Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Quality Report

Worcestershire Royal Hospital
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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Worcestershire Acute Hospitals NHS Trust on the evening of the 24th March 2015 as a part of a responsive inspection. The purpose of the unannounced inspection was to look at the emergency departments (ED) at Worcestershire Royal Hospital and Alexandra Hospital. The services were selected as examples of a high risk services according to our intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

We did not inspect any other services provided at the trust.

The inspection focused on the safety of patients. We found that improvements were needed to ensure that the EDs were safe.

We also looked to ensure each ED was effective, caring, responsive and well led. However, we did not have sufficient evidence to rate domains.

Our key findings were as follows:

Incidents

- Systems were in place for reporting incidents. However, incidents were not always reported. This meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in these services.

Safeguarding

- Children were not routinely screened for safeguarding concerns.
- We found paediatric patients were at risk because there were inadequate measures in place in relation to their security.

Medicines management

- The systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, were not robust or in line with requirements.
- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.

Staffing

- There was a shortfall in nursing staff numbers. There was no evidence shifts were being planned to reflect the patients' acuity and therefore the planned staffing did not always meet the needs of the patients in the department.
- Senior staff told us they had escalated concerns about staffing and capacity in the department to senior managers as they considered the department was "not safe" at times due to the high volume of patients.
- We saw evidence of the department being "Overwhelmed". However the escalation process could not always been carried out because there were no more staff available. This meant that the department was not able to manage the situation safely.

Medical staffing

- Forty percent of the senior staff were locum.
- There was one consultant on site after 5pm covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This was raised as a concern during a peer review from NHS England. If two trauma patients were admitted at the same time on each site, the protocol was that one of the trauma calls would be led by the orthopaedic doctor.

Environment and equipment

Summary of findings

- We found that staff had not documented daily equipment testing for the resuscitation trolley at Worcestershire Royal Hospital to ensure equipment was fit-for-purpose.
- We found single use items on the resuscitation trolley and in the resuscitation room that had expired. Staff told us they did not always have time to check equipment.
- There was insufficient space within the department to assess patients. When all the cubicles and bays were full, patients were cared for in the corridor. This put patient safety at risk because of reduced visibility of patients when in the corridor.

Ambulance Handovers

- There were delays in handover time from ambulance crew to the emergency department team. This meant that patients, including clinical unstable patients, remained under the care of the ambulance crew longer than expected which delayed initiation of treatment.
- In the past 12 months the trust had not consistently met its 15 minute triage target or its target for patient handovers being carried out within 30 minutes of arrival by ambulance.

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

We found breaches with the following regulations:

- Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].
- Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].
- Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Importantly, the trust must:

- Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff mix in the EDs to ensure people who use the service are safe and their health and welfare needs are met.
- Ensure that all equipment is in date and is checked consistently.
- The trust must ensure that service users are protected against the risks associated with unsafe or unsuitable premises, by means of appropriate measures in relation to the security of the EDs.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		Safety in ED was compromised as appropriate steps had not been taken by the trust to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. Also, the trust had not taken appropriate steps to safeguard the health and safety and welfare of patients by not assessing the needs of the patients when determining the number of staff required to be on duty. The trust had not ensured that suitable arrangements were in place to protect patients who may be at risk from the use of unsafe equipment by not ensuring that equipment was properly maintained and suitable for its purpose. Staff had not documented daily equipment testing to ensure that the resuscitation trolley in ED was fit-for-purpose and we found out of date equipment on the trolley. Patients, including paediatric patients, were at risk because there were inadequate measures in place in relation to their security. For example, the doors leading into the ED were left open during our inspection allowing unauthorised access. Incidents were not always reported and the safety matrix was not always completed. There was not always the number of planned nurses on duty. There was no evidence shifts were being planned to reflect the patients' acuity and therefore the planned staffing did not always meet the needs of the patients in the department. There were delays in handover time from ambulance crew to the emergency department team. Patients waiting to be handed over were cared for on trolleys in a corridor by the ambulance crew. Up to 40% of patients were not triaged within the national triage target and the trust's policy which was for all patients to be triaged within 15 minutes of arrival at the ED. Patients were not always appropriately monitored and we saw numerous examples where patient safety was at risk, for example, medication was not always given in a timely manner. Clinical risk assessments were not always completed for each patient and observations were not always recorded in patient notes for each patient. This put patients at risk because notes were not up to date for all staff to view.

Worcestershire Royal Hospital

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Detailed findings

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Background to Worcestershire Royal Hospital

Worcestershire Royal Hospital provides acute services for the people of Worcestershire and the surrounding areas.

We inspected Worcestershire Royal Hospital on the evening of the 24 March 2014 as a part of a focused inspection. The purpose of this unannounced inspection was to look at the Emergency Department (ED). The service was selected as an example of a high risk service according to our intelligent monitoring model and on the basis of information of concern that we had received.

