Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital

Quality Report

Queen Elizabeth 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.

Ratings

Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook an unannounced inspection at the Queen Elizabeth Hospital because of concerns raised by patients and the high number of safeguarding incidents at the hospital including the Emergency Department and the medical wards.

In February 2014, we completed a comprehensive inspection of the trust which was rated as Requires Improvement overall. At Queen Elizabeth Hospital Medical Care was rated as Requires Improvement and the ED was rated as Inadequate.

We inspected on 7, 8 and 18 June 2016.

We visited the ED and the hospital's medical wards including care of the elderly. The inspection was responsive and unannounced based on concerns we had about the care patients were receiving at the hospital.

Our key findings were as follows:

- The Emergency Department (ED) had made some progress since the last inspection, in 2014, including an improved pathway for all ED patients to the urgent care centre (UCC),opening a clinical decision unit and a Frailty Assessment Unit (six days prior to our visit on 18 June 2016). However, on the 7 and 8 June we found problems similar to those during the previous inspection in 2014; rapid assessment and treatment suspended to accommodate patients who were waiting for beds, patients being cared for in chairs (and in public corridors during this inspection), and long waiting times in the ED due to an increase in demand and a lack of available beds in the hospital.
- The trust had introduced other initiatives to help improve patient flow including a discharge lounge but, on the first two days of the inspection we found the discharge lounge was being used as an escalation area and was unable to meet the needs of some of the patients admitted there
- Patients' vital signs were not always monitored, or action taken, in line with the trust's policy and national guidelines.
- Delays in responding to referrals by speciality teams outside of the ED was impacting on waiting times for patients.
- Staff in the ED provided compassionate care and patients spoke positively about the staff.
- Risks, in relation to capacity identified during the inspection were included on the risk register.
- Staff were working in a difficult and challenging environment but, were positive about the support they received from their immediate line managers, but were less positive about the executive team
- In medical care patient safety was compromised through incomplete, inaccurate and contradictory recording in patient's notes and variable compliance with infection prevention and control procedures, including good hygiene practice, and medicines management.
- Although, we saw many staff being kind and caring towards patients on the medical wards, we also observed some speaking inappropriately to patients demonstrating a lack of sensitivity and compassion. They either did not have enough time to help patients with their personal needs or did not see it as part of their role.
- We found problems with delayed discharges, over 50% of patients had a delayed discharge, and patients had extended stays on the acute medical unit which were also found during the previous inspection.
- There were limited resources and support for staff to meet the individual needs of patients, for example those living with dementia or patients for whom English was not their first language.
- Governance and risk management processes were not effective and senior nurses in medical care were unaware of the key risks for their areas.
- We found a significant variation in the leadership of the medical wards and although quality monitoring was taking place we found a number of problems which should have been identified through the quality monitoring process. Staff gave differing responses about support from their managers and in some areas felt there was a lack of oversight.

During our inspection, we did not observe any areas of outstanding practice.

Summary of findings

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure patients are cared for in areas that are appropriate, meet all of their needs and have sufficient space to accommodate the potential number of people using the service at any one time.
- Ensure assessments of patients and observations are recorded and action is taken, where appropriate, in line with hospital policy.
- Do all that is reasonably practicable to mitigate any risks related to delays in patients being seen and assessed and treated in the ED and transferred to an appropriate ward/clinical area for on-going treatment.
- Ensure patients on medical wards have appropriate risk assessments fully completed that meet their needs. This includes where patients have a Protected Characteristic under the Equality Act.
- Have effective systems and processes to assess and monitor the quality and safety of care and treatment in the ED and medical care.
- In medical care, all medicines must be stored safely, securely and in a temperature-controlled environment in all areas. This must include documented daily temperature checks and a documented stock control system.
- Ensure patient records, including prescribing records, contain all relevant information.

In addition the trust should:

- Develop a formal induction for agency nurses in the ED
- Ensure staff comply with infection prevention and control policies and procedures.
- Should have better oversight of cleaning and hygiene standards on ward 18. This should include bedside equipment, equipment storage rooms and food preparation areas
- Ensure staff training in medical care meets the needs of those working in clinical areas. This should include input from staff that indicates the level of training they have received is sufficient to carry out their responsibilities safely.
- Ensure staff, in medical care, receive up to date life support training at a level appropriate to their role and responsibilities.
- Continue to work to reduce the number of delayed discharges
- Ensure staff fully understand the role of the dementia lead nurse and how to access services available to patients.
- Ensure staff working on medical wards have the values and attitude necessary to treat patients, their relatives and visitors with dignity and respect. This includes staff treating them in a caring and compassionate way at all times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Requires improvement 

Why have we given this rating?

We rated the Emergency Department (ED) as requires improvement overall because;

- Following our inspection in 2014, the trust has made some improvements to the ED; a new clinical decision unit consisting of two five bedded bays was opened and extra cubicles were created, including an isolation room. However, despite these improvements the ED was struggling to keep up with the demand and provide safe quality care.
- During the first two days of our inspection, rapid assessment and treatment (RAT) of patients arriving by ambulance was suspended in order to accommodate patients waiting for hospital beds in the blue area.
- The trust was not meeting national waiting times and patient flow was poorly managed. This resulted in long waiting times in the ED for patients and ambulances queuing outside waiting to transfer patients to the ED.
- Patients were waiting too long to be seen by a doctor and many of them were in the ED for longer than 12 hours because of a lack of available beds in the hospital.
- Once the ED was full patients were cared for in public corridors which compromised their privacy and dignity.
- While waiting for beds to become available patients were cared for in areas such as the discharge lounge and imaging department. These areas did not meet all of their needs and there was a lack of oversight of these areas by senior staff.
- Patient care was sometimes compromised as those at risk of developing pressure ulcers were not always transferred to a bed from a trolley within the trust's policy.
- The number of consultants was less than the recommended minimum of 10 in line with national guidelines.

However we also found:

Summary of findings

- During our visit on 18 June 2016 patients were being seen and treated quicker and were not being cared for in public corridors. Beds were available on the wards to admit patients.
- There was good multidisciplinary working within the ED.
- Risks identified in this report were included on the risk register for acute medicine and the ED. Some of the risks pre-date the trust and were related to the previous organisation.
- Staff had access to policies and procedures based on national guidance and best practice.
- Staff were caring and compassionate and patients spoke positively about how they were treated by staff.
- Staff told us their immediate managers were visible and approachable and felt supported by them. They said the executive team were less visible. Some staff felt morale was low because they were tired and not always supported when the ED was busy.

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Medical care (including older people's care)

Requires improvement

Overall we rated medical care, including elderly care, as requires improvement because:

- The service did not have effective systems to protect patients from the risk of harm. There was inconsistent feedback and learning from incidents, compliance with infection prevention and control practices was variable and there were significant deficiencies, inaccurate, incomplete or contradictory information, in some patient's records.
- Patients were not always cared for on wards that could meet their needs. The acute medical unit was equipped to care for patients for up to 72 hours but due to a lack of available beds many patients spent much longer on the unit. On the short term pre-discharge ward we found length of stays of more than four months and patients requiring end of life care.
- Patients were not always treated with dignity and staff were not always able to meet their

Summary of findings

personal needs. This was partly due to insufficient staff but staff also told patients it "wasn't their job" to help a them have a bath or shower.

- We observed most staff were kind and compassionate towards patients but, we also observed a lack of sensitivity in how some staff spoke to patients. Patients told us that at times staff spoke to them "sharply".
- The hospital did not always meet the individual needs of patients. Support for patients living with dementia was limited and staff we spoke with were unaware the hospital had a dementia lead nurse.
- We were told the hospital experienced significant delays with discharges due to a lack of elderly care beds in the community.
- Governance and risk management structures were in place but, they were not always effective in identifying and reducing risks and improving the quality and safety of care.
- The system for sharing information about the quality and safety of care with staff was not effective; none of the senior nurses we spoke with were aware of the significant items on the risk register for their area or how they were managed.
- The quality of leadership was variable; some staff told us team working was good but it was difficult to escalate problems to more senior people or they wanted to make improvements but didn't know who made decisions in their area.

However, we also found:

- Completion of mandatory training was good
- Good multidisciplinary working
- There was some evidence of clinician-led audit activity, learning and dissemination in medical areas.
- The discharge coordination team were proactive in trying to reduce discharge delays and improve discharge planning.
- More effective responsive leadership during our visit on 18 June 2016.

Queen Elizabeth Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care)

Detailed findings

Contents

Background to Queen Elizabeth Hospital

Queen Elizabeth Hospital is part of Lewisham and Greenwich NHS Trust. The trust was formed on 1 October 2013. Queen Elizabeth Hospital was part of South London Healthcare NHS Trust which was placed into administration in July 2012.

Lewisham and Greenwich NHS Trust provides acute and community services for more than 526,000 people living in the boroughs of Lewisham, Greenwich and Bexley..

Our inspection team

Our inspection team was led by Inspection Manager Margaret McGlynn.

The team included CQC inspectors covering emergency care and medical care. The team was supported by Specialist Professional Advisors including; two consultant physicians and two senior nurses with experience in ED and medical care.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out an unannounced visit on 7 and 8 June and undertook a further visit on 18 June 2016. The inspection was conducted using the Care Quality Commission's new inspection methodology.

We spoke with 80 members of staff, including doctors, nurses, allied health care professional, health care assistants, managers and non-clinical staff. We reviewed 42 sets of medical notes. We spoke with 50 patients and family members/carers.

Detailed findings

Facts and data about Queen Elizabeth Hospital

Queen Elizabeth Hospital provides hospital services for people living in Greenwich, Bexley and other neighbouring boroughs. It provides a full range of adult, elderly and children's services across medical and surgical disciplines and has just under 500 beds.

In 2015/16 150,219 patients attended the ED and in 2015 medical services treated 30,525 patients.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Urgent and emergency services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Emergency Department (ED) at Queen Elizabeth Hospital (QEH) provides a 24-hour, seven days a week service. The ED saw 150,219 patients in 2015/16 and 25% of these patients were children and young people.

The ED consists of 20 major treatment trolleys, a five bedded resuscitation area with a paediatric resuscitation bay, a 10-bedded blue area used for rapid assessment treatment (RAT), a green area for ambulatory care consisting of five rooms, and a paediatric emergency unit consisting of eight trolleys and a high dependency unit. The ED also has a clinical decision unit (CDU) consisting of two bays, two side rooms and six blue recliner chairs for patients. Each bay had five beds.

The department has an urgent care centre, which provides treatment for minor injuries, illnesses and non-life threatening conditions. This is not managed by the trust. This is managed by a separate healthcare provider.

We carried out an unannounced inspection on 7/8 June 2016 and then returned to the ED on Saturday 18 June 2016. We observed care and treatment and looked at 17 patient records and seven prescribing records. We spoke to 33 members of staff including nurses, doctors, consultants, administrative staff, domestic staff and ambulance crews. We also spoke with 22 patients and relatives who were using the service at the time of our inspection.

Summary of findings

We rated the Emergency Department as requires improvement overall because;

- During the inspection, we found patients were often cared for in escalation areas including corridors within the department. We observed that other people could overhear consultations with patient in these areas.
- The ED was often overcrowded. There was poor patient flow and waiting times were above the national average. Many patients were not being seen by a clinician within the 15-minute national target.
- A significant number of patients remained in the ED for over 12 hours after a decision to admit them had been made due to lack of beds in the rest of the hospital.
- Patients at risk of developing pressure ulcers were not always transferred to a bed from a trolley within the trust's four-hour target.
- There were many ambulances queuing and the ambulance handover times were above the national average.
- There were fewer consultants than the recommended minimum of 10 in line with national guidelines. The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 14 hours a day, seven days a week.

Urgent and emergency services

- Patients' vital signs were not always monitored in line with the trust's policy and national guidelines.
- The department had a higher re-attendance rate compared with the national average.
- Many of the problems that we found in 2014 still existed; there were long waiting times in the ED due to increase in demand and lack of available beds in the hospital, rapid assessment and treatment was suspended to accommodate patients who were waiting for beds, and patients were being cared for on public corridors during the inspection.
- Interim measures in place were insufficient to mitigate the problems with capacity in the ED.

However,

- ED staff were caring, kind, and compassionate and involved patients in their care and we received numerous positive comments from patients. Patients' feedback was sought and the latest Friend and Family Test results showed over 93% of patients would recommend the ED.
- Policies and procedures were developed in line with national guidance and best practice. Guidelines were easily accessible on the trust intranet page and staff were able to demonstrate ease of access.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- The ED had a vision and strategy to improve the service in the long term. Staff were supported in their role and had opportunities for training and development.

Are urgent and emergency services safe?

Requires improvement

Overall, we rated safe as requires improvement because:

- Many patients who arrived in the ED were not seen by a clinician within 15 minutes of their arrival and this meant they were at risk of deteriorating and experiencing poor outcomes.
- There were several ambulance queues and the ambulance handover times were above the national average
- Patients whose condition might deteriorate were not monitored properly.
- The ED environment was overcrowded during the two days of our initial unannounced inspection. There were patients on trolleys and chairs along the corridor and this constituted a barrier to evacuation in the event of an emergency.
- Although infection prevention and control practices had improved since our last inspection in 2014, there were still areas of poor compliance with infection prevention and control (IPC) guidelines.
- There were fewer consultants than the recommended minimum of 10 in line with national guidelines.

However;

- Incidents were appropriately reported and investigated, and lessons learned were communicated to staff
- There were effective arrangements in place for safeguarding vulnerable adults and children.

Incidents

- Staff reported incidents on an electronic system and all the staff we spoke with during the inspection knew how to report an incident. Staff told us they received feedback and learning from incidents through emails, during handovers and at staff meetings..
- There were 2,599 incidents reported in the ED between 1 April 2015 and 31 March 2016. One resulted in death,

two were classified as severe, eight resulted in moderate harm, 137 were classified as low harm, 26 were classified as near misses and 2425 resulted in no harm.

- There were seven serious incidents reported between June 2015 and May 2016. There were two diagnostic incidents involving failure to act on test results. There were three cases of sub-optimal care of deteriorating patients and two involved delays in treatment meeting the serious incident criteria.
- We looked at the investigation of a serious incident from September 2015. This was in relation to a missed diagnosis of cervical spine injury. We saw that the incident was fully investigated using the serious incident framework and an action plan was developed as a result. The investigation team recommended training for ED triage nurses and ED doctors to ensure that c-spine immobilisation was carried out for patients who present to the ED with a history similar to how the patient presented. The team also recommended training for doctors on the management of cervical spine injuries with emphasis on the indication for c-spine imaging. Arrangements were set out to share learning across the trust at clinical governance meetings, teaching for junior doctors and nurses and through the ED quarterly risk newsletter.
- Nursing and medical staff were familiar with the duty of candour and were able to explain what this meant in practice. They identified the need to be honest about mistakes made, offer an apology and provide support to an affected patient.
- Senior staff informed us that mortality and morbidity meetings were held on a trust wide level. We have been provided with an annual mortality review summary. This showed 13 key findings and actions taken in the course of the year.

