West Cumberland Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Urgent and emergency care at the North Cumbria Integrated Care NHS Trust operates from two district general hospital sites: West Cumberland Hospital (WCH) in Whitehaven; and Cumberland Infirmary in Carlisle (CIC).

Both hospitals operate a 24/7 consultant-led emergency department (ED). However, the WCH ED accepts trauma cases for stabilisation only, before transferring these to either CIC or a tertiary centre.

At WCH there are also a selected number of conditions that follow a high-risk transfer pathway from WCH to CIC. These include:

- Gastro-intestinal bleed
- Respiratory patients assessed as high risk (i.e. those with an initial diagnosis of pneumothorax or potential empyema, cardiac NSTEMI/ACS/ endocarditis, or bradycardia requiring urgent cardiac pacing).
- Emergency surgical pathways including; General surgery, orthopaedics, ear nose and throat, ophthalmology, Urology and vascular.

Both sites operate emergency assessment units; there is a 29-bedded unit at WCH for medicine and surgical admissions. The unit is supported by acute care physicians (ACPs).

Each site also operates an emergency ambulatory care unit Monday to Friday, supported by the acute medical and surgical consultants and nurse practitioners. The WCH unit operates five chairs, one bed and two examination couches from 8am to 8pm.

The emergency assessment unit and ambulatory care unit were inspected under our Medical Care Core Service Framework. This part of our report focuses on the emergency department (ED). The ED has a large waiting-room, with a reception station behind transparent screens, a triage room, a 'majors' area comprising six cubicles, a 'minors' area comprising eight cubicles, including one room designed to accommodate patients who present with mental health needs and another designed for ear, nose and throat (ENT) patients, a separate paediatrics area, comprising a waiting room and three cubicles (one of which can be used flexibly as an adult or paediatric room), a spacious resuscitation area containing three bays (one of which is also equipped for paediatric patients), a viewing room, and a relatives' room.

Summary of findings

During the inspection, we visited the emergency department only. We spoke with 12 members of staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with five patients and one relative. During our inspection, we reviewed 22 sets of patient records. These included records of mental health patients and children and young people who had attended the department as well as medical and nursing records.

We carried out an unannounced inspection of the emergency department at the West Cumberland hospital on the 25 February 2020 due to concerns of crowding and patient care.

Services we rate

During this inspection we used our focussed inspection methodology. We did not cover all key lines of enquiry, we looked at the safe domain and aspects of both the responsive and well led domains.

We rated it as **Requires improvement** overall.

- Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff did not complete risk assessments for each patient. They did not remove or minimise risks or update the assessments. Staff did not identify or quickly act upon patients at risk of deterioration.
- The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always recognise and report incidents and near misses.Although when incidents were reported managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Local leaders were visible and approachable. However, their ability to effectively manage the department was limited by staff shortages and poor access and flow of patients. Leaders at senior levels did not comprehend the challenges faced within the department and had not identified suitable action plans to mitigate the risks such as challenged medical and nurse staffing.
- Staff satisfaction was poor, and staff did not always feel actively engaged or empowered.
- Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not effectively planned or implemented.

Following this inspection, wrote a letter of intent to the trust to gain assurance regarding the concerns we found in particular safe staffing, timely triage and assessment for both adults and children; In addition we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notice(s) that affected Urgent and Emergency. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	**Requires improvement** 	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We found breaches of regulations from previous inspections had not been effectively acted upon. The quality of health care provided by North Cumbria Integrated Care NHS Foundation Trust required significant improvement.

Summary of findings

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Summary of this inspection

Background to West Cumberland Hospital

North Cumbria Integrated Care NHS Foundation Trust provides a comprehensive range of acute hospital for approximately 320,000 people across North and West Cumbria, with a total Cumbria population of approximately 500,000.The trust is a newly formed legal entity following the acquisition of North Cumbria University Hospital NHS Trust by the Cumbria Partnership NHS Foundation Trust on 1 October 2019.

The trust manages 2 acute hospital sites and eight community hospitals. There is a workforce of over 5400 staff working across the hospitals and in the community.

The trust operates community inpatient hospital services from five community sites:

- Brampton War Memorial Hospital
- Mary Hewetson Cottage Hospital
- Cockermouth Hospital
- Penrith Community Hospital
- Workington Hospital.