We did not inspect any other service provided at the hospital.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team of five included one CQC head of hospitals inspector, one CQC inspection manager, one CQC inspector, an emergency department consultant and a clinical fellow.

How we carried out this inspection

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

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

The inspection team inspected the core service at the Worcestershire Royal Hospital:

- Urgent and emergency care

Prior to the unannounced inspection, we reviewed a range of information we held about Worcestershire Royal Hospital and information that we had received from the trust to assure us of patient safety. We asked other organisations to share what they knew about the trust. These included the Clinical Commissioning Groups, the Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

The focused inspection of the emergency department at Worcestershire Royal Hospital took place on 24 March 2015.

Detailed findings

We talked with patients and staff from the ED. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Worcestershire Royal Hospital

Worcestershire Acute Hospitals NHS Trust serves a population of approximately 550,000 people in Worcestershire and the surrounding areas. Over 95,000 patients are cared for each year with more than 130,000 A&E attendances and approximately 500,000 outpatient appointments. The county contains a mixture of urban and rural population.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Worcestershire Royal Hospital was built under the private finance initiative (PFI) and opened in 2002. It serves a population of approximately 550,000 and has 500 beds.

Worcestershire Royal Hospital provides specialist services for the whole of Worcestershire including stroke services and acute cardiac services. The hospital has nine operating theatres including four laminar theatres, a level 2 neo-natal intensive care unit and a cardiac catheterisation laboratory.

The emergency department (ED) at Worcestershire Royal Hospital provides a 24-hour, seven-day a week service. It saw 16,615 patients between 6 April 2014 and 1 February 2015. Patients present to the department either by walking into the reception area or arriving by ambulance. If a patient arrives in the department on foot, they are seen after booking in at reception by a senior nurse who triages them to the appropriate area. If a patient arrives by ambulance, they are transferred to the main ED. The department itself consists of four main areas: 'paediatrics' with two cubicles and one seat, 'majors' with 12 bays, 'minors' with six seated spaces, 10 trolley spaces in the corridor and a four bedded resuscitation room. There is a separate triage area attached to the front reception and an eight bedded clinical decision unit.

We spoke with over 20 members of staff including: nurses; doctors; administrators; and senior managers. We spoke with 15 patients and 7 relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's ED performance data.

Summary of findings

Safety in ED was compromised as appropriate steps had not been taken by the trust to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. Also, the trust had not taken appropriate steps to safeguard the health and safety and welfare of patients by not assessing the needs of the patients when determining the number of staff required to be on duty.

The trust had not ensured that suitable arrangements were in place to protect patients who may be at risk from the use of unsafe equipment by not ensuring that equipment was properly maintained and suitable for its purpose. Staff had not documented daily equipment testing to ensure that the resuscitation trolley in ED was fit-for-purpose and we found out of date equipment on the trolley.

Patients, including paediatric patients, were at risk because there were inadequate measures in place in relation to their security. For example, the doors leading into the ED were left open during our inspection allowing unauthorised access.

Incidents were not always reported and the safety matrix was not always completed.

There was not always the number of planned nurses on duty. There was no evidence shifts were being planned to reflect the patients' acuity and therefore the planned staffing did not always meet the needs of the patients in the department.

There were delays in handover time from ambulance crew to the emergency department team. Patients waiting to be handed over were cared for on trolleys in a

corridor by the ambulance crew. Up to 40% of patients were not triaged within the national triage target and the trust's policy which was for all patients to be triaged within 15 minutes of arrival at the ED.

Patients were not always appropriately monitored and we saw numerous examples where patient safety was at risk, for example, medication was not always given in a timely manner.

Clinical risk assessments were not always completed for each patient and observations were not always recorded in patient notes for each patient. This put patients at risk because notes were not up to date for all staff to view.

Are urgent and emergency services safe?

Safety in ED was compromised as appropriate steps had not been taken by the trust to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. Also, the trust had not taken appropriate steps to safeguard the health and safety and welfare of patients by not assessing the needs of the patients when determining the number of staff required to be on duty.

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Patients, including children, were at risk because there were inadequate measures in place in relation to their security. For example, the doors leading into the emergency department were left open during our inspection allowing unauthorised access.

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There was not always the number of planned nurses on duty. There was no evidence shifts were being planned to reflect the patients' acuity and therefore the planned staffing did not always meet the needs of the patients in the department.

There were delays in handover time from ambulance crew to the emergency department team. Patients waiting to be handed over were cared for on trolleys in a corridor by the ambulance crew. Up to 40% of patients were not triaged within the national triage target and the trust's policy which was for all patients to be triaged within 15 minutes of arrival at the ED.

Incidents

- Staff told us they knew how to complete incident reports and were encouraged to complete reports, including those for overcrowding of patients in the department. However, staff told us that they were often too busy to complete reports and therefore incidents were not always reported.