Cleanliness, infection control and hygiene

- Most areas of the ED was clean and tidy. Antibacterial hand gel was available in waiting areas, bays, entrances and exits. Basic personal protective equipment (PPE), such as gloves and aprons were available in each bay and we observed staff using them appropriately. In addition, the ED had adequate hand washing facilities and we observed staff washing their hands. The 'bare below the elbows' policy was observed by all staff. Disposable curtains were labelled with the date they were last changed. This date was within the last one month of our inspection.
- Equipment used in the unit, including commodes and bedpans were clean. Staff used "I am clean" labels to indicate that an item of equipment was clean and decontaminated. However, we observed there was an open bottle of bleach liquid in the sluice room within the Majors area. The sluice room was unlocked presenting the risk of patients accessing potentially hazardous materials.
- We saw cleaning staff adhered to a colour coding procedure for cleaning the department and for the disposal of waste. Waste was disposed in a secure area and there was a separate area for clinical and domestic waste. On the first day of our inspection, we observed that the area for storing domestic waste was generally untidy and the bins were overflowing with black bin bags. The area was tidy when we looked at it the following day.
- There was a lead nurse for infection prevention and control and staff carried out monthly hand hygiene audits. The ED achieved 79% hand hygiene compliance between January 2015 to December 2015 against the trust's target of 95%. Recent hand hygiene data submitted by the trust showed poor compliance in March and April 2016. Hand hygiene compliance was 65% in March 2016, 40% in April 2016 but was 95% in May 2016.
- We spoke to a patient within the majors' area. He told us he was placed onto a trolley bed that had a clean bed sheet.He later noticed blood stains on his body and realised that although staff had changed the bed sheet, they did not clean the blood on the rails and by the side of the trolley. The patient told us he raised the incident with staff and the situation was remedied.
- Mandatory training records show that 96% of nursing staff and 85% of medical staff had completed the infection control training against the trust's target of 85%. Only 68% of administrative and clerical staff had completed the non-clinical infection control training.

Environment and equipment

- The ED had a separate emergency only entrance from the rest of the hospital. There was a streaming desk and two triage cubicles near the reception area. The ED consisted of the majors' area, a green area for ambulatory care, the resuscitation area, a blue area used for rapid assessment treatment (RAT), a clinical decision unit (CDU) and a paediatric emergency unit.
- The paediatric emergency unit was brightly decorated and had toys and visual stimulus appropriate for young children. Access to the unit was restricted by a swipe access card and staff informed us the entrance was locked between 10pm to 7am. The paediatric emergency unit had eight cubicles and one high dependency unit (HDU).
- The ED had a wide range of specialist equipment, which was clean and maintained. Labels were used to indicate when items of equipment had been cleaned and when they had been reviewed for safety. We found that equipment checklists for the resuscitation area were checked and signed for. However, there were gaps each month when checks were not documented. For example, three days were missed in May, two days in April, one day in March and two days in February 2016. We also found gaps in the equipment checklist for the blue area. There were three gaps in May.
- The resuscitation area had five bays. This included a paediatric resuscitation bay, which had the appropriate specialised equipment to resuscitate children. Staff told us that it was sometimes converted for adult use when available.
- The location of the resuscitation unit was conducive for the rapid transfer of patients from incoming ambulances to the care of the emergency team. However, staff explained that they often "doubled up" the resuscitation bays in order to accommodate more patients. We observed the resuscitation bay was "doubled up" to accommodate eight patients on the second day of our inspection.
- The majors' area had limited space for the volume of patients seen in the department. It was divided into two by a toilet and sluice. There were twelve trolleys in the majors' area and eight trolleys on the other side of the area, called the majors' extension.
- An escalation area consisting of six trolleys had been created along the corridor within the majors' area. On one occasion, we observed up to ten patients in this area. Some of these patients were sitting on chairs. We also found several ED patients in areas which were not located within the ED including imaging, recovery area and the discharge lounge.
- During the first two days of our inspection, rapid assessment and treatment (RAT) of patients arriving by ambulance was suspended in order to accommodate patients waiting for hospital beds in the blue area. As a result, we observed up to seven ambulance crews waiting in the main hospital corridor to the ED.
- There was a specific room for patients with mental health conditions in the ED. The room adhered to national standards with two doors, no locks and soft heavy furniture. It was ligature free.
- The department was overcrowded during the first two days of our unannounced inspection. We noted that trolleys on the corridors presented a barrier to evacuation in the event of a fire safety incident.
- We conducted a further unannounced inspection on a weekend and observed there were fewer patients in the department. The environment was clean, tidy and organised. In addition, the blue area was open for RAT assessment. There were no ambulance queues, no patients on the corridors and the resuscitation area had only the required number of beds.

Medicines

- Medicines were stored safely. The drug cupboard was kept locked and when opened, we saw that the drugs inside were kept in an orderly fashion. The senior nurse on duty held the keys to the controlled drugs cupboard and we saw recorded evidence that daily checks were made.
- Temperature checking system was in place for refrigerated medicines. However, we observed that there were twelve days in May 2016 and two days in June 2016 when the fridge exceeded the maximum temperature of 8 degrees. There was no record of any actions taken to address this.

Records

- We examined 17 sets of patients' notes during our inspection. For most of the records, staff had completed all documentation including vital signs,

national early warning score (NEWS), pain score, allergy and pressure ulcers. However, in one of the records, we found that observations were recorded but not always initialled. In another record for a paediatric patient, we found that observations were recorded but the paediatric early warning score (PEWS) was not recorded. There were some untimed entries by ED doctors in a third record.

- Our review of seven prescribing records showed four had no time recorded for prescribing and one had no date recorded for prescribing. Only two of the records were correctly completed with the time and date of prescription recorded.

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. However, there were varying levels of compliance with safeguarding training against the trust's target of 85%.
- All administrative and clerical staff had completed the safeguarding adult non-clinical level one training and the safeguarding children and young people level one training. However, only 14% of administrative and clerical staff had completed safeguarding children and young people level two training against the trust's target of 85%.
- Nursing staff had 97% compliance with safeguarding adult level two training and 83% compliance with safeguarding children and young people level two training. Seventy three per cent of nursing staff had completed the safeguarding level three training.
- Medical staff had 81% compliance with safeguarding adult level two training and 83% compliance with safeguarding children and young people level two training. Only 31% of medical staff had completed safeguarding level three training.
- Staff in the paediatric ED unit reported they attended weekly safeguarding meetings to discuss incidents and referrals. Staff completed a safeguarding risk assessment for children who they felt were at risk.

Mandatory training

- A practice development nurse (PDN) managed mandatory training and induction for new staff. Compliance with mandatory training was 74% against the trust's target of 85%. Senior staff told us that compliance with mandatory training had improved from two years ago when it was just 50%.
- Mandatory training included safeguarding, resuscitation training, major incidents training, medicines management training, datix reporting, infection control, tissue viability and pressure ulcer reporting, and conflict resolution/breakaway techniques.
- Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice.

Assessing and responding to patient risk

- All walk-in patients including children above the age of two were seen by an urgent care centre (UCC) nurse who determined if they were suitable for the UCC or needed to go to the main ED. Patients who are sent to the ED were then triaged by a ED triage nurse to the relevant pathway. The UCC saw 40% of the patients attending the department.
- Children under the age of two, patients with referrals from their GP and patients undergoing chemotherapy were booked in directly to attend the ED. There was a streaming nurse for these patients behind a screen at the reception.
- ED staff told us a number of patients were incorrectly sent to the UCC and then sent back to the ED, thereby delaying the patient's treatment. During our time observing the triage area, we noticed three patients sent back from the UCC to the main ED triage nurse who then had to re-triage them on the ED pathway.
- We spoke to a UCC member of staff who showed us a one-page list describing high risk patients that should not be streamed to the UCC. These included patients with chest pains, heavy bleeding or difficulty in breathing.
- Our review of patient records who attended the ED during the period of our inspection, showed that one patient presented with chest pain and had a history of heart disease with previous stents. He was sent to the UCC and then sent back to the ED after 14 minutes.

Urgent and emergency services

- During our inspection, triage was completed within approximately 15 to 35 minutes of patients' arrival. The national target is for patients to be triaged within 15 minutes of their arrival in the ED. We observed triage nurses mitigating the risks to patients by reviewing the waiting list and picking out patients with high-risk symptoms such as chest pains.
- The triage process was appropriate and adhered to the national framework of the Manchester triage system. We observed triage nurses carrying out full assessments and recording presenting complaints, vital signs, past medical history, allergy and pain score.
- Children and young people had access to the paediatric assessment unit called the Hippo unit where children could go for further management or assessment.
- The department had a system of rapid assessment and treatment (RAT) for the immediate review of patients arriving by ambulance. Staff carried out RAT in an area called the blue area. This system is meant to ensure that staff received a clinical handover from the ambulance service, an early clinical diagnosis and early treatment. However, during our initial inspection, RAT was suspended and the blue area was being used as an escalation area for patients requiring inpatient admission. Staff explained that they had not undertaken RAT for some time due to high rate of attendance and unavailability of bed spaces for patients on the ward. This meant effective clinical decision-making was being delayed which might lead to poorer outcomes for patients.
- We raised concerns regarding the RAT process with the clinical leadership of the trust. They explained that the blue area was often used as an escalation area for patients requiring inpatient admission. However, whenever the area was not used for escalation, RAT was immediately resumed.
- Between October 2015 and March 2016, the ED achieved 55% of ambulance handovers under 15 minutes and 90.5% under 30 minutes. The monthly average number of ambulance handovers over 30 minutes was 100 and the monthly average number of ambulances handovers over 60 minutes was 122.
- We observed up to seven ambulance crews waiting on the public access corridor leading to the ED on 8 June 2016, the second day of our inspection. One of the ambulance crews had been waiting for 90 minutes.
- The result of a vital signs re-audit in March 2016 showed that only 44% of patients with abnormal vital signs had them repeated within 60 minutes. In 88% of the records with abnormal vital signs, there was no documentation of escalation to the nurse in charge. Only 52% of the records had evidence of some action taken in response to the abnormal result. This showed deteriorating patients were not being monitored in line with the trust's policy.
- During our inspection, we observed a patient who had been admitted to the ED with sepsis. The patient's notes indicated the patient had a cardiac arrest six weeks previously. The patient arrived by ambulance at 15:13 and was triaged at 15:17. The patient's observations were recorded at 15:17 with a NEWS score of 1. Although the patient received continuous treatment from staff until 18.27, they did not have any further documented observations until his condition deteriorated at 21:00. At 21:00, the patient complained of shortness of breath and was coughing and shaking repeatedly. Observations were completed with a NEWS score of 8. This was an extremely high score requiring immediate medical intervention. This was escalated to a consultant and continuous monitoring was commenced. We raised our concerns with senior staff and they recognised the delay to carry out observations as a risk to patient safety. The department investigated it as a serious incident.
- We carried out a further unannounced inspection on a 18 June 2016. The average time to triage was 15 minutes and RAT was being undertaken for patients arriving by ambulance. Patients arriving by ambulance were seen by a consultant within 15 minutes and there were no ambulance queues.
- The resuscitation training records showed that 83% of nursing staff and only 25% of medical staff had completed the adult and paediatric basic life support training (BLS) against the trust's target of 85%. In addition, 74% of nursing staff had completed the

hospital life support (HLS) training and only 55% had completed the paediatric hospital life support (PHLS) training. Seventy per cent of medical staff had completed the management of resuscitation training.

Nursing staffing

- A Band 8a Matron led the Nursing team. The department had the established level of nursing staff required. There was a Band 8a Practice Development Nurse (PDN), seven Band 7 senior sisters, 13 Band 6 junior sisters and 67 work time equivalent (WTE) Band 5 nurses in post. Three Band 4 Emergency Department Technical Aide (EDTA) and 13 Band 3 emergency care practitioners (ECP) supported the nursing team.
- The daily allocation reflected the number of nurses for each area. The nursing to patient ratio was 1:4 in the majors' and 1:2 in the resuscitation area. Two nurses were allocated to care for patients in the six bedded escalation area. However, patients in the escalation area often exceeded the numbers of trolleys in the area. During our inspection, we observed one nurse receiving a hand over for ten patients on the corridor.
- All registered nurses in the paediatric ED were paediatric trained. In the paediatric area, there were four nurses per shift during the period of our inspection.
- We observed a nursing handover and found it to be structured, detailed and relevant. Nursing staff discussed capacity on the unit and the effect on patient experience.
- Senior staff confirmed that there was no formal induction for agency staff, although they were creating one. They told us they conducted a verbal handover of important information with agency staff.

Medical staffing

- There were eight consultants in the ED. This is less than the recommended minimum of 10 in line with national guidelines. There were five consultant vacancies with one consultant appointment (a registrar in the ED) due to start in August 2016. The consultants were supported by 21 middle grade doctors, nine junior specialist trainee doctors, nine junior clinical fellows and 14 foundation year 2 doctors.
- Consultants provided cover between 8:00am and 22:00pm, seven days a week. An on-call consultant covers the night shift from 22:00pm to 8:00am. Other medical staff were rostered to provide cover for 24-hours a day, seven days a week. There was always an ED registrar on duty 24 hours a day, seven days a week. We saw copies of the medical staff rota and staff told us the cover was adequate.
- We conducted a further unannounced inspection on Saturday, 18 July 2016 and observed that there were at least two consultants from 8:00am to 22:00pm. An on-call consultant was rostered to provide cover from 22:00pm to 8:00am.

Major incident awareness and training

- There was a major incident plan for the trust with action cards in place for dealing with internal and external major incidents. These included procedures for dealing with hazardous materials incidents and chemical biological, radiological and nuclear defence. It also included a hospital site evacuation plan; mass casualty, burn, blast and critical care surge guidance for clinicians; pandemic influenza plan; severe weather plan and fuel shortage plan.
- Staff we spoke with told us they attended a major incident training as part of their induction. Staff were able to explain the action plans to follow for internal and external major incidents.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because;

- Some local audits were being undertaken but, we saw limited evidence of improvements to patient care.
- The department had a higher re-attendance rate compared with the national average.
- The department did not meet the seven day working standard requiring 16 hours consultant presence, seven days a week. Consultant presence in the ED was 14 hours a day, seven days a week.

However,

- Policies and procedures were developed in line with national guidance and best practice. Guidelines were easily accessible on the trust intranet page and staff were able to demonstrate ease of access.
- Patients were cared for by appropriately qualified nursing and medical staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently.

Evidence-based care and treatment

- There was a programme of local clinical audits based on the needs of the ED. We identified six audits carried out in the last one year. These included a re-audit of vital signs, moderate/severe asthmas in adults, sickle cell painful crisis audit, paracetamol overdose, acute urine retention audits and mental health in ED audit. All the audits were completed in March 2016.
- The acute urine retention audit identified only 12% of affected patients had analgesia within one hour in line with the trust's policy. In addition, only 10% of the patients had catheterisation within one hour against a standard of 90%. The audit recommended the need to improve documentation and use of analgesia. It also recommended the education of nurses and doctors. Following the inspection the trust provided us with an action plan (not dated) which recommended the need to improve documentation with regards to timings and pain management. It indicated this was reinforced at junior doctor induction every four months
- The paracetamol overdose audit identified that the triage term for overdose was very broad making it difficult to identify those needing urgent treatment. It recommended that patients with paracetamol overdose should be given a higher triage category of two to enable urgent treatment. Following the inspection the trust provided an action plan that included revisiting up to date management of paracetamol overdose at various teaching sessions for junior doctors by November 2016. The action plan recommended quarterly re-audits
- Results of a vital signs re-audit carried out in March 2016 showed that of the 75 patients audited, 65% had vital signs completed within 20 minutes of arrival. All vital signs were recorded for all the patients. Of these patients, 30% had abnormal vital signs, but only 44% of patients with abnormal vital signs had them repeated within 60 minutes. In 88% of the records reviewed, there was no documentation of escalation to the nurse in charge. Only 52% of the records had evidence of some action taken in response to the abnormal result.
- The audit indicated that the department was overcrowded during the period of the assessment, hence, assessments were difficult to undertake. The audit recommended "further work to be done with the nursing team to improve this". It was not clear what further work was required. Following the inspection, the trust provided us with an action plan which indicated that the audit result for the vital signs audit was discussed at the ED clinical governance meeting in June 2016. The action plan reiterated the need to inform staff to repeat vital signs and document result. This was to be disseminated to staff via email and the ED risk newsletter. The timescale for this was in August 2016.
- The results of a mental health audit showed that of the 52 cases audited between the last week of December 2015 and the 2nd week of January 2016, 71% of self-harm patients had risk assessment completed. This was an improvement from 64% in the last audit in 2014. Staff documented previous mental health issues in 87% of the cases (up from 74% in the last audit). Staff documented a mental state examination in 71% of the cases (up from 18% in the last audit). 90% had a provisional diagnosis documented in the notes (up from 52%). 96% had documentation of referral or follow-up arrangements in the notes (up from 66%) and 45% of referred patients were seen within one hour of referral by the mental health team (up from 0%). All patients were assessed in an appropriate facility for assessment of mental health patients.
- This re-audit showed improvement in all the standards compared to the last audit in 2014. This improvement was attributed to the development and use of the referral proforma, which covers all the standards of the audit. The audit concluded that there was still room for improvement and emphasis should

be placed on utilisation of the referral proforma by doctors and nurses to drive improvements. Following the audit, the results was shared with the mental health team.

- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies, such as the College of Emergency Medicine (CEM) and the National Institute for Health and Care Excellence (NICE).
- Guidelines were easily accessible on the trust intranet page and were up to date. Staff were able to demonstrate ease of access. Staff could also access hard copies of the guidelines in the event of a system failure.
- Adherence with guidelines was encouraged through the development of illness specific proformas to prompt use of best practice guidelines. For example, we saw evidence of sepsis guidelines and the ED adult triage and assessment form.
- Our review of patients' medical records showed that staff adhered to the sepsis protocol and gave patients antibiotics within one hour of arrival, in line with NICE sepsis guidelines.

Pain relief

- Patients told us that they received pain relief when they required it. Our review of patient records showed that staff used a standardised scoring tool to assess patients' pain and recorded pain assessments in patients' notes.
- Eighty seven per cent of patients surveyed in January 2016 agreed that their pain needs were met during their attendance. Ninety per cent of staff surveyed in the same period agreed that patients' pain levels were assessed on arrival.
- The ED carried out a sickle cell painful crisis audit between August to October 2015. Of the 39 patient records reviewed, 98% had the appropriate triage category, 80% had pain score at triage, 46% had analgesia prescribed within 30 minutes but only 15% had analgesia administered within 30 minutes. 30% of the patients had their pain reviewed within 30 minutes of initial analgesia. 15% received repeat analgesia within 30 minutes and 18% within 60minutes. 64% received repeat analgesia at any time. The audit recommended more education for doctors and nurses on the need to give analgesia quickly and awareness on the sickle database especially for new staff.

Nutrition and hydration

- Patients and their relatives had access to a trolley stocked with tea and beverages in the majors area. There was also provision for drinking water within the department. There was a kitchenette in the clinical decision unit (CDU) and staff provided patients with hot food based on their preferences. Patients and relatives also had access to the main hospital café.

Patient outcomes

- The percentage of patients who returned to the ED within seven days of discharge from their last ED attendance (unplanned re-attendance) was 13.2% against a target of 5% or less. This showed the department was performing worse than the national average.
- The trust had undertaken a number of national and local clinical audits that identified how the trust was performing against other similar trusts and areas for improvement. The department had undertaken specific audits managed by the CEM around the areas of vital signs in children and procedural sedation in adults in 2015/16. We reviewed the audits and found that the department performed below the CEM standard of 100% in all areas.
- The ED performed below the national average in three of five CEM standards for vital signs in children. Only 14% of children had a full set of observations and capillary refill time recorded within 15 minutes of arrival or triage. Only 63% of records indicated that the clinician recognised abnormal vital signs. None of the children with abnormal vital signs had a further complete set of vital signs recorded within 60 minutes of their first set.
- The ED performed above the national average in four of seven CEM standards for procedural sedation in adults. It was the same with the national average in one standard and performed below national average in two standards. Only 8% of the records met the requirement that patients undergoing procedural sedation in the ED should have documented evidence

of pre-procedural assessment, including ASA grading, prediction of difficulty in airway management and pre-procedural fasting status. None of the records met the requirement that monitoring during procedural sedation must be documented to have included non-invasive blood pressure, pulse oximetry, capnography and ECG.

- Only 21% of patients were discharged after documented formal assessment of suitability in five areas. Although the ED performed above the average of 3%, this performance was far below the CEM standard of 100%.
- The Trauma and Audit research Network (TARN) data published in May 2016 showed the quality of patient data submitted to TARN was 85% which was below the national average of 94.8%.
- Only 15.7% of all TARN eligible patient data were submitted compared with the national average of 69.5%. Only 12.9% of all TARN eligible patient data were submitted within 40 days of discharge or death (excluding coroner's cases) compared with the national average of 41.7%. As a result, there was insufficient data submitted for effective national comparisons.

Competent staff

- A professional development nurse (PDN) monitored/ recorded nurse competencies to make sure they were up to date with current practice based on national benchmark standards.
- New nurses undertook a two week induction period with the PDN and received training and clinical supervision in all areas of the ED including triage, NEWS, incident reporting and safeguarding.
- Only paediatric trained nurses worked in the paediatric emergency unit. Senior staff confirmed they did not use agency staff for the paediatric unit except for registered mental health nurses (RMN). We observed only permanent staff on shift during the period of our inspection.
- There was no formal induction programme for agency nursing staff. Staff told us they received a verbal handover of important information prior to caring for patients.
- All nursing staff had completed their revalidation when due.
- Junior doctors received an orientation and induction programme following their employment.

Multidisciplinary working

- Staff in the ED reported they worked closely with the joint emergency team (JET) which included a team of physiotherapist that attended the department to access patients' mobility. The team included the social service team that assessed patients before they were discharged. They provided immediate social and therapy support for patients once discharged, either at home or in an enhanced care bed.
- Nurses reported that they worked well with medical staff to deliver care in the department.
- The paediatric ED maintained good working relationships with health visitors, school nurses, social workers and the safeguarding team. We saw a copy of an information sharing form referring children to these agencies were appropriate.
- Patients presenting with mental health issues had access to mental health practitioners based on the site 24-hours a day, seven days a week. Staff reported they arrive within one hour of referral. Staff also had access to a substance misuse team to assess patients with drug or alcohol problems and related health issues.
- Staff informed us that ineffective working relationships between the departments often led to delays in patient management. For example, staff said surgical clinicians would insist on CT scans for abdominal pain being performed before they would review patients in the emergency department. In addition, staff said investigations such as echocardiograms and MRI scans could take three to four days.
- The trust informed us there were clinical indications for some emergency patients where the surgical team will request a CT scan prior to surgical review, but these were usually where patients have re-presented with abdominal pain within seven days. This particular protocol was implemented as part of an action plan following a serious incident.
- The trust informed us that echocardiograms which are clinically indicated are carried out by the department

physiologists within the ED where required and are done whilst the patient is in ED. The cardiology team attend the patient flow meetings three times a day, where all requests from the ED are flagged and prioritised to ensure this maximises the patient flow in the ED.

- The trust also informed us that there were internal standards for referrals to speciality teams. These state that a referral must be accepted and seen within an hour and if the speciality team did not think the patient was appropriate for them, they must make an onward referral. Performance against these standards was recorded and reviewed at divisional performance meetings chaired by the trust's Chief Executive.
- We were provided a copy of the Clinical Protocol: Internal Professional Standards for Emergency Pathways. The protocol outlined the arrangement for ensuring that there were clear pathways in place for referral to speciality teams. The protocol stated that specialities will have arrangements in place to access patients within 60 minutes of referral.
- We were also provided with the ED speciality response time. In May 2016, the median ED speciality response time for medicine was 78 minutes. The median response time for surgery was 115 minutes. The median response time for trauma and orthopaedics was 51 minutes whilst the median response time for gynaecology was 75 minutes. The target time for response was 60 minutes.
- The average median response time between June 2015 and May 2016 was 117 minutes for medicine, 99 minutes for surgery, 72 minutes for trauma and orthopaedics and 80 minutes for gynaecology. There was no data provided for September and October 2015.

Seven-day services

- Medical and nursing staff provided cover in the ED for 24-hours a day, seven days a week. The department had consultant presence from 8am to 10pm every day and on call overnight.
- Portable X-ray was available on request and there was one radiographer on duty between midnight and 8am.
- The JET team was available seven days a week from 7.30am to 8.30pm.

Access to information

- The department had a computer system that showed how long patients had been waiting and their location within the department.
- Our review of patient notes showed that all clinical staff recorded their care and treatment using the same document.
- Policies and guidelines were available on the trust intranet and were generally up to date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were clear about their responsibilities in relation to gaining consent from people, including people who lacked capacity to consent to their care and treatment. We observed that documented consent forms were completed where required.
- Staff had access to best practice guidance and local mental capacity policies on the unit. Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- ED staff provided a caring, kind, and compassionate service, which involved patients in their care and we received numerous positive comments from patients.
- Staff were aware of people's individual needs and considered these when providing care.
- Staff provided emotional support to patients and patients were able to access the hospital multi-faith chaplaincy services, when required.

- Patients' feedback was sought and the latest Friend and Family Test results showed over 93% of patients would recommend the ED.

However,

- We observed that other people could overhear consultations with patient in escalation areas.

Compassionate care

- We spoke to 22 patients and relatives and most of them provided positive feedback about their care. Patients said they were well looked after and had received good care. They said that staff were polite, courteous and professional and they had no complaints about their care.
- We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw most staff maintained patient privacy and dignity by drawing the curtains around patient areas before completing care tasks.
- Patients and their families in the paediatric ED area were all positive about their care. They said staff promptly attended to them when they arrived in the department. They praised the professionalism and competence of staff and confirmed that their privacy and dignity was maintained. Staff displayed many "thank you" cards given by patients and relatives on the notice board within the paediatric ED area.
- However, we observed a patient in the blue area calling for help for several minutes. The nurse allocated to the area had taken another patient to the ward and it took a while for another nurse to attend to the patient. This resulted in the patient trying to urinate over the side of his bed before he was assisted with a urine bottle. This delay in assisting led to a situation where patient privacy and dignity was compromised.
- We observed patients being cared for in the ED escalation area, which was a space, created on the corridor within the ED and demarcated by a screen. In one instance, we observed a patient could be seen through a broken screen whilst being changed. We also observed an ED doctor assessing a female patient on the main public access corridor to the ED and their conversation could be overhead.
- We raised concerns about the privacy and dignity of patients in the ED to the trust. During a further unannounced visit on 18 June 2016, we observed that the trust had addressed the concerns raised. Staff told us the trust had purchased six privacy screens for patients and we could see some of them in the escalation area. In addition, we observed there were no patients on the corridors during this visit. All observations of care we made were positive, showing kind and compassionate care and staff maintained patient privacy and dignity.
- Between December 2015 and May 2016, 6580 patients completed the friends and family test. The results showed that 93% of patients would recommend the ED.

Understanding and involvement of patients and those close to them

- Patients and relatives reported they were involved in their care and given explanations about their treatment. Patients said staff introduced themselves before attending to them. They explained the procedure they were about to carry out and the risks were discussed. Patients described the team as courteous and polite.

Emotional support

- The ED staff had a protocol on how to care for relatives who experienced bereavement. In the paediatric ED, families were provided with "comfort" boxes containing a teddy, a card, a candle and a booklet. There was also a balloon included in each box to send a message to heaven. Each box contained an information pack with information about bereavement support, death review processes and finances for funeral. An appropriate box was also provided to families of adolescent patients.
- Emotional support was also provided by the multi-faith chaplain service within the trust and patients could access representatives from various faith groups.

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

Urgent and emergency services

Requires improvement

We rated responsive as requires improvement because:

- The ED was often overcrowded. There was poor patient flow and waiting times were above the national average.
- Many patients were not being seen by a clinician within the 15-minute target.
- A significant number of patients with decision to admit remained in the ED for over 12 hours due to lack of beds in the rest of the hospital.
- Patients at risk of developing pressure ulcers were not always transferred to a bed from a trolley within the trust's four-hour target.

However,

- There were systems in place for identifying patients with complex needs such as dementia and learning disabilities and responding to their needs.

Service planning and delivery to meet the needs of local people

- Since our inspection in 2014, the staff room and offices within the ED had been relocated to a portakabin to create spaces for more cubicles, a green area for ambulatory patients and a 12 bedded clinical decision unit (CDU). Senior staff told us that following this, patient flow had initially improved and they were meeting the 4-hour performance target.
- However, the ED was not meeting the 4-hour target during the period of our inspection. Data provided by the trust indicated that the ED had an 8.4% increase in attendance in 2015/16 compared to the previous year. This included a 29% increase in the London ambulance service (LAS) blue light traffic.
- The trust cited the closure of several community services in Greenwich and Bexley as a factor affecting patient flow in the ED. For example, 63 community beds had been decommissioned in the area since 1st April 2016. There were plans to decommission further 18 beds by July 2016.
- To address these challenges, the trust established a silver command operational procedure, which was implemented as the capacity pressures within ED build up. The trust had introduced the use of escalation areas to facilitate the release of some ED capacity. These included six trolleys on the corridor within the majors' area. In addition, the blue area which was an area designated for rapid assessment treatment (RAT) was sometimes converted to a clinical decision unit (CDU) for patients awaiting beds on the ward.
- The trust requested ambulance diverts where necessary, but this was not always approved due to a lack of alternative care pathways in the area.

Meeting people's individual needs

- There were leaflets in the paediatric waiting area about child safety, common illnesses, injuries, temperature and infections. The main ED reception area had an information point where visitors could access information from various services via a telephone. These included the patient advice liaison service (PALS), voluntary services, NHS direct, blood and transplant and smoke free helpline.
- However, we observed that the information board in the ED waiting area did not specify current waiting times and patients we spoke with were not aware of the current waiting times.
- Apart from patients in the clinical decision unit (CDU), all patients were nursed on trolleys in the ED department. During our inspection, there were difficulties accessing beds and mattresses for patients. Patients were lying on trolleys for over 12 hours putting them at risk of pressure ulcers. During our unannounced return, we found that the concerns had been addressed. Patients were promptly discharged to the ward and staff were able to obtain pressure relieving mattresses for patients when required.
- Patients and their relatives had access to a trolley stocked with tea and beverages. There was also provision for drinking water within the department. Patients and relatives also had access to the main hospital café.
- Staff reported they could access interpreter services for patients through a help line or face to face when required.

- We observed a learning disabilities nurse attending to a young patient with learning difficulty. Their use of language was appropriate and this helped to reassure the patient and their relative whilst waiting for treatment.
- We saw passport templates for patients with dementia and learning disabilities. It was designed to be completed by patients or their relatives to identify information about the patient that staff needed to know, such as how they preferred to communicate, how they behaved when anxious or distressed, how they would tell staff if they were in pain and their support needs in aspects of daily living.
- Staff in the paediatric ED area told us all children with special needs had a passport in their record. They showed us a folder kept in the department used to record details of all children with special needs that had attended the department.
- Staff worked closely with substance misuse teams and psychiatric teams, who provide support to patients. Paediatric staff liaised with external organisations, such as charities who provide support to teenagers. Staff gave examples where they had referred teenagers to charities that supported young people against violence and knife crime.

Access and flow

- Trusts in England are given a target of admitting, transferring or discharging 95% of patients within 4 hours of their arrival in the ED. The data submitted to us by the trust showed that between May 2015 and April 2016, performance against the 4-hour target was 88.29%. This was consistently below the England average. Only 4.2% of patients left the ED without being seen against the target of 5% or less.
- The ED performance dashboard showed that between October 2015 and March 2016, an average of 620 patients a month spent more than 12 hours in the ED. The time to initial assessment was 99 minutes and the total time spent in the department for all patients was 16 hours. Total time spent in the ED for admitted patients was over 24 hours and the average daily number of patients waiting for beds was eleven.
- One patient had been in the department for 48 hours during the first two days of our inspection and at least eight other patients had been there for more than 12 hours. Thirty-two patients had a 'decision to admit' but were still in the department as there were no beds available in the hospital. These excessive delays in moving patients to specialist wards increased the risk of them receiving poorer outcomes.
- Staff indicated that patients breached the 4-hour target mainly due to a lack of beds on the wards and insufficient services in the community to facilitate discharge. Staff also expressed concerns about the triage system in place and its effect on waiting times.
- The UCC did not undertake blood tests, as a result, patients were referred back to the ED from the UCC for blood tests to be carried out.
- An ED performance report submitted by the trust states that between January 2016 and March 2016, the UCC referred over 2700 patients back to the ED. This was an average of 30 patients per day for the period and 16% of the total UCC attendances for the period. The report stated that the average time of referral back to the ED was three hours and the patients spent an average of two hours in the ED before a referral to speciality could be made thereby leading to the 4-hour breach. The report stated that the UCC contributed to 8% of the total breaches in the ED in the last year.
- We found the ED well organised during a further unannounced visit on Saturday 18 June 2016. The average time to triage was 15 minutes and the overall wait to see a doctor was 1hour 22 minutes.
- There were only three patients with "decision to admit" in the clinical decision unit (CDU) and two patients with "decision to admit" in the paediatric ED area. Staff told us they had been able to discharge patients to the wards. In addition, a frailty unit had opened within the acute medical unit (AMU) to accommodate elderly and frail patients from the ED.

