levels (discounting nurse practitioners and advanced nurse practitioners who had their own caseload of patients to manage), on six they had more and on 23 they had their actual planned level. Agency staff were used on 14 days.
- Not all day shifts had advanced nurse practitioners cover with 25 days having no advanced nurse practitioners on shift (maximum of four on other day shifts). There was no guidance to say how many advanced nurse practitioners there should be.
- There were 41 days when the number of registered nurses (excluding nurse practitioners and advanced nurse practitioners) on duty was under ten and no additional staff were booked.
- There were 28 nights when there were less than nine registered nursing staff (excluding nurse practitioners and advanced nurse practitioners) on duty and no additional staff were booked.
- The trust told us that there were only two days in the period when minimum staffing levels were not met. They told us there had been no incidents of patient harm reported on either of these days.
- We spoke with medical staff during our inspection. They told us that overall, they were well supported by senior medical staff. However, when the department was busy, they felt under pressure and could not always see patients as quickly as they wanted to.
- Staff told us that there was a reliance on locums to keep the rota covered. However, they were usually block booked and, therefore; familiar with the department. Locums told us they had full access to all information technology (IT) systems and, therefore; did not need to rely on other staff to get test results.
- Some medical staff were concerned as they had been told that the number of locums was being reduced but with no substantive replacements. They also told us that the clinical fellows (a grade of senior medical staff) role had been abolished. However, we were unable to corroborate this when we spoke with senior staff.
- The department held regular two hourly board rounds attended by all medical staff in the department as well as the bed manager and the nursing coordinator. We observed one of these and saw it to be very comprehensive with NEWS used and management plans discussed for the benefit of patients.
- Medical staff told us that team work in the department was 'phenomenal'.
- Information the trust sent us in October 2017 showed the department had a smaller percentage of consultant staff than the England average (22% compared to 29%) and a higher percentage of junior medical staff (30% compared to 25%). Middle grade and specialist trainee percentages were about the same as the England average.
- We looked at staff rotas for January 2018 and February 2018. These showed that there were times when there was a minimum of two junior doctors on duty and a minimum of one middle grade doctor on duty.
- The February rota showed more reliance on locum staff with 40 shifts being covered by locums. Of the 40, four were to cover consultant shifts.

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

We did not re-rate urgent and emergency care at the time of this inspection. We found the following areas for improvement:

Urgent and emergency services

- We had concerns about the responsiveness of the department. It was not able to meet the demand from the number of patients attending. The department had severe problems with capacity.
- The hospital was also full to capacity and as a result, emergency department patients were waiting for long periods of time in corridors before being admitted to wards. There was very poor flow through the department on to wards and from wards home. The department was performing poorly against national government performance indicators such as waiting time targets meaning patients did not have access to treatment and care in a timely manner.
- There was no system of data validation in place to ensure waiting time information was accurately reflecting the time patients spent in the department.
- Escalation processes in place were not effective and patients were waiting excessive time in the department as a result.

However:

- Staff worked hard to meet the needs of patients whilst they were in the department.

Service planning and delivery to meet the needs of local people

- At the time of the inspection the department was full to capacity and there was insufficient space to house beds and trolleys in designated bays/rooms. Consequently, the corridor had eight posters identifying areas of space stuck on the wall. These were named corridor one to eight for the purposes of locating patients. The corridor is an inappropriate area to treat or manage patients. These areas had no oxygen or suction present and no way to ensure patients confidentiality and dignity were protected.
- The department was in the process of building an area to house further escalation beds. This was in recognition of the increasing demand on the department. However, the process was not expected to be ready for use for some months.
- The department had a service level agreement in place to support and manage patients living with a mental health condition. Staff from the local Crisis team and mental health liaison team attended the department regularly.

Meeting people's individual needs

- During our inspection the department was at capacity for the full day. We arrived at 8am where we found patients still waiting from the previous night. We spoke with patients who told us that they had tried to sleep in the corridor on hospital beds. The patients we spoke with were elderly patients, some of whom were frail or vulnerable, such as those living with dementia. There was no additional support in place for these patients, such as a dementia pathway.
- There were facilities available for patients living with mental health conditions and the designated room was ligature free and free from other hazards that may cause a risk to such patients. The department was able to access mental health support services. This was usually in a timely manner. However, staff told us that there were longer waits overnight.
- There were adequate facilities for patients in cubicles. However, the department was not big enough to manage the number of patients attending. This meant that the department struggled to meet the privacy and dignity needs of patients.
- Staff could access specialist equipment such as bariatric (for patients who are clinically obese) beds, trolleys and wheelchairs.
- Staff told us that they were able to access interpreting services. However, during our inspection we did not see a need to do so.
- Staff in the department tried to meet individual patient needs. However, this was difficult for them because they were unable to dedicate the time some patients needed because they were so busy.

Access and flow

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The median time to treatment for ambulance patients was 71 minutes in January. This was worse compared with the England median of 57 minutes.