- NHS Safety Thermometer information showed that Harm Free care between November 2014 and February 2015 Worcestershire Acute Hospitals NHS Trust was between 91.2 and 93.4%. This was worse than the England average for the same period. The number of pressure ulcers and falls with harm in the trust had been worse than the England average in November 2014 but had improved since and in February 2015 was better than the England average. However, the number of venous thromboembolism had increased since November 2014 and peaked in February 2015, making the trust worse than the England average.
- Staff told us that there had been three incidents reported where patients had gone into cardiac arrest in the corridor area within the last three months. Two patients had died as a result. One patient had been in the corridor for two to three hours prior to their deterioration being identified. We saw from the clinical co-coordinator records two days prior to our inspection that a patient who had been in the corridor area for nearly two hours subsequently had a cardiac arrest and their deterioration had not been recognised immediately.
- There was a dedicated clinical governance lead who investigated all critical incidents. However, staff told us that dissemination of learning was informal, through teaching sessions for junior doctors.

Cleanliness, infection control and hygiene

- Staff generally followed the trust's infection control policy. Staff were 'bare below the elbow', used sanitising hand gel between patients and used personal protect equipment (PPE).
- Generally, appropriate hand washing facilities were available, but we noted that the hand sanitiser gel dispenser on the entrance to the ED had a sticker on it stating "broken". This meant people before entering the ED were not able to sanitise their hands as was the hospital's policy.
- Not all staff followed the trust's infection control procedures as we observed two instances where staff went from different cubicles in the ED without washing their hands or using sanitising hand gel.
- A blood gas machine in the ED had blood spilled on it and therefore was not clean. We reported this to a staff nurse. We also saw that nine vials of blood samples for cardiac marking for use in this machine had been left unsecured on the shelf next to the machine. A staff nurse we spoke to did not know where these samples should have been kept secured. This presented a risk that patients or visitors could have had access to these blood samples representing potential infection control risks.

Environment and equipment

- We found patients were at risk because there were inadequate measures in place in relation to their security. For example, the door from the waiting area in the reception area to the ED was left open at all times during our inspection allowing unauthorised access. Staff informed us that it was usual practice to leave this door open and it was rarely closed. We did not see this door closed at any point during our inspection.
- We inspected one resuscitation trolley centrally located in the main ED treatment area. It was clean and that defibrillators had been serviced. We found two single use items had expired in July 2014 despite checks being recorded as having been done. We reported this to a staff nurse, who disposed of the equipment.
- We found that staff had not documented daily equipment testing for the resuscitation trolley to ensure equipment was fit-for-purpose. There were no documented checks for 45 days since September 2014. For example, in February 2015 checks had been recorded on only three days in the month. Trust policy was for daily checks to be carried out and recorded. Staff told us they did not always have time to check equipment. We reported this to a staff nurse and the matron.
- In the resuscitation room there was an 'airway rescue trolley'. This was visibly dusty. We found two single use items had expired, one in November 2014 and the other in May 2013. We reported this to a sister, who disposed of the equipment. The sister told us that they were aware the equipment was dusty but that they did not have time to check and clean everything.
- The sister in the resuscitation room told us that equipment in patient bays were checked daily and recorded, however, they were unable to locate the folder where checks of equipment were recorded.
- We found the plaster room open off the corridor where patients were being cared for. This meant that equipment such as oxygen and plaster bandages were

not stored safely and securely to prevent theft, damage or misuse. The door to the plaster room was propped open with a dustbin: this was not in accordance with trust policy.

- We also noted that the dirty utility room which was opposite patients on trolleys in the corridor area did not have a lock so presented a risk that patients and visitors could have access to this room as staff were not always present.
- We saw that not all clinical equipment was stored securely and boxes of needles and syringes were left unattended in patient areas. We observed clinical "sharps" boxes left open and unsecured in patient areas. This presented risks that patients or visitors could access to these as staff were not always present.
- We also saw the door to the plaster room was propped open with a dustbin. This was not in accordance with trust policy.
- We saw that a blood gas analyser machine in the majors part of the ED had a sticker on it stating "do not use" dated 18 February 2015. Staff did not know if this had been reported or when it was to be repaired.
- We found a fire door had a damaged electronic retainer unit on the wall. A sticker on this said it had been "reported for repair on 28 January 2015". Staff did not know when this was to be repaired.
- We found that one of the doors to the X ray area at the end of the corridor in the ED had been tied back leaving the door wide open. Staff confirmed this was not in accordance with trust's health and safety procedures and confirmed that they would record this on the trust's electronic reporting procured for incidents.
- Four out of 14 patients (29%) we audited could reach their call bell. However, one call bell did not work when a patient tried to use it. The nurse reported this to the estates management team during our inspection. None of the nurses that we asked could clarify if equipment was checked daily to ensure that it was fit for purpose.
- Medical and nursing staff told us that there was insufficient space within the department and there was a lack of space to assess patients. When all the cubicles and bays were full, patients were cared for in the corridor. This put patient safety at risk because the 'L' shaped corridor did not allow visibility of patients when at one end of the corridor.