Learning from complaints and concerns

- There was an information point in the reception area with direct access to contact the patient advice liaison service (PALS).
- There were 37 complaints about the ED between December 2015 and May 2016. The main themes were around triage, communication and attitude of staff.

The acute and emergency medicine (AEM) performance dashboard showed the AEM division responded to 46% of complaints within 18 days against a target of 70%. It also showed that 78% of complaints were resolved within the agreed timescales against a target of 95%.

- Staff told us they escalated complaints to the nurse in charge. They said they tried to resolve complaints at the time wherever possible and patients were encouraged to involve PALS where appropriate. They told us they received feedback about complaints and learning from them. Following a complaint from a patient about having to provide her medical history for every attendance, the ED implemented patient passports for frequent attendees.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff were unclear about departmental plans to improve the service.
- More than half the records on the risk register had dates of entry which predated the trust's existence.
- Although, local leadership had improved since the last inspection, staff reported less support from the executive team and said they were not always visible within the department. Some staff reported low morale as the department was very busy.
- Senior management staff had established an emergency care redesign programme to address the capacity issues within the ED. However, interim measures in place or the use of escalation areas were not always sufficient to mitigate the problems with capacity.

However,

- The ED had a vision and strategy to improve the service in the long term.
- Staff were supported in their role and had opportunities for training and development.
- Patients were engaged through surveys and feedback forms.

Vision and strategy for this service

- The trust had established an emergency care redesign programme which was part of a trust wide transformation programme covering all aspects of emergency patient pathway.
- The key initiatives under the emergency care redesign programme included an improved pathway for all ED patients to the urgent care centre (UCC); expansion and refurbishment of the ambulatory care unit; improving patient flow in the acute medical unit (AMU) and; delivering a frailty pathway.
- Staff we spoke with were not clear about the plans for the ED, however, they confirmed that the leadership wanted to improve the ED.

Governance, risk management and quality measurement

- The ED was part of the acute and emergency medicine (AEM) division and led by a divisional director.
- The divisional director, head of nursing, consultants, senior matrons and senior non-clinical staff attended a monthly divisional governance meeting. The leadership team discussed the AEM performance scorecard, staffing, serious incidents, complaints, finance and quality improvement projects. Action points were raised following each meeting.
- Senior ED staff also attended monthly ED management team meeting and quarterly clinical governance meetings. Minutes of the meeting show that the ED leadership team had been liaising with the urgent care centre to improve the triage process. Senior staff also discussed capacity management issues in the ED, staffing, serious incidents and the ED performance scorecard.
- We were provided with two risk registers which covered the department and AEM. We saw evidence risks were reviewed and mitigating plans were in place, however, some of the risks had dates of entry which indicated they had been on the risk register since 2010. The trust was formed on 1 October 2013, however, up to 16 risks (out of 27) on the ED risk register had dates of entry which predated the

existence of the trust. Two of the records had no date of entry, 13 of the records had no expected date for completion and nine had dates that had passed (March 2013 to December 2013). The last date of review on the ED risk register was in October 2015.

- In addition, up to six risks (out of 12) on the AEM risk register had dates of entry which predated the existence of the trust. One of the records had no date of entry.
- The trust informed us that an incorrect data transcription error had occurred within the spread sheet. They referred us to minutes of divisional meetings which showed risks were regularly reviewed as a new risk was added to the AEM risk register in March 2016.

Leadership of service

- There were clear lines of responsibility in the department and staff understood their roles and how to escalate problems. There were seven nursing teams, and a Band 7 nurse led each team. Staff reported they received verbal recognition and compliments from senior staff within the ED.
- Nursing staff spoke highly of the matron and professional development nurse (PDN). Staff said they were approachable and visible within the department. Doctors also said they were supported by the consultants within the ED. We observed consultant interactions with junior doctors and saw that they provided leadership and direction when required. Black and minority ethnic (BME) staff confirmed they have equal opportunities with other staff.
- However, staff reported less support from the executive team and said they were not always visible within the department. Staff said they came down to the department when an internal incident had been declared.
- Although the local leadership had improved since the last inspection, steps taken by the trust were insufficient to manage the fundamental issues of capacity and flow.

Culture within the service

- Staff at all levels told us there was a culture of support for continuing professional development and clinical supervision.
- Most staff told us that there was a positive culture within the department and they were happy to work in the ED. They confirmed they had good working relationships with other teams within the department.
- Staff said they were encouraged to raise concerns with senior staff. Staff we spoke with understood their responsibility under the duty of candour regulations and could articulate the process to follow.
- Staff reported the department was very busy and some staff said morale was low because staff were tired. A nurse within the paediatric ED said they sometimes felt unsupported during busy night shifts, as paediatric consultants did not always attend the department when called. However, they were able to escalate concerns to the divisional director and deputy service manager.

Public and staff engagement

- The department monitored patient satisfaction through patient surveys and feedback forms. Senior staff told us they meet with patients and their relatives to resolve complaints and applied learnings to improve the service.
- Nursing staff told us that each team had “away days” where they received training in aspects of their role and updates on the current trends within the department.
- The ED carried out a survey in January 2016 involving staff and patients under the “Living Our Values” project. The survey showed that 84% of ED staff would recommend the service to friends and family. 95% of staff agreed their team supported them through difficult situations and 88% agreed they always felt able to ask their colleagues for help. 98% felt they were sufficiently well trained to do their job.
- In the same survey, 50% of staff did not agree they had sufficient time to perform the necessary tasks during their shift. In addition, 42% of patients did not agree that staff had sufficient time to meet their needs. 33% of staff did not agree that patients’ needs and concerns were attended to in a timely manner.

- Staff indicated that to provide the best care for patients the team needed to "be under less stress" and the "workload needed to be lowered" to allow them to do the "little important things to make a big difference". Staff also highlighted the need for "more space to see patients, a better environment" in order to provide the best care.
- Most staff members referred to the capacity issues in the ED when answering the question on the biggest change they would make. Staff stated they would "increase the size of the hospital and volume of staff to help with the patient flow demands". When asked to provide one or two words that described the service they currently offer. Some staff stated that it was "overstretched", "under pressure", "we do the best we can" whilst other staff said it was "satisfactory".

Innovation, improvement and sustainability

- Following our inspection in 2014, the trust embarked on an improvement plan to address patient flow within the ED. A new clinical decision unit consisting of two, five bedded bays opened and extra cubicles were created in the ED, including an isolation room for infectious diseases. However, these facilities were no longer sufficient to address increasing demand on the ED.
- To help manage the increased demand the trust had put interim measures in place to use escalation areas for patients when the ED reached full capacity. However, these areas compromised patient privacy and dignity and increased the waiting times for patients to be admitted to the ED.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Acute and Emergency Medicine Directorate provides medical care services at the Queen Elizabeth Hospital. Acute medical services include nine inpatient wards, a 79-bedded acute medical unit, a cardiac care unit and a discharge lounge escalation area. Two wards are dedicated to healthcare for older people and there is a respiratory ward and ward dedicated to patients medically fit for discharge. A surgical ward also has beds available for medical patients when there is a lack of capacity elsewhere.

Medical services treated 30,525 patients in 2015. 40% of these were day cases, 58% were emergency admissions and 2% were elective admissions. The most common treatment was for general medicine, medical oncology, clinical haematology, gastroenterology, geriatric medicine and diabetic medicine.

During our inspection we visited all of the medical care areas, including a ward used for medical outliers and an escalation ward. We did not visit surgical wards, the medical discharge unit or the diabetic day care centre. To help us understand the quality and safety of medical care services, we spoke with the senior executive and leadership team responsible for this directorate as well as 10 doctors, three matrons, 17 nurses and healthcare assistants and 8 other healthcare professionals. We also spoke with 28 patients, observed care in all clinical areas and looked at over 45 individual pieces of evidence including 20 prescription records and 25 care and treatment plans.

Between April 2015 and April 2016 the average occupancy of medical care wards was between 96% and 99.7%.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care, including elderly care, as requires improvement because:

- The leadership team had addressed some of the concerns around bed capacity found during our last inspection in February 2014 to some extent. This included opening new beds and transferring some services. However, there were areas where we did not observe sustained improvement, including in the attitude and approach of some nurses and inconsistent use of risk assessments.
- There was limited evidence of embedded processes to ensure learning from incidents was disseminated to all staff.
- The trust had increased medical staffing levels out of hours, which improved cover for inpatient wards and the medical 'take'. However, some staff told us this did not always meet patient demand and said it was often difficult to obtain a doctor review overnight or at a weekend.
- There was room for improvement in infection control processes and environmental management, including hazardous waste storage and disposal.
- Results of medicines management audits were inconsistent and we did not always see good medicines management practices.
- The standard of patient records was highly variable and there were significant gaps in the completion of risk assessments.
- Not all of the clinical staff required to have life support training were up to date with this.
- During the inspection, there was limited evidence local audit activity included a range of staff and contributed to patient outcomes. After our inspection the trust provided information that demonstrated there was an audit plan in place for 2015/16, that included four local audits.
- Staff did not always treat patients in a manner that maintained their dignity.
- Individual needs were not always met, including those who could not speak English and those with a characteristic protected under the Equality Act, such as sight loss.
- Governance processes were in place including regular team meetings for feedback and learning.

However, it was not always evident they were effective, understood by staff or led to service development and improvement to make governance stronger.

However, we also found:

- Nurse staffing levels were consistent and senior staff had improved support and working conditions in some areas to improve staff retention.
- Performance relating to patients with a fragile hip fracture and some cancer care indicators was consistently good.
- A dedicated discharge coordination team worked proactively within multidisciplinary environments to reduce discharge delays and improve discharge planning.
- There was evidence of multidisciplinary working with dieticians, physiotherapists and occupational therapists.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical services at the Queen Elizabeth Hospital as requires improvement for safe because:

- Senior staff did not consistently provide feedback to staff on incident investigations and outcomes. This meant there was limited opportunity for learning as a result.
- Infection prevention and control practices were variable, both in the environment and in staff adherence to guidelines.
- Medicines management was poor with low rates of adherence to minimum trust standards in documentation and auditing of safety processes.
- There were significant deficiencies in patient records. This included missing, incomplete, contradictory or inaccurate risk assessments and observation documentation in multiple areas. The hospital used paper records and it was often not possible to identify who had written medical notes and reviews.
- Medical staffing out of hours was variable.
- Although fire and emergency protocols were in place, staff knowledge of these was variable.

However, we also found:

- Mandatory training rates were good and in most cases met the trust's minimum standards for compliance.
- Site practitioners enhanced out of hours medical cover by supporting wards in addition to on-call clinical teams, the out of hours consultant and critical care outreach team.
- Nurse staffing levels in most medical areas were close to the minimum established number needed and we saw very good working practices within teams.
- Handovers and ward rounds were patient-centred and well-coordinated.

Incidents

- The trust reported 16 serious incidents between May 2015 and May 2016, including 12 pressure ulcers and 2 infection control incidents. As a result there was a demonstrable focus on reducing pressure ulcers and caring for patients admitted with these. This included the provision of more equipment to prevent pressure ulcers and improved support from the tissue viability nurse.
- Staff demonstrated a proactive approach to reporting incidents but felt these were not always acted upon. For example, staff in the discharge lounge escalation area told us they submitted incident reports when they felt patients were admitted there inappropriately or unsafely. However, they told us senior staff had not addressed the issues that contributed to this. After our inspection the trust told us they felt escalation processes were robust for all staff to use.
- A member of staff on ward three said they only found out about incident outcomes if they asked the ward manager for information. One member of staff on the acute medical unit (AMU) said they had been very worried about the outcome of an incident because they did not understand the investigation and had not been kept informed. They told us it took a lot of effort and courage to ask the matron for feedback.
- The trust did not provide data specifically for the Queen Elizabeth Hospital with regards to incident outcome investigations. Across the trust as of March 2016, 4416 incidents did not have a documented outcome.
- In other areas staff felt more positive about the response they received to incidents. For example, staff on ward 18 submitted a serious incident report after a patient fell and fractured a bone. As a result senior staff reviewed the admissions process and the quality of risk assessments used on this ward to prevent falls.
- Not all staff had access to the electronic data reporting system. A healthcare assistant (HCA) on ward three said they were not given access to this and they would have to ask a nurse to submit an incident on their behalf. This member of staff worked clinically with patients, including those at risk of falls and pressure ulcers.

Safety thermometer

- Medical care services participated in the NHS Safety Thermometer data collection programme. This information was clearly displayed in individual wards in public areas.
- The trust had a target to provide harm-free care to 95% of patients. Between April 2015 and April 2016, medical care services met or exceeded this target in ten out of 12 months. In the two months this was not met, services achieved 93% and 94% harm-free care.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- Between April 2015 and April 2016, the trust reported 26 cases of Clostridium difficile and one case of MRSA. The trust audited medical wards on compliance with the Saving Lives National Audit Programme, which included hand hygiene standards and compliance with the central venous catheter care bundle and urinary catheter care bundle. The trust had a minimum compliance level of 80%. The latest available data for April 2016 indicated all wards exceeded this target with the exception of ward 14a in relation to hand hygiene.
- On the first day of our inspection, we found evidence of a build-up of dust in several areas on ward 18. The cleaning contractor did not keep information on cleaning schedules and audits available on the ward. During our inspection the nurse in charge did not know if regular audits took place. However, after our inspection the trust provided evidence from the cleaning contractor of monthly audits. The audits were comprehensive and included a 25-point check of each individual room, bed bay or designated area. In the three months prior to our inspection, ward 18 achieved an average of 96% compliance in cleaning standards. Staff maintained a local check of night time cleaning of medicine storage areas, the nurses station and the resuscitation trolley. In the patient kitchen on ward 18 we found a broken fan on a food preparation bench. The fan was very dirty and dusty and was labelled as decommissioned. Staff could not tell us why this was stored in a food preparation area. We found some improvements when we returned for a weekend unannounced inspection. For example, staff had removed the build-up of dust as well as the broken fan in the kitchen.
- Most staff demonstrated good hand hygiene practice when examining patients, including the use of personal protective equipment. However, staff did not always wash their hands after visiting a patient's bedside, including where a patient was potentially infectious on the AMU. In addition, it was not always evident staff followed trust guidelines on infection prevention and control practices. For example, we saw a nurse enter a side room clearly labelled as an isolation room for an infectious patient. The nurse did not gel their hands or wear personal protective equipment. However, staff told us signs used on side room doors worked well and they always adhered to the instructions.
- Staff used green 'I'm clean' stickers to indicate when equipment had been cleaned and sanitised. Due to a lack of storage space in some wards, clean equipment was stored in corridors. This meant it was not possible to guarantee the equipment was free from bacteria or dirt when it was ready to be used.
- A discharge lounge was regularly used as an escalation area for patients for spells of up to 24 hours. However, there were no hand hygiene or other cleanliness audit information displayed in this unit and staff told us they did not take place here. Staff did not know why this was the case and said if audits did take place they were unaware of them. After our inspection the trust provided information to show us audits were untaken in the discharge lounge.