Community services for children and young people and also adults including end of life care services are also provided in people's own homes and a range of community clinics across the geography of the trust.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, a CQC inspection planner, and two specialist advisors with expertise in emergency department care. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about West Cumberland Hospital

West Cumberland Hospital emergency department is a consultant led service that operates 24 hours a day 7 days a week to manage critically ill patients including children. From 1 January 2019 to 31 December 2019approximately 39,722 patients attended the department, 7,735 of which were children.

We carried out an unannounced focused inspection of the emergency department at West Cumberland Hospital on the 25 February 2020. The inspection took place in response to concerning information we had received in relation to patient care.

We did not inspect any other core service at this hospital, however we did discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry.

During our inspection we spoke to12 members of staff, patients and relatives and reviewed 22 sets of patients records.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated it as **inadequate**.

Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff did not complete risk assessments for each patient. They did not remove or minimise risks or update the assessments. Staff did not identify or quickly act upon patients at risk of deterioration.

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always recognise and report incidents and near misses. Although when incidents were reported managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services responsive?

Requires improvement

We rated it as **Requires improvement** because:

People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Are services well-led?

Requires improvement

We rated it as **Requires improvement** because:

Summary of this inspection

Local leaders were visible and approachable. However, their ability to effectively manage the department was limited by staff shortages and poor access and flow of patients. Leaders at senior levels did not comprehend the challenges faced within the department and had not identified suitable action plans to mitigate the risks such as challenged medical and nurse staffing.

Staff satisfaction was poor, and staff did not always feel actively engaged or empowered.

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not effectively planned or implemented.

Requires improvement

Urgent and emergency services

Safe	Inadequate
Responsive	Requires improvement
Well-led	Requires improvement

Are urgent and emergency services safe?

Inadequate

We rated safe as **inadequate**.

Safeguarding

Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.

During our inspection we found that 77% of the 35 eligible registered nursing staff had undertaken child safeguarding level three training.

Staff explained that attending 'face to face' sessions was extremely difficult due to low staffing numbers and challenges in accessing the course. This meant the majority of training was completed online as electronic learning and that important discussions, examples of scenarios and professional curiosity did not take place.

The Royal College of Paediatric and Child Health Standards for Children in the Emergency Care Setting document specifies that all staff who regularly look after children must have up to date safeguarding training and competence.

Information provided by the trust, following our inspection, demonstrated that 87% of medical staff had undertaken level three children's safeguarding training and 80% had undertaken level two adult safeguarding training.

No staff were specified as being eligible for level three adult safeguarding training and the number of eligible versus completed staff was not provided. The Royal College of Paediatric and Child Health Safeguarding Children and Young People: roles and competences for health care staff intercollegiate document specifies that all clinical staff working with children, young people and/ or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should undertake level three training.

During the inspection, we reviewed records and found that a serious incident had taken place which was the delay in assessing and making a safeguarding referral for a patient fitting the trust safeguarding criteria.

The national electronic child protection information sharing system was embedded within the department. Any information received into the department was checked at the point of arrival and shared by way of a flagging system on the electronic record and by documenting on the triage paperwork.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance set out in the Department of Health Building Note 15-01: Accident and Emergency Department planning and design document. For example, lighting, temperature and special awareness. Call bells were located in each cubicle which were all individual with doors and not curtains.

There was a separate waiting area for children which was bright, colourful and secure. There was an alarm system to press if assistance was required. A cleaning schedule was in place to ensure the hygiene of the many toys and books which were available for the children to play with.

There were three appropriately equipped paediatric cubicles, a designated ophthalmology room and a resuscitation area which were also appropriately

equipped. A relatives room with access to privacy and hot/cold drinks was available. There was also a room directly next to the resuscitation bay where bereaved relatives could sit privately with deceased loved ones.

Resuscitation equipment was available and stored appropriately within the department and the environment was visibly clean and dust free.

However, during our inspection we observed patients struggling to pass personal details onto the receptionists because the speakers between the glass screen connecting them both were of poor quality. This meant the receptionists could not hear and the patient had to repeat the details loudly several times. Other patients in the immediately adjacent waiting room could hear the conversations being undertaken meaning there was little or no privacy.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. They did not remove or minimise risks or update the assessments. Staff did not identify or quickly act upon patients at risk of deterioration.