Medicines

- Generally the hospital had appropriate systems in place regarding the safe handling and administration of medicines.
- However, we did observe one nurse handle medicines without wearing protective gloves which was not in accordance with trust policy. We informed the senior nurse on duty of this concern.
- We found that medication was not always given in a timely manner. For example, we spoke with a patient's relative at 9.40pm who told us that their relative had been waiting since 7.30pm to have medication. They stated that there were not enough staff on duty and had had to ask the staff five times to assist their relative to use a toilet. A nurse arrived whilst we speaking to the relatives to administer the medication at 9.45pm.

Records

- We saw clinical risk assessments were not always completed for each patient. For example, two patient notes had documents for the EDs elderly person screening, however, one was not completed and the other was partially completed. This meant that risk assessments were not always completed in a timely manner.
- The white board in the department that recorded patient names to track their location did not always reflect the actual patients in the department. Therefore there was a lack of oversight for the whole department, allowing the charge nurses and doctors to reliably identify where all patients were, at any given time. Staff said they did not always have time to keep this board up to date.
- Whilst the hospital had systems in place to keep records stored confidentially. We saw one computer terminal screen in the resuscitation area had not been locked and we were able to view confidential patient details as there were no staff present.

Safeguarding

- We found paediatric patients were at risk because there were inadequate measures in place in relation to their security. For example, the department provided a waiting room and two separate side rooms for paediatric patients in an area to the side of the majors section of the department. The door from the majors section of the department to the paediatric area was left open for the duration of our visit. Standards for EDs state that paediatric areas should be monitored

securely and zoned off, to protect paediatric patients from harm. Staff told us that sometimes this door was closed and would normally be locked after 10pm. We did not find the door locked after 10pm on the day of our inspection.

- We witnessed on numerous occasions during our visit that patients and relatives were entering the ED without any form of challenge from staff and were allowed to walk freely around the department.
- Twice during the visit, we walked unchallenged from the reception area through the open door into the majors part of the department, and then continued through the open door into the paediatric area where the two paediatric rooms were occupied. We spoke with one parent and their child for ten minutes and left this area without any staff being present in this area throughout this time. We informed the senior members of staff on site of our concerns about the security of the paediatric area in the department.
- Immediately following the inspection, the trust informed us that they had taken action to address this security risk by implementing clear procedures for the maintaining the security of the ED and paediatric areas.

Assessing and responding to patient risk

- When we arrived, there were 59 patients in the ED with 14 patients awaiting a clinical assessment (triage) in the reception area. The onsite bed manager confirmed that 11 of these patients had not had not been triaged within 15 minutes, as was the trust's policy. One patient had been waiting for 52 minutes for this triage assessment.
- The matron on duty told us during our visit that the average time for triage was 45 minutes that evening.
- The trust provided evidence that showed 10,455 out of 16,615 (63%) of patients who arrived at ED between 6 April 2014 and 1 February 2015 were triaged within 15 minutes. Six out of the 10 (60%) patient notes we reviewed showed that patient had been triaged within 15 minutes of arrival. This meant that the trust failed to ensure that all patients underwent a full initial assessment within 15 minutes of arriving in the ED which did meet the national triage target.
- There was a reliance on non-medically trained reception staff to prioritise patient's initial assessment need and escalate any concerns they may have if a patient appeared to deteriorate in the waiting room. Senior staff told us that receptionists did "an initial sift" of patients. Receptionists told us that there were no nurses in the EDs reception area and if they had any concerns, they would leave to find a nurse. Staff told us there were no written procedures in place regarding what receptionists should do if a patient was deteriorating in the reception area.
- A health care assistant from another ward was relocated to ED during our inspection to complete observations of patients in the corridor. They told us that it was the first time they had worked on the ward but that they had received a quick local induction. They recorded patient observations on a piece of paper which they then handed over to a staff nurse who was to record the observations in the patients notes. However, when we checked patient notes some observations had not been documented at all. The staff nurse told us that they were too busy to constantly update the patient notes. Three out of four patient notes we looked at, had no observation sheets present and the fourth patient's notes had two observation sheets making it difficult to assess which was the ongoing document. This put patients at risk because notes were not up to date for all staff to view.
- We observed patients being cared for in corridors were left alone for periods of time and regular observations to monitor whether their condition was deteriorating were not carried out. For example, we observed a patient sitting on the end of a trolley leaning over and at risk of falling left unattended by staff in the X-ray area of the department. We brought this to the attention of a nurse, who responded appropriately to reposition the patient. Furthermore, we observed that five patients in the corridor were left unattended by staff for a 10 minute period during our inspection. Staff were not aware of any standard operating policy for care of patients in the corridor.
- The trust had a standard operating procedure for the safe care of patients who were managed in the corridor of the ED due to bed capacity problems, but this was in draft form and had not been fully implemented.
- The local ambulance service trust had a policy for managing patients in the ED whilst awaiting formal handover the hospital's ED staff. These patients remained under the care of the ambulance trust until formal handovers had been completed. The local ambulance trust also provided a senior paramedic who monitored the number of patients awaiting handover and liaised with the trusts ED staff regarding handovers and patient flow.