Environment and equipment

- Site managers were able to source specialist equipment at short notice out of hours, including mattresses for patients with pressure sores.
- Five bed spaces were available in a discharge lounge, which staff used as an escalation area when there was a lack of capacity in wards. The environment was untidy and poorly maintained. For example, there were holes in some walls behinds beds, the only available toilet was out of order and food was not stored safely in the kitchen.
- Resuscitation equipment, including airway equipment and oxygen, was available in each medical ward. Staff documented daily checks on this equipment. We found this was completed consistently and there were no gaps in recording in the three months prior to our inspection.
- Ward managers conducted daily walk rounds that included an environmental check. The walk rounds were documented inconsistently and it was not always clear corrective action was taken or they were used as a tool to improve standards. For example, on the first day of our inspection on ward three we found an unlocked dirty utility room with a full sharps bin on the floor. In the AMU we found a sharps bin readily accessible in a public corridor with the aperture open. This was not compliant with hazardous waste management regulations. On ward three we found an unlocked metal cage used to store old copies of patient discharge notes. This presented a risk to confidentiality as the cage was in an open area of the unit and there was easy access to its contents, which included patient names and NHS numbers. In the dirty utility room on ward 18, a bin

marked for glass, tin and plastic only contained used personal protective equipment and antibacterial wipes. This meant potentially infectious material was not disposed of in accordance with hazardous waste requirements.

- On our weekend unannounced inspection, we saw some improvements in waste management procedures, including the safe storage of sharps bins in the AMU. The cage used to store old paper records on ward three had also been removed.

Medicines

- In all 19 of the patient records we looked at on AMU, staff completed medicine administration records. In all cases MARs were up to date and signed by the prescribing doctor.
- Medicines in the discharge lounge were stored inappropriately without proper documentation, temperature recording or date records. For example, some medicines were stored in a fridge that was also used to store food and drink. There was no record of routine temperature checks. A large quantity of medicine was stored loosely on top of filing cabinets in a storage room in the discharge lounge. Some of the medicine was labelled with the names and patient numbers of patients who had been discharged several months earlier and there were three bags of loose medicine not in original packaging and not marked with an open or expiry date. This included two bags of loose-sleeve medicine, including warfarin and ampules of heparin. Staff told us there was no stock rotation system in place and no system for disposing of medicine. Staff did not record the temperature of this room and we found it to be extremely hot. This meant staff could not be certain medicine would still be effective as there was no evidence it was stored below the manufacturer's maximum temperature guide.
- Senior staff told us a medicine trolley had been ordered and was awaiting delivery. We brought our concerns to the attention of the senior team and saw refrigerated medicine was subsequently stored correctly with documented temperature checks.
- Medicines were not always stored securely. For example, on ward 14 we found a drugs cupboard unattended with keys in the lock. There were no members of staff within eyesight of this and this ward had patients who were confused and wandering. On one day of our inspection in the discharge lounge, the keys to the storage room used for medicine were left in the lock without staff attendance. On the first day of our inspection on ward 18, a bedside medicine box was broken and could not be locked. Staff continued to use this, which meant there was medicine inside the box that was readily accessible. We spoke to the nurse in charge about this and they ensured the box was fixed the same day.
- All of the treatment charts we looked at were legible, signed and dated.
- Clinical staff did not always follow best practice or safety guidelines when administering medicine. For example, in the discharge lounge escalation area we observed nurses prepare intravenous fluid away from a patient's bedside. They did not check the patient's identification number or complete a safety check before giving the fluids.
- Compliance with medicines management protocols was audited monthly. Performance in most of the indicators was generally worse than minimum trust targets. For example, between January 2016 and April 2016, medical care services did not meet the minimum requirements in the correct and safe storage of medicine, the recording of fridge temperatures or compliance with controlled drugs documentation. The target for administering intended doses of prescribed medicine was 90%, which medical care services achieved during this period.

Records

- Patient documentation in the AMU was completed inconsistently. Staff used paper records and in most cases we found written entries were legible. However, some staff did not write their name or bleep number after making notes. For example, in four patient records on the AMU, it was not possible to trace who had written the last medical notes in each as they used only a signature. In 10 patient records on this unit, staff had not completed a cognitive assessment. We asked a member of clinical staff about this. They said, "Sometimes we come in and it is hectic, it feels chaotic. You have confused patients wandering; people with dementia and UTIs [urinary tract infections] and you have a lot of safeguarding to do. It is not possible to stay on top of the paperwork with so few staff and so much to do."
- We looked at eight sets of patient records on AMU during our weekend unannounced inspection. Staff did not always record observations at the intervals prescribed by the admitting doctor. For example, one

patient was due to have observations every two to four hours. However, in the 48 hours prior to our inspection, staff recorded observations on only four occasions. In some cases staff had not recorded how regularly observations should be recorded.

- Staff on ward 18 did not complete treatment and care plans consistently. For example, one patient had an incomplete cognitive assessment in which staff had written only, "very confused, refer to medical team." During our observations we were not confident staff had the understanding of this person's mental capacity to provide appropriate care. Pressure ulcer prevention care plans were not always up to date. For example, one patient's care plan indicated they needed repositioning in bed every two hours. Elsewhere in their care plan a member of staff had written the patient was able to mobilise independently. One of the assessments was undated and unsigned and so it was not possible to identify the most up to date assessment.
- Staff used body maps to record any areas of concern, such as pressure areas or bruising. Where these were used, we found them to be followed up by an appropriate member of staff and related care, investigation or treatment documented.
- We looked at the records of three patients cared for in the discharge lounge escalation area. There were a number of omissions in risk assessments. For example, two patients had no risk assessments for waterlow or pressure ulcers and none of the three patients had a documented nurse care plan. The trust had a 90% minimum compliance rate for the completion of waterlow scores. Between April 2015 and April 2016, medical care areas met or exceeded this target in every month. However, during our June 2016 inspection we found inconsistent waterlow documentation.

Safeguarding

- Staff demonstrated a good awareness of members of the public entering unsecured areas in some cases. For example, we saw the ward manager on the AMU challenge a person who was wandering between bed bays. When they could not name who they were there to visit, the member of staff ensured they left the unit and made staff aware of the situation.
- A new safeguarding lead was in post and working to standardise processes across the trust's sites and to improve staff training. This member of staff identified a number of gaps in the provision of safeguarding training and learning, such as the need for more detailed awareness of regulations relating to the Deprivation of Liberty Safeguards. New training was being provided to staff in the 'PREVENT' programme in line with Home Office guidance on preventing radicalisation. Twice monthly training sessions were provided for staff in all areas of safeguarding, including recognising exploitation and providing care for patients who experience female genital mutilation.
- Safeguarding adults and safeguarding children formed part of staff mandatory training, including for non-clinical staff. In medical wards and departments, 100% of staff had up to date level one safeguarding training. In addition, 92% of staff had adult safeguarding level two training and 89% had child safeguarding level two training. This was better than the trust's target of 85% compliance. Staff training in child safeguarding level three was worse than this target, at 72%. No members of staff were trained to adult safeguarding level three in the medical division. Staff were positive about their safeguarding training and said this included enough detail to help them protect the wellbeing of their patients, including those with dementia.
- A new safeguarding lead planned to streamline referral pathways across the hospital to provide more responsive care to patients and support to staff. There were insufficient specialist staff to adequately respond to all safeguarding referrals in the hospital and from the local authority. A temporary member of staff was contracted to provide support and the trust had established this role as a permanent position. The safeguarding lead delivered intensive training to staff to help them make referrals appropriately and planned to introduce closer working links between the Queen Elizabeth Hospital and Lewisham Hospital.

Mandatory training

- The trust target for rates of up to date mandatory training was 85% and was measured in 29 different training courses. Staff in medical care were compliant with minimum training requirements in 13 areas, including in clinical infection control, conflict resolution and health and safety. In April 2016, the latest available to us, 74% of all medical care staff had received all mandatory training updates in the previous 12 months.

- Staff training was significantly lower than the trust's minimum standards in fire safety for clinical staff (53%), PREVENT awareness levels one and two (20%), PREVENT WRAP level three (30%) and PHLS resuscitation training (45%).
- Some of the mandatory training was delivered online through e-learning software. Staff told us it was difficult to keep this up to date because they were not given protected time to do it during a shift. Two members of staff said they previously completed this out of hours during unpaid time and did not get the time back.

Assessing and responding to patient risk

- Staff used the National Early Warning Scores (NEWS) system to identify deteriorating patients. This system was monitored by the resuscitation team and the critical care outreach team (CCOT) to make sure staff responded appropriately. For example, a NEWS score of 9 was considered a peri-arrest and staff were required to contact the cardiac arrest team. Patient records indicated staff did not always respond quickly to increasing NEWS scores. For example, one patient's record in AMU indicated their NEWS score had increased to six, which was higher than the minimum required to trigger a consultation from the critical care outreach team. However, staff did not escalate this for 24 hours and there was no documented clinical reason for this. We looked at another 10 sets of patient notes in various medical areas and found in each case staff responded appropriately to NEWS scores.
- A hospital at night team responded to deteriorating patients in all areas of the hospital, including medical wards. A senior house officer (SHO) and critical care outreach team (CCOT) nurse led care and treatment on this team and at the time of our inspection they were reviewing the standard response policy. Staff aimed to use the outcome of this to ensure the most appropriate member of staff responded to each call for assistance, such as when a CCOT nurse could provide support instead of the SHO.
- Some ward areas were not secured, which presented a risk to patients who were confused might leave the area. We saw this on ward 14, a care of the elderly ward. During a 45 minute observation, three patients left the ward. Although a healthcare practitioner watched them leave they took no action. On one occasion another member of staff noticed and gently escorted the patient back and on two other occasions a senior nurse had to leave the unit to find the patients. There was no formal system in place for monitoring patient movements.
- Clinical staff in some medical areas told us they were not confident in the escalation processes in place related to patient need and risks. For example, a member of staff in the discharge lounge escalation area said they felt "isolated" because they had no control over patient admissions. They said, "We can escalate our concerns over patients when we think they're too sick to stay here but they are never moved."
- A member of staff on ward 18 told us senior staff often overruled the established policy for patient admissions to the ward. This meant patients with a high level of need were admitted and were subsequently at risk of deterioration. They said, "Once patients are admitted to this ward, they are never accepted back to medical specialties, no matter how seriously ill they are. We escalate patients when they deteriorate but medical wards never take them back. We are not equipped to deal with this level of need." We asked two senior hospital staff about this. They said patients were reviewed and transferred to another ward after an escalation took place, which contradicted what we heard from staff on the ward. During our weekend unannounced inspection, we spoke with the CCOT team and the senior matron in charge. They told us this was an issue under review with the out of hours escalation policy as they recognised there were challenges between the admission policy to ward 18 and what happened when patients deteriorated. Extended periods of stay in ward 18 and a number of unexpected deaths indicated patients with high levels of need were cared for there. This included patients who were completely immobile, did not have mental capacity and/or were blind.
- In one patient record, staff had written 'not applicable' next to each factor known to contribute to a falls risk. However, the patient wore glasses and did not have appropriate footwear. In another patient record, a member of staff had signed and completed a checklist of falls risks but had not documented action taken to reduce risk. This meant staff had not accurately or fully assessed the patient's risk.
- Patients had a risk assessment for venous thromboembolism (VTE) in all of the records we looked at. The trust audited compliance with VTE risk

assessments in medical care against a target completion rate of 95%. Between April 2015 and April 2016, medical care met or exceeded this target in six out of 12 months. Rates of completion in the remaining six months ranged from 84% to 94%.

Nursing staffing

- A matron, three ward managers and three senior nurses led nursing care in the AMU. This team had 117 nurses and the vacancy rate was very low, with only seven band five nurse posts vacant. This meant the units rarely used agency staff.
- Ward four was regularly short-staffed by up to two nurses per day. Bank and agency nurses were used to ensure each patient bay in the main ward had at least one qualified nurse per shift and two qualified nurses were assigned to each cardiac care bay. This ward was short of seven substantive nurses based on the minimum needed to safely care for patients at all times and senior staff ensured daily nurse to patient ratios were maintained with bank or agency staff.
- Additional nursing staff or healthcare assistants were provided to support patients who were confused or delirious.
- A discharge lounge was equipped with five beds, which staff used as an escalation area when there was reduced capacity elsewhere in the hospital. When this was in use, two nurses and two healthcare assistants staffed this.
- During a morning handover on the second day of our inspection in the AMU, we observed the clinical team to be well organised with robust quality and safety leadership from the ward manager. This included a 15 minute safety handover that staff used to discuss patient risks such as infection control, pressure ulcers and falls.
- We observed a nurse handover on ward 18 on the second day of our inspection. This was task based and it was not evident staff knew patients individually. There was no discussion of social status or personal needs and in some cases the nurse in charge did not know that discharge or moving and handling status had changed. This was updated by the senior nurse during the handover. Staff were not allocated to patients based on their knowledge of them, which meant patients did not consistently receive care from staff they recognised. The bedside handover between nurses and a healthcare assistant was more patient-centred. In this staff discussed if the patient had slept well, explained how they had reduced their anxiety and reminded incoming staff that a patient's incontinence was causing them embarrassment. Staff discussed strategies to overcome this.
- Bank and agency nurses were required to complete a local induction for each area they worked in. This included an introduction to required standards of hand hygiene, where to find local policies and procedures and emergency bleep numbers. We looked at a sample of these in four different areas and found them to be fully completed in all cases for the three months prior to our inspection.
- HCAs worked in some clinical areas to support nurses. For instance, on ward three HCAs were trained to operate blood monitors, take echocardiograms and conduct oral checks.

Medical staffing

- The skill mix of medical staffing was similar to the national average. This included 38% consultants, 2% middle career doctors, 32% registrars and 28% junior doctors.
- Out of hours medical cover was sometimes insufficient for demand. For example overnight on a weekend, a registrar and two senior house officers were responsible for clerking patients and a senior house officer and junior doctor covered the wards. During weekend daytimes, a registrar, three senior house officers and a junior doctor were responsible for the medical 'take' for inpatient wards of up to 60 patients per day. A consultant was available on site from 12pm to 9pm. As part of the Hospital at Night service, the critical care outreach team supported the medical team. This represented an improvement in out of hours medical staffing although this was not always acknowledged by clinical staff. One doctor told us they relied on the critical care outreach team out of hours to support the lack of medical cover but described this as "very stretched" and said there had been a number of "lucky escapes" as a result.
- Four respiratory consultants provided cover on ward three Monday to Friday between 9 am and 5pm and two trainee doctors provided weekend cover.
- Five cardiologists provided medical cover on ward four, which included the cardiac care unit. However medical cover was only available between Monday to Friday between 8am and 4pm. Outside of these times if a

patient deteriorated or presented at the emergency department with a heart attack, they were transferred to another hospital. This formed part of an established service level agreement.

- Medical ward rounds took place daily, Monday to Friday and a consultant led a ward round twice each week. Consultants were available Monday to Friday between 8am and 9pm.
- Weekend medical cover on the AMUs was provided by four junior doctors and two consultants.
- Locum doctors did not always receive an adequate induction. We spoke with three locum doctors who had not received an induction or been allocated a supervisor.
- Medical staffing outside of defined medical wards was not planned to meet patient needs. For example, when patients were cared for in the discharge lounge escalation area, the responsible consultant did not always include them in ward rounds or reviews. Staff told us it was "often a struggle" to obtain medical reviews for patients in this area.