Comprehensive risk assessments were not undertaken in line with national guidance which meant the department could not respond appropriately to the changing risks of people using the services, such as those with deteriorating health or wellbeing. The department used a national early warning scoring (NEWS2) system and deemed that a warning score of five or above would prompt escalation to a senior clinician as well as increased monitoring of the patient. This was designed to quickly identify patients at risk of and prevent deterioration.

During the inspection, we reviewed 22 patient records. Twelve were adult patients and nine children. We found that from the 12 adult notes, there were five occasions where the early warning scoring system had not been completed and of the nine children's records, five occasions where a child specific early warning system had not been undertaken. The remaining four children's notes had no score calculated. This was not in line with the Royal College of Emergency Medicine Emergency Department Care best practice guidelines 2018, the National Institute for Health and Care Excellence (NG51) Sepsis: recognition, diagnosis and early management or The Royal College of Paediatric and Child Health Facing the Future: Standards for Children in Emergency Care Settings. The system employed by the department to identify deteriorating patients in a timely manner was not effective.

We found whilst undertaking the inspection that the triage area was left largely unmanned and that no clinician was allocated solely to the role of triaging patients. On the day of our inspection we saw the clinician allocated to this area was also responsible for the minor injury/illness area and paediatric areas. This meant that the clinician could be caring for numerous people across three separate areas.

Initial patient assessment (triage) is an important feature of patient safety within an emergency department. The Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients (2017) document, sets the standard for the time to undertake the triage of patients as within 15 minutes of arrival. During our inspection we witnessed examples of patients waiting longer than 15 minutes. Of the 23 people within the department, one patient had waited one hour 23 minutes to be initially triaged and on review of 22 patient records found eight further cases where patients waited more than 15 minutes.

We saw that patients arriving by ambulance waited in the corridor with staff from the ambulance provider until they could be triaged and moved into a cubicle

Patient safety checklists were to be used within the department however were not always completed in line with the trust policy. The patient safety checklist prompted hourly checks on things like levels of pain, nutrition and hydration and pressure area care. During our inspection we found three examples where the patient safety checklist had not been completed fully and one that had not been completed at all. This was concerning because the department could not be sure that patients were not in pain, were appropriately hydrated and were not developing pressure ulcers. We saw that an audit to check pain management was carried out on a monthly basis however scored 40% compliance pain in December 2020.

Patients attending the department with symptoms associated with mental health were not always cared for in line with Royal College of Psychiatrists in the Psychiatric Liaison Accreditation Network (PLAN). We

found three examples of patients not receiving a physical health review by an emergency department doctor as part of the initial assessment, prior to being referred to for a mental health assessment by the mental health team. This meant that important initial mental health and ligature risk assessments were not undertaken. Staff we spoke to told us referral to the mental health was difficult. Despite the team be co-located next the department referral could only be made via telephone. We were told on several occasions that phonelines were engaged and delays in referral were seen.

The department took part in a quarterly sepsis and deteriorating patient steering group within the hospital and had dedicated sepsis link nurses who undertook monthly sepsis audits. This was in line with the National Institute of Health and Care Excellence guideline 51 Sepsis: recognition, diagnosis and early management.

All policies were available for staff on the trust intranet. We found these to be easily accessible. During our inspection we spoke to three doctors who were all able to identify how to access these guidelines.

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.

Children were not always cared for by a registered sick children's nurse as there was only one employed within the department, who worked three days a week. Adult registered nurses did not have any competency based additional training to enable them to care for a sick child or recognise their deterioration. The Royal College of Paediatric and Child Health Facing the Futures: Standards for Children in the Emergency Care Setting states that two registered children's nurses should be present on every shift. The department did not have any mitigations in place to counteract this.

The service did not have enough nursing staff to keep patients safe. The trust deemed that four nursing staff were required at night and six during the day. The assessed staffing levels included provision of cover for the five areas within the department including, transfers of adults and children to wards and a shift coordinator role. This meant that staff were required to undertake multiple roles for example minors, paediatrics and triage at the same time. We observed the shift co-ordinator was included within the staffing numbers and not supernumerary. We were also told the shift co-ordinators were often was based in an area such as the resuscitation bay away from the department with little oversight.