- Regarding the patients that were cared for in the ED corridor area, individual patient risk assessments were not being carried out to reflect their conditions and potential risks, but the ED had a general risk assessment in place for the use of this corridor area to provide care and treatment.
- Staff told us that the nurse in charge also functioned as the clinical co-ordinator on all shifts. This did not allow for dedicated oversight of the flow of patients through the department.
- There was no formal process to rapidly assess and treat patients (RAT) by a senior doctor, as there was insufficient consultant numbers to consistently complete this. We found that this was completed informally and inconsistently by certain doctors.

Safety Matrix

- The staff in the ED recorded the safety risk of the department every two hours by measuring the safety level of key areas of the department, such as the number of ambulances arriving, the number of patients, the number of staff on duty and how long patients were waiting. The levels of safety were either "normal", "busy", "critical" and "overwhelmed". There were clear guidelines for staff to follow for each of the levels. In particular, if the department was "overwhelmed" the following actions were required:
- All actions must prioritise patient care and safety.
- Ensure all actions above have been completed.
- Emergency department senior clinician to do round with dedicated nurse and junior doctor of majors/ resuscitation/ ambulance queue to expedite assessment.
- Ensure site manager has escalated the problem.

We found that:

- The safety matrix forms for the three days before our visit did not have the safety assessment of the department completed for 13 out of the possible 36 assessments (36%).
- Staff told us they were too busy to complete these forms.
- There was no evidence in the co-ordinators reports or the duty rota that any more staff had been supplied when the safety matrix demonstrated that the department was "critical" or "overwhelmed", or what action had been taken by managers when staff had escalated their concerns.
- We looked at the safety matrix forms for the department that had been completed from 2 December 2014 to 2 March 2015. Not all of days had a completed safety matrix and overall, only 73% of the matrix forms were completed. This meant that the safety matrix which was designed to identify when patients in the ED were at risk had not always been completed. Therefore staff did not always formally identify that patients were at risk and were not able to escalate this information to managers.

Nursing staffing

- We looked at the staff rota for the night of the inspection and noted there were 10 qualified nurses on the night shift with two health care assistants. The planned rota did not meet the needs of the patients in the department at the time of our inspection.
- We saw from the trusts Safer Staffing Report from January 2015 that there were 16 shifts in this month that there were fewer than 10 qualified nurses on duty.
- The number of registered nurses in the department had reduced by 3.4% and health care assistants by 5.6% between December 2014 and February 2015.
- Nursing staff rotas for February 2015 showed that in the day there was an average of 96% planned registered nurses on shift, compared to 73% at night. There was an average 111% planned health care assistants on shift in the day but only 56% at night. This meant that there were not enough nursing staff on shift at night in February 2015.
- Staff told us the normal shift pattern was for 10 qualified nurses and two healthcare assistants per shift, this was the number of staff on shift during our inspection. Staffing was based upon the capacity of the emergency department being 42 patients (including 10 being patients being cared for in the corridor area). However, at the start of our visit, there were 59 patients in the department, including 13 in the reception area. This meant that the level of staffing for 42 patients had not been increased to care for the extra 17 patients.
- The trust stated that the planned staffing for the corridor was a patient to nursing staff ratio was 5:1 in the ED. However, nurses and doctors we spoke with told us this was never achieved and usually one trained nurse cared for 10 patients. There was no evidence shifts were being planned to reflect the patients' acuity and therefore the planned staffing did not always meet the needs of the patients in the department.