Major incident awareness and training

- The hospital had a centralised major incident policy including fire and evacuation plans. In some areas staff were not able to tell us about the local emergency plans. For example, staff on ward three showed us what they believed to be an up to date fire resource folder. This folder was last updated six years previously and included a staff list that applied before the previous team moved to a different part of the building. The named fire wardens and matrons were no longer in post in the area. The fire resource folder on ward 18 was similarly out of date and did not reflect staffing there. The trust told us the most up to date information was available electronically and staff should refer to this and not hard copies of evacuation plans. Some areas, such as the AMU, had an up to date list of staff names and contact numbers that could be used to call in extra staff in the event of an emergency.
- Training was not always updated quickly following ward moves. For example, the medical respiratory team had moved from ward 14 to ward 3. Staff in this team said they had not received up to date evacuation training since the move, which was important because they needed to know how to move patients with a tracheostomy in an emergency. Three members of staff on the AMU said they had not been given fire training and would not know what to do in an emergency. A senior member of staff on ward 18 said they were not sure who the local fire warden was.
- It was not clear there was continual oversight or fire prevention measures in all wards. For example, in ward 18 a fire door to a room used for storage of broken or discarded equipment and laundry was wedged open. This was directly opposite a patient bed bay and next to a fire escape route.
- A discharge coordination team worked with trust senior staff during the winter pressures period to ensure the most vulnerable patients were admitted appropriately. This team also worked with community healthcare providers to maximise the use of community beds for elderly and frail people.

Are medical care services effective?

Requires improvement

We rated medical services at the Queen Elizabeth Hospital as requires improvement for effective because:

- During our inspection there was limited evidence of clinician-led audit activity, learning and dissemination in medical areas. This was because staff could not readily demonstrate how practice was influenced by audit results or how audit programmes drove improvements. After our inspection the trust provided the local clinical audit plan for 2015/16. This included three planned audits and an audit carried over from the previous year.
- The hospital performed variably in the national inpatient diabetes audit. For example, the rates of prescription errors were lower than the national average, at 13% compared with 22%. However, fewer patients were seen by a specialist diabetic team and the national average, at 30% compared with 36%.
- Pain relief was recorded inconsistently and some patients reported delays in obtaining this.
- Waterlow and malnutrition risk assessments were not completed consistently and in some cases were incomplete or inaccurate.
- Only 70% of clinical staff had up to date life support training against a trust standard of 85%.

- Length of stay in some areas was significantly longer than wards were equipped for. This included a 72 hour limit in the acute medical unit (AMU) and stays of more than four months in ward 18, a short-term pre-discharge ward.
- There were gaps in knowledge and practice with regards to the Deprivation of Liberty Safeguards, although a new safeguarding lead was planning improved training and awareness of this.

However, we also found that:

- Performance in targets relating to consultant assessments of fragility hip fractures was better than the trust's minimum target.
- The average length of stay for the majority of patients was in line with national averages for all medical specialties.
- A practice development nurse and critical care outreach team were developing a broader range of training opportunities for ward-based staff.

Evidence-based care and treatment

- Staff adhered to local policies and procedures in the care and treatment of patients who were admitted with high risk conditions. For example, patients with low skin integrity or pressure areas had pressure ulcer treatment plans and patients with skin wounds had wound treatment plans and evaluations.
- Local audits led to improvements in practice, care and treatment. For example, an oral care audit on ward three led to four-hourly mouth checks and an improvement in training for healthcare assistants and staff on mouth care. Although this was evidence of good practice, there was a lack of evidence that clinician-led audits were embedded in all practice areas. For example, clinicians we spoke with said they did not have a coherent audit plan or advance schedule of auditing activity. After our inspection, the trust provided a local audit activity plan for 2015/16. This included audits for ward round observation documentation, venous thromboembolism risk assessments and treatment times in the acute medical unit (AMU). A diabetic foot inspection audit from the previous year was extended into the current audit cycle.
- There was limited evidence of clinician-led research learning in staff rooms or education areas. Some standardised audits were included in the quality dashboard, which staff used to monitor performance. This included surgical treatment times for fractured neck of femur. A member of staff in the AMU had conducted a frailty audit in November 2015. This involved an assessment of the frailty score attributed on admission and whether this was appropriate. The audit was thorough and helped staff to identify areas for improvement in assessment and documentation. At the time of our inspection a re-audit had not taken place, which meant it was not possible to determine if there had been an improvement in practice.
- The AMU participated in the Society for Acute Medicine Benchmarking Audit (SAMBA) in 2015 to assess performance against three targets. The unit was 64% compliant against the SAMBA targets of each patient being given an early warning score within 30 minutes of admission, a medical review within four hours and a consultant review within eight or 14 hours.
- We observed a multidisciplinary board round on the AMU and saw it was multidisciplinary and included a detailed review of each patient. Levels of engagement between doctors was variable however and we did not note a demonstrable focus on supporting timely patient discharge.

Pain relief

- The discharge lounge escalation area did not have facilities to store controlled drugs and staff told us pain relief was often delayed because they had to obtain this from medical wards elsewhere in the hospital.
- Staff documented pain relief administered on medicines charts but did not always record pain assessments or scores. Instead this was recorded based on what the patient reported their pain level as.
- One patient we spoke with said they did not feel their pain was managed well. They said it had taken a long time to get their regular prescribed medicine when they were admitted and they missed one of their daily doses as a result. We observed the patient ask staff repeatedly for pain relief. Staff told the patient they were still preparing it. One patient on ward three said they asked a nurse for some paracetamol. This was given to them from a loose sleeve blister pack in the nurse's pocket and was not recorded on the patient's medicines chart.

Nutrition and hydration

- Staff completed waterlow, fluid balance and nutrition screening risk assessments on patients' admission to the AMU. However, risk assessments were not always

fully completed. For example, in one record we looked at, only part of the assessment was completed and it was not signed or dated. In another record a risk assessment was completed but the total risk score had not been calculated. Staff used a pressure ulcer prevention plan when they identified patients with a low waterlow score.

- Staff did not always appropriately assess or respond to risks associated with malnutrition. For example, in one patient record staff documented a totalled body mass index score without recording a weight. In the same record, staff indicated the patient had a very high waterlow risk but there were no documented actions.
- Patients gave us variable feedback about the quality of food offered. One patient said they asked for salad and was told there wasn't any available. They said they were only offered 'heavy' food such as stew, which made them feel uncomfortable lying in bed all day. Another patient said they were happy to be offered fresh fruit and vegetables and found the food tasty.

Patient outcomes

- Between April 2015 and April 2016, over 90% of patients with a fragility hip fracture had a consultant-led assessment within 72 hours of admission. This was better than the trust target of 87%.
- Between April 2015 and April 2016, 468 general medical inpatients and 790 care of the elderly or stroke patients experienced a length of stay over 14 days. The average length of stay for medical specialties was similar to or longer than the national average in all disciplines. For example, the average length of stay for cardiology patients was 1.9 days, which was the same as the national average. For care of the elderly medicine, the average length of stay was 10.1 days, compared to the national average of 9.9 days.
- In the September 2015 national inpatient diabetes audit, the hospital performed better than the national average in eight out of 17 indicators and worse than the national average in nine indicators. For example, 100% of patients were seen by a multidisciplinary footcare team within 24 hours of admission, compared with the national average of 58%. Management errors occurred in 9% of patients and insulin errors in 11% of patients. This was significantly better than the national averages of 24% of patients with a management error and 23% of patients with an insulin error. Areas for improvement included in meals choice where 35% of patients had an appropriate choice of food for their condition, in comparison with the national average of 54%. In addition, the audit highlighted only 52% of clinical staff had adequate knowledge of diabetes, compared with 66% nationally.
- Readmission rates for the six main medical services were significantly better than the national average for elective patients and slightly worse than the national average for non-elective patients.
- A new frailty pathway opened in the AMU during our inspection. As part of this 10 beds were allocated to patients on the pathway and were managed by a team of geriatricians. The pathway enabled staff to provide targeted care and treatment and to identify appropriate community beds when patients were ready for discharge. A hospital elderly and frailty group worked with local clinical commissioning groups and care managers to avoid unnecessary hospital admissions.
- Staff required life support training at a level appropriate to their role and responsibilities. The trust's minimum standard for up to date resuscitation training was 85%. None of the staff groups in medical care met this standard. For example, 71% of required staff had up to date basic life support training and 70% of required staff had up to date management of resuscitation training.
- A clinician with advanced life support skills and advanced airway management skills with the ability to intubate was available on site 24-hours, seven days a week.
- Patients were sometimes cared for in medical inpatient areas that did not meet their individual needs. For example, ward 3, a respiratory ward, was not equipped for high-acuity patients. There was insufficient specialised medical or nursing cover in this ward to provide continuous individualised care. However, patients who required non-invasive ventilation or who had a tracheostomy were often cared for in this area. This was being addressed. A practice development nurse (PDN) and the critical care outreach team (CCOT) recognised a knowledge gap in the respiratory ward relating to the care of patients with a tracheostomy. Nurses we spoke with confirmed this and said they sometimes felt there were more patients admitted with acute needs than nurses with specialist training to care for them. In response to this, the ward manager ensured every shift had at least one tracheostomy trained nurse. In addition, the PDN and CCOT team were developing joint training for non-invasive ventilation and

tracheostomy care. This included practical assessment of competencies through bedside observations. Following our inspection the trust provided evidence that all clinical staff had specialist training in non-invasive ventilation, tracheostomy care and the management of chest drains. The trust attributed the discrepancy between what staff told us and evidence of training to the ward being placed in an 'enhanced management' programme.

- Ward 18, a pre-discharge ward, was not equipped for patients who required end of life care. However, patients who had deteriorated and required palliative care were often cared for in this area. This ward also cared for patients who were bed bound or needed the use of hoists to mobilise. Patients often had to stay in the ward for extended periods of time but there was little evidence the ward was equipped for this, either with continuity of staff or the environment. For example, one senior nurse said five patients were cared for on end of life pathways between December 2015 and January 2016. They said support from the palliative care team was very good but they were not resourced to provide appropriate care for patients who needed syringe drivers and other end of life treatment.
- The AMU was equipped to provide short-term care for patients for a maximum of 72 hours. However, due to a lack of capacity and flow in the hospital, patients were routinely cared for in this area for significant periods of time. Patient records did not indicate such patients had individualised care plans in place.

Competent staff

- A practice development nurse (PDN) supported staff in training updates in the AMU and wards three and four. Staff told us they were not given the opportunity for ad-hoc bedside teaching and learning during shifts but the PDN was supportive in making sure mandatory training was up to date. Four staff we spoke with said they did not know what the role of the PDN was but had seen her e-mail address on display in staff areas.
- In addition to trust mandatory training, staff were offered specialist training appropriate to the medical care provided in their ward. For example, all nurses in ward two had completed a chest drain course that enabled them to provide chest drain care for patients who were stepped down from the intensive care unit.
- Locum doctors we spoke with they were not sure who was responsible for their appraisal or how they would arrange this. Locum doctors usually have a responsible officer through their agency who would also arrange appraisals. Only where locum doctors are placed on a long-term basis would we expect an appraisal to take place locally. Although it was not the trust's responsibility to provide locum doctors with appraisals or supervision, an agreement with agencies regarding staff competence was not applied to check the work of individual doctors demonstrated competence.
- The trust tissue viability nurse worked closely with ward nurses to provide support and learning in the care of patients with skin wounds and pressure sores. For example, they provided '10 minute bite size learning' sessions on an as-needed basis and provided on-going training for a new formulary they had established. Tissue viability link nurses were available in many medical areas and they received additional training for this role.
- The agency nurses who staffed ward 18 had full access to all trust training and learning opportunities including away days. Some senior staff told us attendance from the agency team was quite low on training events but they were satisfied with the quality of their work.
- Nurses recruited from overseas worked as supernumerary staff whilst taking a preceptorship course.
- The trust's target for annual appraisal rates was 90%. The latest data available to us was from April 2016, when 73% of staff in medical care services had received an appraisal in the previous 12 months.
- Staff received training updates on the use of national early warning scores (NEWS) and managing acutely ill patients during team away days.
- Permanent staff in some areas said the use of agency staff without appropriate training added pressure to them and made it more difficult to care for patients safely. For example, ward three cared for patients with respiratory needs and often relied on agency nurses. One member of permanent staff said agency nurses assigned to the ward were often not trained in respiratory care or in managing non-invasive ventilation.
- Staff were generally positive about their training opportunities but said there was room for improvement in how they could provide feedback for improvement. For example, one member of staff said the PDN on ward three had introduced themselves but had not discussed what their role was or if they could be approached for training. Another member of staff said their non-invasive

ventilation (NIV) training was useful but very basic. For example, they said it would be useful to know why a patient needs NIV, what the risks are and how they can be taken out so the patient can eat.

Multidisciplinary working

- We observed a ward round on the AMU led by a consultant with five junior doctors. This was well organised and patient-centred although did not include opportunities for experiential learning for junior doctors.
- Two consultant-led multidisciplinary ward rounds took place each week for long-term patients on ward 18.
- There was evidence of good working practices and information sharing between appropriate specialist nurses and community staff. For example, the tissue viability nurse and safeguarding nurse worked together to investigate patients who were admitted with pressure ulcers, skin wounds or unexplained bruising. Nurses also communicated with colleagues who worked in the community, such as district nurses, to ensure discharge plans were appropriate and took account of patient's tissue viability needs. This Included meetings with clinical commissioning groups to reduce the numbers of patients admitted with pressure sores acquired in the community.
- Physiotherapists and occupational therapists were based on the AMU and worked with the clinical team to provide rehabilitation services that support timely discharge. Therapy teams were available on demand across the hospital and staff had access to dieticians when required. Dieticians completed weekly visits to each ward.
- There was a hospital-wide initiative to improve patient uptake of nicotine replacement therapy, particularly in wards where a large number of patients were smokers. We asked one nurse in charge about this in relation to publicity on display in their ward. They said this was not an integrated multidisciplinary process and just meant a member of smoking cessation staff sometimes spoke with patients on the ward. They said none of the ward staff were involved in working on this.
- Staff demonstrated proactive working with community services as part of packages of care prior to discharge. For example, where a patient was due to be discharged on a community treatment order, they were reviewed by an appropriate drug and alcohol liaison nurse or psychiatric liaison nurse before discharge.

Seven-day services

- The hospital provided an acute cardiac service Monday to Friday from 8am to 4pm.
- Consultant cover was not available seven days a week on the cardiac care unit and out of hours medical cover was provided by an on-call physician. There was no out of hours respiratory service and doctors told us if this was needed it was provided on a goodwill basis. However, the consultant of the week accepted calls directly from the ward. In addition, the consultant on call for medicine took responsibility for inpatients at the weekend and cardiology junior doctors were included in the acute on-call rota.
- Physiotherapy cover was not available seven days a week due to shortages in the team. This meant some physiotherapists had worked up to 12 days continually, which they said left them exhausted. After our inspection the trust told us this was a voluntary arrangement as physiotherapists managed their own working patterns.
- A pharmacist visited each medical ward daily, Monday to Friday and there was on-call cover provided seven days a week.

Access to information

- Bed managers and discharge coordinators shared information with community staff to expedite the discharge of patients into nursing homes or other community providers. This included the use of discharge checklists and access to information held in the community, such as risk assessments relating to safeguarding or social needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a lack of understanding and consistency amongst clinical staff in the use of DoLS. For example, one patient on ward 18 asked to go home repeatedly. Their care plan stated they had dementia but we observed a number of interactions in which the patient was lucid and orientated. They did not have an up to date cognitive assessment and staff were not able to tell us why a best interests assessment had not taken place. However, social services staff visited the ward weekly and senior nurses said social workers supported them to provide appropriate care.

Medical care (including older people's care)

- A new safeguarding lead conducted an audit on the use of the Deprivation of Liberty Safeguards (DoLS) in the hospital. This found out of 25 medical inpatients who needed a DoLS, only one patient had an authorisation in place. The member of staff used this information to work with clinical staff to raise awareness of when a DoLS authorisation was needed. Following the inspection the trust told us the audit found that all patients who required to have a DoLs in place, did have a DoLS in place.
- The Mental Capacity Act (2005) and consent to treatment were part of the trust's mandatory training programme. In medical care, 87% of staff had up to date training. This was better than the trust's minimum standard of 85%.
- Staff completed appropriate mental capacity and risk assessments when they used bed rails for a patient.