Urgent and emergency services

- The median total time in the department for patients not requiring admission in January was 147 compared to the England median time of 129. This means that performance was worse than the England performance.
 - The median total time in the department for patients requiring admission in January 2018 was 348 minutes compared to the England median time of 249. This showed that patients waiting to be admitted waited longer in the department than the England median time.
 - NHS England data for the trust showed that the trust's re-attendance rate to the department within seven days was 7.5%. This was better than the England average of 7.9% for January 2018.
 - At the time of the inspection the department was very busy. There were 28 patients in the department. We witnessed patients waiting on trolleys and hospital beds in corridors. Corridors within the majors department had laminated number signs on the walls to indicate bed spaces. There were six laminated signs plus a further two hand written signs on the walls. This meant that up to eight people were waiting in designated corridor spaces being nursed by emergency department staff.
 - At 11.30am, nine of the patients waiting in the department were waiting for hospital beds on wards throughout the hospital.
 - Some patients on the corridor were actively receiving treatment. For example, we saw patients attached to intravenous infusions (IVI) in the corridor and patients with urinary catheters in place. The corridor area had no oxygen or suction available and no curtains for privacy.
 - The department had an overflow area with three beds, oxygen and suction. However, this area was closed due to low staffing levels in the department.
 - Patients brought to the department by ambulance waited to be triaged in queues at the emergency department entrance. Ambulance staff were unable to leave patients even after formally handing over the patient as hospital staff told us that these patients remained the responsibility of ambulance staff. However, trust staff started giving patients medicines.
- We had concerns about this as patients should be handed over to hospital staff as soon as possible and responsibility for patients should lie with the receiving hospital. We escalated this risk to the trust at the time of our inspection.
- At the time of our inspection, the department did not have a robust system in place for measuring the length of time patients waited from arrival at the department to being seen by triage staff. When we looked at the information the trust submitted on their latest provider information request (PIR) in October 2017, we noted that this information showed a consistent zero value rather than an actual triage time. However, this had not been identified by the trust as a concern as part of their data validation process.
 - We observed three patients being booked in to the department and monitored the length of time they waited to be triaged. We noted that each patient waited longer than the 15 minute good practice target. When we looked at historic patient records we consistently saw that the triage time was exactly the same as the booking in time. We spoke with staff who told us that they were aware of the problem and had been so for several months. We also brought the problem to the attention of senior management at the trust who told us they had known about the problem for about seven days.
 - The department had a bed management policy in place. However, at the time of our inspection, this was not effective in managing demand or facilitating the flow of patients through the department. We asked staff whether they thought the policy was effective. Staff told us that they thought that it was not effective because patients still waited a long time to be admitted.
 - Medical staff told us that there were often delays with specialty staff (other than medicine) visiting the department to decide management plans for patients who needed to go to wards. They said this meant the emergency department bore the pressure of overcrowding and if specialty patients deteriorated, emergency department staff managed them.
 - The hospital had escalation beds on some wards such as the discharge lounge and surgical assessment unit. We spoke with staff from some of these areas. They

Urgent and emergency services

told us they had to accept the patients they were told to receive, some of whom could have complex needs. They confirmed that they didn't always receive extra staff to manage these patients.

- The department was not meeting national waiting time standards.
- Between November 2017 and February 2018, the department failed to meet the 95% four hour target for patients in the department. In week commencing 17 December 2017, 35.7% of majors patients met the four hour target. The department met the 95% target for patients in the minors sector, one week over the period we looked at. The combined performance was consistently under 60% across the period we looked at. The England average was between 85% and 90% during this period.
- Information provided by the trust showed that in the week commencing 17 December 2017 and week commencing 7 January 2018, the trust experienced a high number of patients waiting more than 12 hours

from decision to admit, to being admitted to a ward. National guidance from the Royal College of Emergency Medicine states no patient should wait more than 12 hours in an urgent and emergency care department before being placed on a ward.

- The matron told us that there was a formal process in place for managing 12 hour waits. This included four daily escalation bed meetings with the bed manager and other senior staff. After eight hours from decision to admit, the situation was escalated to the senior manager on call. During our inspection, we saw that there were no beds available in the hospital to move patients to.
- During our inspection we witnessed patients waiting in the department for long periods of time. Some of the patients had been in the department for over 15 hours. These patients were waiting for beds on wards or to be seen by medical staff from other departments within the hospital such as medicine or orthopaedics.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital **MUST** take to improve

Action the hospital **SHOULD** take to improve

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The service did not ensure patients receiving treatment had their privacy and their dignity respected. This was a requirement from our previous inspection in November 2017.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The service did not ensure that patients received care in a timely way.

The trust did not ensure that the service worked collaboratively with other departments around the hospital to improve the length of time patients waited to see specialist medical staff and to reduce the length of time before a decision whether to admit or not was made.

The service did not ensure all staff followed the same triage process and assess patients in order of urgency and not chronology.

The trust did not have a process that meant it took responsibility for patients brought to the department by ambulance as soon as handover had been carried out. The trust's staff did not administer ambulance patients' medicines and manage their needs.

The trust's staff were not prescribing and administering pain relief in a timely way to ensure patients were not left in pain for long periods of time. This was a requirement at our last inspection in November 2017.

This section is primarily information for the provider

Requirement notices

The service did not make sure processes for the management of medicines was robust, that expired drugs were removed and replaced and oral medicines were dated and disposed of once expired. This was a requirement at our previous inspection in November 2017.

Staff within the department did not adhere to infection prevention and control standards including cleaning of rooms, following hand hygiene and other infection control processes. This was a requirement at our last inspection in November 2017.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service's quality of record keeping was not in line with trust policy. This included completion of risk assessments, national early warning scores (NEWS), safeguarding and capacity assessments. Records were not consistently stored appropriately to ensure no information was not lost or misfiled.

The trust did not ensure the data provided by the service was appropriately validated or had sufficient oversight.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust was not ensuring sufficient medical and nursing staff were deployed in the department to meet the need of patients. This was a requirement at our previous inspection in November 2017.