- We found evidence that demonstrated there were less nurses on shift on Fridays compared to any other day. The three safety matrix forms available for the Fridays in February (6 February was not available) were not fully completed however, they indicated that at times there were more than 10 patients in corridors.
- Senior nursing staff told us they had escalated concerns about staffing and capacity in the department to senior managers as they considered the department was "not safe" at times due to the pressure on staff given the high volume of patients being seen in the department.
- We reviewed the clinical co-ordinator notes for the three days of 21 to 23 March 2015. Concerns were highlighted including: "Only two corridor nurses until 10pm: will escalate to on call manager although nothing will be done as no free resources spare; will ask minors and paediatric nurse to assist although will leave 2 areas uncovered"; "Grave concerns for the department and patient care. 17 speciality patients await beds"; and the following recorded five and a half hours after becoming black on the matrix: "Black on the matrix since 08:00 hours. This means we are overwhelmed". The protocol for patient safety states that when the department is "overwhelmed" then the EDs senior clinician is to do a round with dedicated nurse and junior doctor of majors, resuscitation areas and the ambulance queue to expedite clinical assessments. There were no more staff available and therefore staff could not carry out the escalation process of providing a dedicated nurse for key areas. This meant that the department was not able to manage the situation safely.
- We observed the resuscitation room unattended by staff for five minutes whilst patients were in this room. This was not in accordance with trust policy as this area was to be supervised at all times when patients were present.
- A qualified nurse told us that they were not a permanent member of staff in the ED but that they had been transferred from another ward to help for a couple of hours. They said this practice was commonplace. The nurse confirmed that they had had a handover when starting work in the ED.
- Senior staff told us that the department would be increasing capacity by another 15 cubicles in the next month, yet there were no plans in place to increase the clinical staffing levels.
- However, the matron told us workforce planning had been conducted that had resulted in the trust's agreement to recruit an administration support assistant who would support the shift coordinator. Also, ED assistant (band 3 nurses) roles had been agreed and recruited to. These new posts were to commence from 1 April 2015. Senior staff also told us of the trust's plans to introduce a second triage nurse to help alleviate waiting times.
- We spoke with one patient in a cubicle who told us they had been waiting half an hour for a nurse to cannulate their arm so that pain relief could be given.
- We spoke with the parent of a child in the paediatric area who told us their child had been waiting over two hours to have pain relief medication and that no staff were around. A nurse arrived whilst we were present to administer the medication.
- We spoke with the relatives of another patient who told us their relative had been waiting over two hours to have their medication. They stated there were not enough staff on duty and had had to ask the staff five times to assist their relative to use a toilet. A nurse arrived whilst we speaking to the relatives to administer the medication.
- We observed one patient on a trolley in a state of agitation was being reassured by the relative of another patient, as there were no staff in attendance.

Medical staffing

- There were 4.8 whole time equivalent consultants for the department. Consultants were on site 9am to 5pm and they provided on call cover from 8am to 7pm on weekdays.
- There was one consultant on site after 5pm covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This was raised as a concern during a peer review from NHS England. If two trauma patients were admitted at the same time on each site, the protocol was that one of the trauma calls would be led by the orthopaedic doctor.
- On reviewing the medical rota, we were told that six out of nine (33%) shifts were filled with permanent staff, with the remaining shift covered with locum staff.
- Doctors told us that they "Worried" that there could be patients deteriorating in the corridor and that "They wouldn't know".

Ambulance Handovers

Urgent and emergency services

- Staff told us that delays in handover time from ambulance crew to the emergency department team meant that patients remained under the care of the ambulance crew longer than expected which delayed initiation of treatment.
- The board meeting minutes for the 25 March 2015 showed that the trust's emergency departments performance metrics overview report had not met the trust target of 80% of patients admitted via an ambulance having handovers carried out within 15 minutes in all 12 previous months. The trust was also not meeting its target of having 95% of patient handovers being carried out within 30 minutes of arrival by ambulance in any of the previous 12 months.
- The trust and the local ambulance service had a written agreement that when the ED had more than 10 patients in the corridor, that the ambulance service would supply their own staff to look after any extra patients. The agreement included protocols to ensure that ambulance staff would look after patients who were at lower risk, for example, had not received morphine or had observations that demonstrated that the patient was clinically stable.
- The agreement stated that the escalation procedure for a deteriorating patient (where the early warning score was 3 or above) was via the corridor nurse and the lead ED clinician. However, we found that in this event, the department would be at capacity and the risk of the lead ED clinician already attending an emergency was high. There was no clear emergency plan and the ED co-ordinator was not involved.
- The ambulance service provided evidence for the amount of staff they had provided in the ED to care for patients between February and 18 March 2015.
- Between February and 18 March 2015 there were 612 patients who arrived at ED that required an ambulance crew to look after them in ED. The data shows that these patients waited a total of 189 hours (on average 18.5 minutes) for a nurse to assess the patient and allocate them to be cared for by the ambulance staff. Once in the department, these patients were cared for by the ambulance crew for a total of 736 hours (average 72 minutes). The data showed that the longest cohort times were 11 hours and 40 minutes in February and 5 hours and 5 minutes in March 2015.
- Of these patients, 173 were over 80 years old and one was below 14 years of age. This meant that patients of a venerable age were not receiving a nursing assessment in a timely manner.
- In February 2015, 17 of the 429 patients were cared for on ambulance trolleys as there were no ED trolleys available.
- Twenty six (6%) of these patients deteriorated whilst being cared for in the corridor by ambulance staff, who alerted ED staff so that action could be taken. The ambulance crew provided a number of interventions such as oxygen therapy, taking of blood sugars and cannulation.
- Twenty nine (7%) patients had an early warning score (early warning score is a guide used by clinical staff to help determine the degree of illness of a patient; a score of 3 or above indicates a patient is clinically unwell) of 3 or above, of these 15 (3%) patients had an early warning score of 4 or 5. This meant that 29 patients had had their observations taken and found to be clinically unstable and require immediate medical attention.
- One patient had been with the ambulance crew an hour and 40 minutes when the patient's early warning score changed from 2 to 5, which meant that they required immediate medical attention. The data shows that it took a further 25 minutes before the ED staff took this patient into the resuscitation area. The records show that this person was being looked after by an ASO, not a paramedic
- Another patient arrived at 2.30pm with an early warning score of 0, after an hour and 10 minutes their early warning score had changed to 3, which meant they required immediate medical attention. The records showed that the co-ordinator was notified at 3.40pm and the ambulance crew had to follow this up 15 minutes later by speaking with the co-ordinator and the doctor at 3.55pm. The records also showed that the ambulance paramedic carried out the electrocardiography (ECG) (a process of recording the electrical activity of the heart over a period of time using electrodes placed on a patient's body) and cannulation.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Staff reported good multidisciplinary team working and we found confirmation to support evidence based treatment for one patient. However, we found inconsistencies with patients being able to access fluids.