Are medical care services caring?

Requires improvement

We rated medical services at the Queen Elizabeth Hospital as requires improvement for caring because:

- We had variable feedback from patients regarding personal care, privacy and dignity. This included patients in some areas without access to regular showers.
- Short staffing in some areas resulted in a reduction in the ability of staff to meet the personal needs of patients. For example, on ward 18 patients who wanted to wash their hair often had to wait considerable lengths of time because there were not enough staff to help them. In the AMU, some patients who were able to use commodes had to wear incontinence pads instead because staff were too busy to help them. This had a significant impact on dignity and personal wellbeing.
- During our observations we saw a number of staff speak to or interact with patients and relatives in an unacceptable manner, including with a lack of kindness.
- Some patients reported a lack of involvement in their care and poor communication from staff, such as not being told why they needed a particular test.

However, we also found:

- Most staff spoke to patients with respect and in a manner that ensured their dignity.
- A team of healthcare assistants provided support to nurses, such as with mouth care and personal care.
- Results in the Friends and Family Test were consistently good.
- Emotional support services were readily available for patients and their relatives.

Compassionate care

- A team of healthcare assistants (HCAs) provided patients with personal care support in many areas. For example on ward three, HCAs ensured patients were given a bed bath or shower and were able to provide support with eating at mealtimes.
- Where a patient was being cared for by a member of staff of a different gender to themselves, staff asked for permission before offering personal care. We saw this was an embedded practice in ward three and patients responded well to the privacy and dignity this offered them.
- Medical care wards contributed to the Friends and Family Test (FFT). Between April 2015 and March 2016, 46% of patients in the hospital contributed to the survey.
- Staff on ward 18 had been designated as FFT champions from March 2015 to October 2015 and had received consistently good feedback. The latest available data was from February 2016, when 94% of patients said they would recommend the ward. Staff in the AMU performed similarly well in the same period, with a 93% recommendation rate.
- During most of our observations we saw staff were naturally compassionate and able to provide patients with kindness and reassurance. In some areas staff compassion was variable. For example, we observed a nurse in the discharge lounge speak gruffly to a young relative who was upset and vulnerable. In ward 18 we observed a nurse who was clearly uncomfortable in speaking with two patients who were becoming agitated due to disorientation. We asked four patients on ward 18 about their care. All four patients said staff attitude was variable. One patient said, "They're not friendly but they are professional and polite." Another patient said, "The nurses don't have any interest in talking to you, I'm very bored here." On the AMU we observed a nurse instruct a confused patient to "go back to your bed" with unnecessary sharpness.

Medical care (including older people's care)

- The senior matron responsible for the discharge lounge identified staff compassion as an area for improvement and included it on an action plan. Following additional training, this was due to be re-audited in July 2016.
- We spoke with a patient on ward 18 who told us they had repeatedly asked staff for a bath or shower and had been told it wasn't their job to provide this. Two other patients on this ward told us they would like to have their hair washed but staff told them they were too busy. We spoke with the nurse in charge who said staff were often too busy to provide personal care and this meant some patients could go up to two months without having their hair washed. In the AMU, one patient told us they had to use pads for incontinence because staff were too busy to help them use a commode. They said they felt very embarrassed because it meant they went to sleep with dirty pads. We asked the nurse in charge about this who said patients were encouraged to wear pads because there were not enough staff for the volume of patients who would use commodes.
- Some patients told us they felt staff always treated people with dignity and respect. For example, one patient said someone else in their bed bay had been very upset and agitated during the night and a nurse had sat with them and talked to them until they fell asleep. Another patient said, "I can't fault the care, everyone has been lovely."

Understanding and involvement of patients and those close to them

- During a handover on the AMU staff demonstrated detailed knowledge of each patient and involved them in discussions. For example, each member of staff introduced themselves and shared information about their treatment options and plan. Staff knew if patients preferred to be called a nickname or by a name other than their official first name and gave each person the opportunity to ask questions and talk about how they felt. Staff also asked each patient if they had any issues or symptoms they felt had not been discussed by the clinical team.
- Staff on ward 18 had prepared a noticeboard of information for relatives on how to reduce the risk of falls at home after a patient was discharged. This was presented in easy to understand language and included practical advice such as avoid bright lighting, remove environmental hazards and don't use wax on hardwood floors.
- Patients could be admitted to the AMU directly from the emergency department. This included older teenagers who did not want to be cared for in a children's ward. Where this happened, senior staff ensured their privacy and dignity was maintained by providing an appropriate bed space.
- We spoke with patients about their care. One patient said staff had kept them well informed during a changing situation and had explained why they were trying to move them to a different ward. They also said they found a needle in their bed that morning having been in the bed overnight but had no memory of having a needle used recently as part of their treatment. The patient reported this to staff and they took the needle away without any explanation or discussion with the patient.. Another patient said they felt staff did not communicate very well with them. They said, "I went for an x-ray yesterday but no-one told me why. I'm hard of hearing so miss most of what is said, staff know this but don't speak up."

Emotional support

- Staff were able to refer patients to community support services including counselling and dementia support. This information was displayed in patient and public areas on inpatient wards.
- One patient told us another patient in their bed bay had died during the night and staff provided them with the chance to talk and provided emotional support in recognition of the upsetting circumstances. Staff on ward 18 had provided patients with opportunities for a referral to trust counsellors when a number of patients died in the ward during the winter.

Are medical care services responsive?

Requires improvement

We rated medical services at the Queen Elizabeth Hospital as requires improvement for responsive because:

- Service planning for patients with dementia was limited and there was only one specialist nurse shared with another of the trust's hospitals.
- An average of 51% of patients per week experienced a discharge delay.

Medical care (including older people's care)

- There was variable evidence staff could meet individual needs. Although an activities coordinator had been appointed, the majority of patients we spoke with told us they felt there was little stimulation. Some areas were not able to meet the needs of patients who did not speak English or those with a visual impairment.
- There was variable performance in the response time to complaints as well as in the time to resolution. Not all patients felt confident enough to raise concerns with staff.

However, we also found:

- Performance in the cancer two week wait was generally good, with over 85% of patients achieving this between April 2015 and April 2016.
- The acute medical unit (AMU) had appointed a new ward manager with experience of emergency department admissions processes. This role provided an expert link between the two units to improve access and flow.
- A discharge coordination team worked proactively to improve timely discharges by supporting staff with paperwork, coordinating community beds and ensuring multidisciplinary teams worked effectively together.

Service planning and delivery to meet the needs of local people

- The tissue viability nurse responded to an increased number of patients admitted with pressure ulcers by increasing the amount of equipment kept on site, such as air mattresses. They also trained a number of ward staff in how to complete comfort rounds for patients admitted from nursing homes with poor tissue viability.
- The hospital saw increasing numbers of patients with dementia and mental health needs. A mental health team was available in the hospital but specialist cover for dementia care was significantly short of demand. A new frailty pathway in the acute medical unit (AMU) had been implemented to increase capacity for elderly patients.
- A joint emergency team worked with medical care wards to avoid hospital admissions and assist patients to access specialist community beds, including for rehabilitation.

Access and flow

- Between January 2016 and May 2016, an average of 45 patients per week experienced a delayed discharge, or 51% of the total number of discharges. The trust told us the most frequent cause of the delay was due to lack of community bed capacity.
- Significant delays occurred to discharges due to a lack of capacity for elderly care beds in the community as well as the complexity of local commissioning relationships. This included negotiating discharges with four local authorities, four local rehabilitation centres and several care homes. Discharge delays often resulted from the amount of time needed to complete checklists and paperwork. This was required 24 hours in advance of discharge and staff told us the process was often "overwhelming".
- The trust met the 93% target for the lung cancer two week wait on seven occasions between April 2015 and April 2016. In the remaining five months, performance ranged from 85% to 93%. The trust performed well in the cancer 31 day maximum wait from decision to treat for lung cancer. This target was achieved in 100% of cases between April 2015 and April 2016. Performance in the lung cancer 62 day referral to treatment audit compared favourably with the 85% national indicator in one month between April 2015 and April 2016. In the remaining 11 months performance ranged from 46% to 83%.
- Medical patients were sometimes cared for in ward 15, a general surgery ward, when there was not enough capacity elsewhere in the hospital. These patients are called 'outliers'. On one day of our inspection there were 14 medical outliers. All of the patients were cared for under different teams and ward staff did not always know who the responsible doctor was, which meant they had to call the switchboard to try and trace medical responsibility through the referring service. Staff told us this sometimes led to significant delays in patients being seen by a doctor. For example, a ward called for a doctor to see one medical outlier patient at 5am but they were not seen until 2.30pm. After our inspection the trust told us all patients had a named consultant in their electronic record and therefore all ward staff had direct access to this, which should not cause delays. The discrepancy in information or understanding was unclear.

- To address access and flow problems between the emergency department (ED) and AMU, a senior member of ED staff was reappointed to a ward manager role in the AMU.
- Due to a lack of capacity in the hospital and problems with patient flow, cardiac patients were sometimes cared for as outliers on other types of medical ward. At the same time, acute medical patients from other specialties were sometimes cared for in the cardiac care unit. To address this, senior nurses in the CCU would try and swap patients between clinical inpatient areas to provide them with the most appropriate levels of care.
- Patients were sometimes transferred to different hospitals out of hours when appropriate medical expertise was not available on site. This was completed using an established transfer agreement and with the input of cardiologists from both services. In the six weeks prior to our inspection, three patients experienced a transfer. In each case a cardiologist from the hospital liaised with an appropriate colleague at the receiving hospital.
- Consultants in gastroenterology, respiratory medicine and cardiology provided a triage service for patients in the AMU. This aimed to reduce the length of time patients stayed there, which was intended for no more than 72 hours.
- Ward 18 was a pre-discharge ward for patients who were medically fit for discharge. This ward was intended for short-term patient stays. Due to a lack of capacity in the community, such as in care homes, patients often stayed in this ward for extended periods of time. One patient had been in the ward for over four months. Staff told us this was a problem because they were not equipped to provide long-term care.
- A discharge team was available to support ward staff with complex discharges from Monday to Friday 9am to 5pm. This included eight clinical and non-clinical staff in bed management and discharge coordinator roles who followed an established process to promote safe and timely discharges. This team worked with patients, relatives and community healthcare teams to reduce discharge delays caused by a lack of community bed capacity and family social problems.
- The discharge team met or attended a conference call four times a day. This included a review of each patient ready for discharge and meetings also helped to identify potential delays to discharges, such as incomplete paperwork or highlighting patients who were not medically fit. There was dedicated time in one of the daily meetings to escalate discharge delays to community colleagues.
- The discharge team attended length of stay meetings, which were used to escalate concerns regarding delayed discharges to the senior hospital team.
- Patients were supported in safe discharge by a hospital at home team. This was a clinical team in the community who could manage intravenous antibiotics and wound care and provide physiotherapy and occupational therapy.

Meeting people's individual needs

- Patient records in the AMU included a social assessment document as part of the nursing assessment tool. This assessment was used to identify risks to the patient such as social isolation or safeguarding. However, this assessment had not been completed in any records we looked at. In some cases staff completed a personal needs assessment of patients, such as for personal hygiene. Staff completed a record of comfort rounds in some case. This included a check toileting needs, a skin inspection and a check of the patient environment. Hourly comfort rounds were completed inconsistently in the AMU. For example, one patient had a comfort round recorded only nine times in the previous 48 hours. Another patient in this unit had comfort rounds sporadically over the course of two days, with gaps of up to 10 hours between them. We asked two nurses about this. They told us there were no specific requirements around comfort rounds and staff aimed to complete these when they had time to check patient needs over the course of a shift, rather than at regular intervals.
- The environment in the discharge lounge in which there were five escalation beds did not guarantee privacy and dignity. This included a bed space opposite the nurse's station in which a nurse did not ensure a patient's dignity.
- We were not confident patients cared for on ward 18 always had access to care and treatment that took into account their protected characteristic(s). This included a patient who was blind and was living with dementia but had no record of access to an advocate for people with a visual impairment or a nurse with specific training. There documentation variably described them as being 'visually impaired' or 'blind' and staff could not tell us what their level of sight was.

Medical care (including older people's care)

- Where wards had changed specialty, the environment was not always updated to reflect the needs of new patients. For example, ward 14 had been a respiratory ward with negative pressure side rooms. This ward was changed to a care of the elderly ward, including for patients with dementia and other types of mental confusion. However, the ward was unsecure and entrances and exits were not monitored at all times. This presented a risk to patients with dementia who were confused. Staff displayed visual signs to help patients identify toilets but this was not consistent across the ward with other rooms and there was no colour-coding system in place. Colour-coded environments are used to help patients with dementia orientate themselves.
- The trust had one dementia specialist nurse and they held a weekly drop-in session at this site for staff. However, very few of the staff we spoke with were aware of this member of staff. Most staff said they would refer to the safeguarding lead nurse for support with patients with dementia.
- A dedicated activities coordinator worked to improve ward environments for long-term patients and those with dementia. This included giving an activities box to each ward and training healthcare assistants and volunteers to be able to provide social interaction to patients. The activities coordinator spent time on each ward and provided activities such as chair-based exercise to help maintain physical activity.
- The AMU matron conducted a daily ward round to ensure patients' needs were met. This helped to make patients more comfortable, particularly those who were there for an extended period of time. For example, staff provided non-alcoholic beer for one patient to help them relax before going to sleep.
- Although AMU staff demonstrated good knowledge of patient needs, documentation did not reflect this. For example, staff indicated a patient had dementia on an admissions document but there was no further documentation or notes on this and the patient did not have a documented cognitive assessment.
- In some medical wards, staff used 'forget me not' tokens. These are discreet symbols used above bed spaces or on patient boards to highlight to staff if a patient has dementia.
- Staff in some areas demonstrated the ability to adapt communication to the individual needs of the patient. For example, a healthcare assistant on ward three explained how they had built a rapport and established some basic communication with a patient with a learning difficulty.
- Staff described difficulty in getting access to interpreters for some patients. This included a patient who spoke an Indian dialect for which the hospital had not sourced an interpreter. Staff caring for the patient said communication was very difficult and the patient could not always make their wishes or feelings known. After our inspection the trust told us all staff were aware of a contract with the agency that sources interpreters and it was therefore not clear why staff in this instance were unaware of the procedure.
- In some areas where patients stayed for extended periods staff found ways to make them more comfortable. For example, staff in ward 18 introduced a morning newspaper round and staff took time to read the news with patients if they wanted this. Staff noticed one patient with dementia becoming increasingly agitated because they thought their babies were missing. To help them, staff obtained some dolls that the patient could keep with them in their side room. This had a very positive effect on the patient and led to significantly reduced anxiety.
- Staff had access to a range of additional services to help them meet patient needs, including psychiatric liaison nurses and drug and alcohol liaison teams.
- Staff monitored patient call bells inconsistently. When completed, comfort rounds included a check that each patient had a call bell within reach. On ward 18, one patient who was visually impaired did not have a call bell within arm's reach. We spoke with a patient on ward 18 who said, "No, the call bell is not always near me, sometimes I have to shout." However, staff indicated during hourly ward rounds the call bell was within reach, which was inaccurate. A patient on the AMU ward told us they had used their call bell during the night and waited 30 minutes for staff to respond.

Learning from complaints and concerns

- Between April 2015 and March 2016, medical care services received 442 complaints. There was an established process for acknowledging, investigating and resolving complaints. During this period, medical

services did not meet the target of a divisional response to 70% of complaints within 18 days in any month. The percentage of complaints responded to within 18 days fluctuated between 35% and 63%.