Staff advised us that several staff members had left the department in recent months, which added to daily working pressures. We were told staffing challenges were further compounded as staff from the department were often redeployed to other wards within the location. Leaders within the department confirmed this was the case, we also reviewed incident reports between September 2019 and February 2020, we found 20 occasions where incident reports had been generated due to poor staffing levels. We saw the reports detailed an inability to provide care needs and long waits and showed evidence of potential harm and not actual harm.

We saw that as late as the 20 February 2020 the sister in charge of the department and the matron were required to work in ward areas within the location due to low staffing levels.

They had trusts nurses and midwifery staffing report was presented at the quality and safety committee in January 2020. This report documented a staffing risk assessment for the department, which was identified as low risk. There were no reported staffing related quality concerns, however we were told by senior nurses and doctors within the department that they had escalated safety issues in relation to staffing. The monthly safer staffing dashboard for November 2019 contained within the report did not feature the emergency department.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

At the time of our inspection the department had 2.6 WTE emergency department consultants. This was due to increase to 3.6 WTE as a member of staff from the middle grade rota had been appointed. In addition we were told one consultant was due to retire in June 2020.

The department saw approximately 40,000 patients annually meaning a ratio of one consultant to 15,000 patients. This was not in line with The Royal College of

Requires improvement

Urgent and emergency services

Emergency Medicine Consultant Workforce Recommendations, 2018 of one whole time equivalent consultant to every 4000 new attendances. It also meant that the wellbeing of those working at such intensity could not be assured.

There was one consultant working in the department who was trained as a paediatric emergency medical specialist. This was in line with The Royal College of Emergency Medicine and The Royal College of Paediatric and Child Health standards.

Medical leads within the department had previously escalated concerns to the trust board regarding the lack of medical staffing and support for the department. However at the time of our inspection no substantive strategy was in place to mitigate the risks associated with the low medical staffing numbers and the upcoming departure of a consultant.

We saw that the consultants achieved the specified 16 hour on site standard from Monday to Friday, and also managed to provide an on call rota, Senior decision making in the department overnight was lacking and not in line with The Royal College of Emergency Medicine Consultant Workforce recommendations, that overnight the department should be staffed by an ST4 (specialist emergency department doctor) or above.

Nights and weekends were largely covered by one general practitioner and one junior doctor. This was a concern because the general practitioner may not have the training or competencies to manage critically ill patients, paediatric or trauma patients beyond what you would expect in general practice and medical teams within the trust did not have the capacity to manage critically ill or trauma patients.

We found that a physician associate (a healthcare professional who is not a doctor) was left in charge of the department overnight on one occasion and that the department had a high reliance on locum staff to support the consultant rota, which in turn impacted negatively on the ability to provide teaching and support for junior colleagues.

Doctors of all grades that we spoke with during our inspection spoke of the supportive nature of the medical staff within the department, but stated they frequently went without breaks and stayed beyond their shift to support the department and other staff.

Incidents

Staff did not always recognise and report incidents and near misses. Although when incidents were reported managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke to during our inspection understood their responsibility to raise safety incidents, concerns and near misses. However, staff also told us they did not always report issues such as difficulty in providing care for patients due to lack of staffing or information governance issues because they felt little was done in response to the issues and often, they were too busy to take the time to report incidents.

Staff and managers also understood duty of candour and knew how to apply it appropriately.

Mortality and morbidity reviews took place quarterly and reviewed all deaths within 24 hours of admission to the department.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated responsive as **requires improvement**.

Access and flow

People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

At West Cumberland hospital national data demonstrated that for a two week period from the 19 February 2020, 74% of patients were treated within 60 minutes of arrival and 89% of patients were admitted, treated or discharged within 4 hours of arrival, against the Department of Health's standard for emergency departments of 95%.

Requires improvement

Urgent and emergency services

National data demonstrated that the number of ambulances arriving at the department was between 170 and 190 per week. We saw there was a corridor policy in operation however due to the issues with staffing levels often ambulances waited with patients to hand over to a member of staff.

The integrated performance report for January 2020 provided by the trust following our inspection showed that 26% of ambulance arrivals waited over 30 minutes to hand over patients to the emergency department and almost three percent waited over 60 minutes. The data was combined for both departments however within the trust and therefore not explicit to West Cumberland hospital.

During our inspection we saw that out of 10 patients, five had waited longer than four hours within the department for a medical bed. The longest of which was 10 hours. National data for the fortnight following the 19 February 2020 showed that the hospital had a bed occupancy rate of 91% including an additional 43 escalation beds and that 24 percent of patients had been 'stranded' for 21 days or more.