Evidence-based care and treatment

- We reviewed the notes of a patient who had a seizure. The patient was managed in accordance with best practice National Institute for Health and Care Excellence (NICE) CG137 guidelines with medication and airway protection. The patient went on to have a timely computed tomography (CT) scan.

Pain relief

- Two doctors and one nurse told us that there could be delays in providing pain relief for patients owing to staff shortages and patients being looked after in the corridors. One staff member described this as a "frequent occurrence."
- We found that pain relief was not always provided in a timely manner. For example, we spoke with one patient in a cubicle at 9.07pm who told us they had been waiting half an hour for a nurse to cannulate their arm so that pain relief could be given. A parent of a child in the paediatric area at 9.15pm told us their child had been waiting since 7.30pm to have pain relief medication and a nurse arrived at 9.20pm to administer the medication.
- Nursing staff and doctors told us that they found it difficult to care for patients in the corridor. We saw evidence of a two hour delay in administration of analgesia (a pain relief medication) for a patient who had cancer as there was insufficient staff to administer the medication.

Nutrition and hydration

- We audited whether patients had a drink within their reach on several wards and found that six out of 14 patients (43%) could reach a drink. Two patients on trolleys in the corridor told us that they had not been offered a drink in the past three hours but that they would like one. We told a staff nurse about this who confirmed that the patients were allowed to drink fluids but asked us to give the patients a drink.

Competent staff

- There was ED specific training for senior house officer doctors each week. This included lessons learnt from incident forms and complaints along with clinical topics.
- There was learning disseminated from national audit reports. For example, there was a dedicated teaching session organised on treatment of paracetamol overdose, in response to results from the national audit.
- New doctors were given a three week induction course that included familiarising themselves with departmental policies, layout of the department and update on clinical guidelines used.

Multidisciplinary working

- Doctors and nurse reported a good working relationship with each other. There was supportive collaborative working.
- Senior clinicians felt that there was a feeling that there was a lack of ownership for ED performance from other specialities within the hospital and that this poor performance was portrayed as the emergency departments problem. This was having an impact on the flow of patients from the department downstream to the wards.
- There was no formal "in-reach" from specialities to the emergency department.

Are urgent and emergency services caring?

Although we saw positive interactions between staff and patients, we found that patient privacy and dignity was not always protected. Patients reported that they did not know what was happening regarding their care and treatment.

Compassionate care

- Patients were being cared for within a corridor area in full view of those passing through the area. For example, we observed a patient on a trolley in the corridor left exposed where staff did not intervene to restore their privacy and dignity. The patient was in view of people in the corridor, including members of the public. We also

witnessed patients vomiting and being cannulated in full view of other patients their relatives and those accessing the radiology department. This did not protect patients' privacy and dignity.
- We witnessed many episodes of patient and staff interaction, during which staff showed caring attitudes towards patients.
- However, we observed a staff nurse and a doctor insert a cannula into patients without drawing the curtains to protect the patient privacy and dignity. We saw no engagement from either staff member with the patients to discuss what they were doing or to help put patients at ease. We also saw a patient having a blood sample being taken in full view of other patients and visitors.
- Patients' reports about staff were mixed. Some patients' acknowledged that staff were very busy and were trying their best under the circumstances. Whereas other patients reported feeling in the way and uncared for. One patient told us "staff are very caring, but there are not enough of them". A relative told us "we have been here since 7.30pm and still don't know what is going on".
- We witnessed a patient history being taken within the waiting area within earshot of other service users. This did not protect the patient's privacy and dignity and confidentiality.
- The Family and Friends Test in December 2014 response rates were worse than the England average for Worcestershire Royal Hospital. However, 95% of responses indicated that most patients would be very likely or likely to recommend the trust as a place to have care and treatment.

Understanding and involvement of patients and those close to them

- One relative we spoke with was distressed that they had brought their loved one to the hospital, they commented: "I blame myself for brining my relative here, it's an awful place".
- All of the patients we spoke with in the corridor reported that they did not know what was happening regarding their care and treatment.

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

We found that the capacity of the EDs and the lack of patient flow within the trust did not meet patient demand.