- The trust had a target of 95% for resolving complaints within agreed timescales. Between April 2015 and March 2016 staff met this target in two months. In all other months, between 52% and 89% of complaints were resolved within agreed timescales.
- A process was in place in the instance a complaint was received relating to ward 18. The trust took the lead on investigating the complaint and agency managers would provide support.
- A patient said they wanted to make a complaint but did not feel confident to do so. They said they felt uncomfortable when nurses talked to each other over their bed in a language they could not understand but felt if they raised this it could affect how they were treated. We observed staff in this area and found some nurses had poorly developed communication skills. Another patient said they wanted to talk to a nurse about what they felt was unacceptable treatment with regards to toileting. However they said the attitude of nurses towards them meant they did not feel comfortable doing so.
- Between April 2015 and March 2016, medical care services and staff received 136 formal compliments.

Are medical care services well-led?

Requires improvement

We rated medical services at the Queen Elizabeth Hospital as requires improvement for well led because:

- We last inspected this hospital in February 2014 and we found medical care services to require improvement. At this inspection there was evidence of some improvement in addressing bed capacity, patient flow, medical staffing and the coherence of nursing teams. The senior hospital and trust leadership team provided evidence of on-going change and improvements but there was variable evidence this impacted patient experience or staff at ward level. This included staff attitude, staffing levels and patient records.
- There was an overarching vision and improvement strategy in the trust that was clearly laid out at senior level. In some areas, such as the AMU, staff were involved in developing their own vision for their service based on this. However, this was variable across medical care services and there limited evidence in some areas that staff were aware of or understand the future direction of their service and the trust.
- A divisional general manager led the acute and emergency medicine division for the trust, with a divisional director for both of the trust's hospitals. A deputy divisional general manager and head of nursing led a service manager and team of matrons at the Queen Elizabeth Hospital. Overall this formed the primary governance structure.
- Day to day governance and risk management structures were in place but there were gaps in how they contributed to a reduction of risks and improved clinical governance outcomes. Consultants, senior matrons, matrons a service manager and ward managers led monthly clinical governance meetings within their areas of responsibility in the medical care services division. Risk registers and a monthly data quality 'dashboard' was used to measure trust performance, including time to treatment and staffing levels.
- There was limited evidence of daily quality monitoring from senior staff, however we did see a notable improvement in management during our weekend unannounced inspection. This included better staff understanding of the escalation procedures in place and a responsive site manager and senior matron team.
- Staff spoke variably about leadership structures and support. In some areas this was very positive and staff could demonstrate how it contributed to better work performance. In other area staff said there was a lack of oversight. The range of disparity and variability between leadership in different areas and amongst different staffing groups was expanded after our inspection when the trust provided significant amounts of information that contradicted what staff told us in the hospital. This included standards of training, availability of out of hours medical cover and staff knowledge of procedures such as booking interpreters. One ward team was in a period of 'enhanced management' to improve staff morale, relations and standards of work, which the trust said could account for some of the contradictory information.

- In some cases staff told us they had not received specialist training they needed to care for patients appropriately. After our inspection the trust provided evidence staff had been provided with the training required to care for patients appropriately. This related to staff who worked in an area with enhanced management oversight in which staff received additional support from the critical care outreach team and practice development team. Whilst we were reassured training was provided to a higher standard than discussed by some members of staff, it was unclear why we received different accounts of this.

However, we also found:

- Senior staff in the acute medical unit developed a new charter for the unit following feedback from staff. This was intended to provide staff with a motivational and empowering environment to work in.
- Training was offered to staff to improve the time they spent communicating with relatives. This resulted from an exercise in which staff were asked for their views.

Vision and strategy for this service

- The trust had established the 'Living our Values Project' as part of its future vision and strategy. This aimed to empower staff in individual wards and services to establish their own service and quality charters and to establish what they wanted their objectives and commitments to be. This formed part of a wider transformation project to improve the organisational culture to one that focused on continuous improvement.
- There was evidence the trust's vision and strategy had been communicated across the hospital and was adaptable at ward-level. However, there was variable recognition of this. Staff in the acute medical unit (AMU) had established a new charter in line with the called 'living our values'. This had resulted from a collaborative process involving staff who were asked to consider what they would like in a charter and strategy for the unit based on the wider trust values. This included discussions about how staff felt the values applied to their work and how they could improve the ward based on these.
- Staff in other medical areas were not aware of a vision or strategy for their unit. For example, staff on ward three told us the unit was so busy they felt their strategy was to maintain patient safety every day. Staff on ward 18 were not aware of a vision or strategy.

Governance, risk management and quality measurement

- Senior matrons, matrons and ward managers led clinical ward services with additional responsibilities in specialist areas. For example, one matron responsible for four medical wards was also the hospital's dementia lead. An NHS matron had oversight of ward 18, which was staffed by agency nurses who reported to both the hospital matron and the agency matron. Clinical governance on this unit was jointly managed by the hospital and the agency through monthly joint meetings.
- The leadership team for ward four tried to recruit new nurses to fill seven vacant posts. However, there had been no applicants in the six weeks this recruitment had been advertised. Staff highlighted this as a key risk for the ward, which often saw patients with complex needs.
- Matrons told us they completed daily ward checks and walk arounds in medical areas. There was no documented evidence of this or related governance quality audits in the wards. For example, a matron completed a daily check of the discharge lounge but when we found this area in need of attention, staff could not provide evidence a senior member of staff had visited. However, staff told us matrons were visible and said they felt they could approach them with concerns about risks. After our inspection the trust provided electronic records that indicated ward checks were recorded.
- Risk management was not always evident in areas where staffing levels sometimes fell short. For example, ward three was scheduled to have a minimum of three healthcare assistants (HCAs) per shift. On two days of our inspection we saw only two HCAs were available. A member of staff said this was unmanageable because it meant they had 14 patients to care for. They said this was more difficult overnight when patients needed a lot of care and attention and they were not able to have this with only two HCAs. During our weekend unannounced inspection we spoke with the senior matron on duty about this. They told us the HCA role was well established and staff were offered

opportunities to feed back any concerns, which they felt were acted on. They also said the change in management of ward three had introduced new leadership that had been missing and this would lead to significant improvements in staff welfare and morale.

- Ward 18 was staffed by agency nurses and trust doctors and administrators. A trust matron and agency matron had joint oversight of the ward and senior nurses told us the relationship worked well. This included trust-led clinical governance meetings and daily escalation discussions between the trust and the agency. This included joint discussions of incidents, including delayed discharges. This was a robust process but it was not evident concerns and risks raised by staff were always addressed, such as in the escalation of patients who needed more specialised care than the ward was equipped to provide.
- Clinical governance of medical care services included the use of a risk register to monitor and track significant risks to services. Senior clinical staff and managers reviewed this as part of monthly clinical governance meetings although it was not clear outcomes from this were communicated clearly with staff. For example, none of the senior nurses we spoke with could tell us the most significant items on the risk register for their area or how they were managed.

Leadership of service

- The senior leadership team had implemented a number of improvement plans following our inspection in February 2014, particularly in relation to how bed capacity was managed and in out of hours medical cover. However, at this inspection we found some problems had continued without successful intervention. For example, during both inspections we found substantive inconsistencies in the lack of empathy and kindness shown by some nurses; inconsistent and poorly completed risk assessments; patients were admitted to inappropriate areas for extended periods of staff because of a lack of capacity in the hospital and a lack of specialist support for vulnerable patients.
- The leadership structure of the discharge lounge escalation area was not clearly understood by staff who worked there. For example, one member of staff said they wanted to make improvements to the unit but did not know who made decisions in this area. They said, "We're not really sure of where this ward sits in the division and I think we get overlooked sometimes because of that."
- We observed robust leadership in the AMU. The ward manager led a twice-daily handover that included a clear establishment of each person's role and responsibilities within teams allocated to specific patients. This helped staff to perform well within a supported framework that was well organised and made the most of their skills and experience.
- Matrons, ward managers and senior nurses had active roles in medical care wards that included clinical and management responsibilities. This included completing daily walk rounds and speaking with staff and patients. Staff in all areas described matrons and senior nurses as visible, approachable and supportive. Out of hours some areas were led by senior band five nurses, such as ward three. Staff told us the team worked well together but it was difficult to escalate problems without a more senior person in charge. We saw differences in leadership approach and responsiveness during different days of our inspection. For example, staff on the first two days told us it was difficult to escalate problems and concerns, which we saw in practice. However, during our weekend inspection we found a more coherent leadership structure in place. For example, the site manager and senior matron coordinated transfers and discharges very quickly and liaised with colleagues across the hospital whenever needed. The senior matron worked closely with the critical care outreach team to respond to deteriorating patients and she was also able to respond to our concerns about specific patients.
- In all areas staff spoke positively of their relationships with site practitioners, discharge coordinators and bed managers.

Culture within the service

- A ward manager had recently been appointed to lead ward three, following a significant period of change for staff in the unit. Some staff spoke positively about this. For example, one member of staff said, "This is a fantastic place to work and even better now we have a permanent leader. Also for the first time I noticed we're starting to get positive feedback for our work – I had an e-mail from the matron about this. It sounds small but we never had that before, it's a good thing." Another

member of staff raised concerns about the workload and working environment. We asked six nurses about the duty of candour. They told us only senior members of staff and doctors were involved in this. The duty of candour was not included on the trust's mandatory training register.

- Staff at all levels told us their commitment to patients was their greatest motivator for doing a good job. One healthcare assistant said, "Helping patients is the most positive part of the job. It's like working with friends and family because some of them [patients] stay here a long time. It keeps me coming back every day."
- Nurses on ward 18 took part in monthly meetings to ensure they remained up to date with changes and developments in the trust.
- The trust's vision and strategy included a focus on improving staff morale, team cohesion and working culture through the empowerment of teams to contribute to their own development plans. In some areas we found this approach had improved the culture. However, there was room for improvement in other wards. For example, several staff on one ward told us they had not received training in the area in which they were providing care. The trust subsequently provided documentation that included evidence staff had completed the training. Senior staff said this related to an area under enhanced management support and training but we were not able to clarify why staff told us they were not sufficiently trained.

Public engagement

- Training in communicating effectively with relatives was available and staff on ward three told us this led to an improved understanding of expectations and skills in talking honestly about treatment plans.
- In a staff survey in early 2016, AMU nurses highlighted the lack of time they had with patients and relatives due to the pace of the unit. Senior staff were considering plans to address this, including effective communicate training to help staff communicate more effectively without feeling pressured by time.

Staff engagement

- As part of an initiative to improve communication between staff across the hospital, the senior matron began a collaborative newsletter between the emergency department (ED) and the AMU. This included information such as details of new fluid balance charts and training opportunities for staff.
- Nurse turnover on the AMU was relatively high as staff took up training and development pathways into intensive care. The senior team was actively involved in reducing turnover by providing incentives to the team to continue their professional development in the AMU. This included opportunities to join NHS Leadership Academy training.
- Staff on ward three spoke positively about their working conditions after the appointment of a new ward manager. They said team meetings took place regularly and they were pleased nurses and healthcare assistants now did some training together.
- The senior AMU team had conducted a staff survey to check staff morale and find out what the team would like to see improved in the unit. As a result senior staff made sure they praised staff for good work and offered more proactive encouragement.
- A senior clinical fellow in the AMU had conducted a staff engagement audit exercise with 74 members of staff to improve team action after a cardiac arrest. This focused on the need for more consistent debriefing from senior clinicians and included a case study assessment of why debriefs did not always occur. The findings of the audit were used to implement a debrief structure that ensured all members of staff involved in the cardiac arrest received an appropriate debrief.

Innovation, improvement and sustainability

- The critical care outreach team (CCOT) team had demonstrable understanding of the training and knowledge needs of clinical teams around the hospital and used this to provide opportunistic training as needed. The CCOT planned to ensure sustainability of their training and education role by establishing a named link nurse between the team and every ward. This would enable ward staff to respond more quickly to deteriorating patients and provide more specialist training for their teams. Overall this strategy represented a proactive approach to service improvement and sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure patients are cared for in areas that are appropriate, meet all of their needs and have sufficient space to accommodate the potential number of people using the service at any one time.
- Ensure assessments of patients and observations are recorded and action is taken, where appropriate, in line with hospital policy.
- Do all that is reasonably practicable to mitigate any risks related to delays in patients being seen and assessed and treated in the ED and transferred to an appropriate ward/clinical area for on-going treatment.
- Ensure patients on medical wards have appropriate risk assessments fully completed that meet their needs. This includes where patients have a Protected Characteristic under the Equality Act.
- Have effective systems and processes to assess and monitor the quality and safety of care and treatment in the ED and medical care.
- In medical care all medicines must be stored safely, securely and in a temperature-controlled environment in all areas. This must include documented daily temperature checks and a documented stock control system.
- Ensure patient records, including prescribing records, contain all relevant information.

Action the hospital SHOULD take to improve

- Develop a formal induction for agency nurses in the ED
- Ensure staff comply with infection prevention and control policies and procedures.
- Senior staff on ward 18 should ensure cleaning and hygiene standards are maintained. This should include clean and dust-free bedside equipment, equipment storage rooms and food preparation areas.
- Ensure staff training in medical care meets the needs of those working in clinical areas. This should include input from staff that indicates the level of training they have received is sufficient to carry out their responsibilities safely.
- Ensure staff, in medical care, receive up to date life support training at a level appropriate to their role and responsibilities
- Ensure all patients have their pain assessed and they receive effective analgesia
- Continue to work to reduce the number of delayed discharges
- Ensure staff fully understand the role of the dementia lead nurse and how to access services available to patients.
- Ensure staff working on medical wards have the values and attitude necessary to treat patients, their relatives and visitors with dignity and respect. This includes staff treating them in a caring and compassionate way at all times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) (2) (a) (b) (g) There were delays in patients being seen and treated in the ED and transferred to an appropriate ward/clinical area for treatment. Patients were not always being regularly reviewed following clinical assessments. During our inspection, one patient did not have vital signs/NEWS recorded for over 5 hours despite having a diagnosis of sepsis and a cardiac arrest four weeks ago. Rapid Assessment and Treatment (RAT) process was not being undertaken on the first two days of our inspection and patients were waiting for significant lengths of time on ambulance trolleys. Patients at risk of developing pressure ulcers were not always transferred to a bed from a trolley within the trust's four-hour target. Medicines were not always stored securely The trust must take action to: Ensure assessments of patients, and observations are recorded, and action is taken where appropriate, in line with hospital policy. Do all that is reasonably practicable to mitigate any risks related to delays in patients being seen, assessed and treated in the ED and transferred to an appropriate ward/clinical area for on-going treatment. Ensure medicines are stored safely, securely and in a temperature-controlled environment in all areas. This must include documented daily temperature checks and a documented stock control system.

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Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1) (C) HSCA 2008 (Regulated Activities) Regulations 2014 The ED was often overcrowded. The resuscitation area had five beds but was doubled up to accommodate more patients. There were up to eight patients in this area during our inspection. There were patients on trolleys and chairs along the corridor and this constituted a barrier to evacuation in the event of an emergency. We found patients were being cared for in several areas used for escalation including imaging, recovery area and the discharge lounge. These areas did not always meet the needs of patients. The trust must take action to: Ensure patients are cared for in areas that are appropriate, meet all of their needs and have sufficient space to accommodate the potential number of people using the service at any one time. .

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (2) (b) (c) The hospital did not have effective systems to assess and monitor the quality and safety of the care and treatment in the ED and medical care.

This section is primarily information for the provider

Requirement notices

Senior staff were not always aware of the key risks in their area.

Risk assessments, care plans, treatment plans, mental capacity records and observations were not always completed in a timely manner. Where assessments and documentation relating to care had been completed, this was not always maintained or updated regularly and was not always accurate

The trust must take action to:

Ensure systems and processes assess to monitor the quality and safety of care and treatment in the ED and medical care are effective. This includes having systems and processes to identify and assess all risks to the health, safety and/or welfare of people who use the service.

Ensure every patient has an adequate, appropriate and individualised care or treatment plan after admission. This must include an assessment of mental capacity. Risk assessments and related observations must be updated at regular intervals by a competent clinician.