Meeting people's individual needs

- We saw delays in access to mental health liaison teams. Patients waited for a number of hours in order to access the team. We saw evidence of patients with mental health problems becoming agitated and angry at these delays.
- Senior staff told us there was no out of hours support provided from mental health services and that at times the ED had to manage patients requiring care and treatment for mental health conditions overnight. The hospital provided a mental health assessment area and if necessary a section 136 suite provided by the local community trust could be accessed for those patients requiring a place of safety under the Mental Health Act.

Access and flow

- There were visible problems with patient flow from the ED into the hospital and causing overcrowding in the department. Nurses and doctors told us that caring for patients within the corridors had become a "normal" part of their job and that this had been happening since January 2014.
- From NHS performance data, the trust's performance in meeting the four hour target for patients being clinically assessed by a doctor in the ED had shown deterioration since October 2014. The monthly data showed a decline in the overall performance from 91% In November 2014 to 83% in February 2015. The ED performance over this period in 2014/15 was worse compared to the same period of the previous year. Attendances at the ED had been 18% higher than 2013/14 on average.
- From NHS performance data, the percentage of beds occupied by patients whose transfer from care had been delayed had steadily increased during the year, from 6% in April 2014 to 12% in February 2015. For the previous three months, the percentage of patients experiencing delays had been more than double the regional average of around 5%.

Urgent and emergency services

- Senior managers told us that on the day of our inspection, there were 91 patients that were experiencing a delayed transfer of care across the trust. This was having a serious impact on the patient flow throughout the hospital and staff told us of the significant pressures on the hospital's bed capacity on a daily basis.
- The clinical decision unit was reported by medical staff to function effectively in managing short stay patients within the hospital. It was designed to care for patients who were expected to be discharged in less than 24 hours.
- Senior staff told us that bed management meetings were held usually two hourly from 8.30am to 8pm, and that capacity and patient flow issues in the ED were highlighted in these meetings. The bed management team staff told us that overall capacity issues within the hospital impacted on the ED patient flow.

Are urgent and emergency services well-led?

Staff reported lack of senior support within ED.

Leadership of service

- There was limited perceived senior support at executive level for staff within ED.
- Some staff reported limited visibility of the department matron out-of-hours.
- Doctors and nurses expressed their frustration of escalating their concerns around the safety of patients in the corridor for a number of months without achieving much traction with senior leadership. Senior staff told us concerns had been escalated about the potential safety risks within the ED given the high demand and limited capacity but that now plans were being drawn up to address these concerns.
- Whilst senior staff were able to tell us of the trust's plans to provide additional beds for the ED and that additional support had been arranged from the regional Emergency and Urgent Care Intensive Support Team (ECIST), not all staff were aware of these plans and the timescales involved.
- Senior staff reported that long standing delays to the proposed reconfiguration of the trust's overall ED service had impacted on the planning and service delivery for both hospital sites and that partnership work was on-going with commissioners and other local stakeholders. Senior staff stated there was an apparent lack of effective engagement with the trust's stakeholders regarding the on-going concerns about the trust's ED service.

Innovation, improvement and sustainability

- The trust was chosen to be a study location for the Randomised Evaluation of modified Valsalva Effectiveness in Re-entrant Tachycardias (REVERT) study looking at treatment of patients with supra-ventricular arrhythmias.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff mix in the ED to ensure people who use the service are safe and their health and welfare needs are met.
- The trust must ensure that all equipment is in date and is checked consistently.
- The trust must ensure that service users are protected against the risks associated with unsafe or unsuitable premises, by means of appropriate measures in relation to the security of the ED

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should ensure all staff are aware of their roles and responsibilities to report incidents.
- The trust should ensure that the initial assessments of all patients are in line with national standards.
- The trust should ensure that all patients are appropriately monitored and receive timely observations and medication.
- The trust should address the concerns regarding patient flow through the hospital, to prevent overcrowding of patients in ED.
- The trust should review the paper records to ensure that the recordings are accurate and are always fully completed to prevent risk to the delivery of safe patient care and treatment.

This section is primarily information for the provider

Enforcement actions

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. The trust did not ensure that at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff mix in the ED to ensure people who used the service were safe and their health and welfare needs were met.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises (1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of— (a) suitable design and layout; (b) appropriate measures in relation to the security of the premises; and (c) adequate maintenance and, where applicable, the proper— (i) operation of the premises, and

This section is primarily information for the provider

Enforcement actions

(ii) use of any surrounding grounds, which are owned or occupied by the service provider in connection with the carrying on of the regulated activity.

(2) In paragraph (1), the term "premises where a regulated activity is carried on" does not include a service user's own home.

Patients, including children, were at risk because there were inadequate measures in place in relation to their security in ED. For example, the doors leading into the emergency department were left open during our inspection allowing unauthorised access.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is— (a) properly maintained and suitable for its purpose; and (b) used correctly. Staff had not documented daily equipment testing to ensure that the resuscitation trolley in ED was fit-for-purpose. We found out of date single use equipment on the resuscitation trolley and within the resuscitation room.