We saw that the department was used as the gateway to the hospital with general practitioner admissions attending the department in the first instance. On the day of our inspection we saw four patients that had been referred by the general practitioner come directly into the emergency department. Staff told us this was practice regardless of whether there were medical beds available or not.

Staff within the department were able to refer patients into the ambulatory care department however there appeared to be a lack of robust criteria and we were advised that patients were rarely accepted.

All high risk surgical patients presenting to the department were assessed and transferred to Cumberland Infirmary site for speciality treatment. An escalation, patient flow and full capacity protocol was in place within the department, however there was no clear pathway to transfer patients to the Cumberland Infirmary site.

Staff told us this meant that often patients waited extended lengths of time within the department before transfer and then due to a lack of beds at the Cumberland Infirmary site waited, further within the emergency department there.

On review of the incidents reported within the department we saw an incident where a patient had been refused transfer to the Cumberland Infirmary site as there was no bed available of them. We saw this patient waited for eight hours from the time of being referred to a specialty team until they were transferred to the Cumberland Infirmary. We were told of a further two occasions where patients waited between eight and 11 hours to be transferred to the Cumberland Infirmary. Staff reported the reasons for the delays was a lack of bed availability.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as **requires improvement**.

Leadership

Local leaders were visible and approachable. However, their ability to effectively manage the department was limited by staff shortages and poor access and flow of patients. Leaders at senior levels did not comprehend the challenges faced within the department and had not identified suitable action plans to mitigate the risks such as challenged medical and nurse staffing.

There was a lack of communication and co-operation between both emergency departments, and a lack of collaborative working across specialities due to trust-wide staffing challenges.

There appeared to be a lack of vision or strategy in place in relation to future planning and we found a lack of flow strategies such as frailty or ambulatory emergency care.

Senior decision makers, particularly at night and weekends, were also lacking in numbers and of a major concern. However, the staff we spoke to were committed and willing to work together to improve the situation.

Requires improvement

Urgent and emergency services

Staff told us that they were tired and weary and there did not appear or were aware of any work underway to address sustainability of the medical workforce.

Despite local leaders highlighting their concerns to the executive leaders within the trust, there appeared to be a lack of trust-wide ownership around the significant safety issues affecting the department. No action plan had was in place and staff told us they had received little support from the executive team. Minutes from the staff meeting on 4 February 2020 showed that a planned meeting to discuss nurse staffing issues could not be fulfilled because members of the executive management team could not attend.

Culture

Staff satisfaction was poor, and staff did not always feel actively engaged or empowered.

Staff we spoke to were tired, and many stated that they were seeking alternative employment. A frustration of being moved from their designated working environment or concerns not being listened to be the overwhelming factors. Staff did speak of a team mentality internally and we saw examples of this with staff covering additional shift to support colleagues and patients.

Although staff were taking part in appraisals, due to the challenges with staffing in the department clinical supervision was not undertaken routinely, and the opportunity of providing staff with opportunities for career development such as career conversations or opportunity for acting upwards was difficult.

Governance, **risks management and quality measure**

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not effectively planned or implemented.

Triage of self- presenting adults and children was not reliable, consistent, safe or effective nor did it improve the patient's experience.

The risk register for the department listed the middle grade capability only with no mention of the concerns around the lack of sustainability in the consultant rota. No actions, such as shared site working, were in place and we found no mention of the issue within quality, improvement and safety committee meeting minutes held in December 2019 and January 2020.

The February 2020 programme delivery highlight report showed a priority for the trust was to ensure the correct staffing models in the emergency department had 'partial slippage' but did not describe how or what this meant.

There was no evidence of audit or governance process to mitigate the issues facing triage of patient.

Mortality and morbidity reviews took place quarterly and reviewed all deaths within 24 hours of admission to the department. This formed part of the governance structure and safety monitoring.

There was a governance structure in place, however, we observed information did not always filter upwards such as the information described in leadership section above.

Junior leaders in the department told us they articulated and escalated their concerns through the appropriate routes however felt this escalation had not been supported appropriately.

Outstanding practice and areas for improvement

Outstanding practice

The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the provider MUST take to improve

- The service must ensure the timely triage of patients arriving to the department and ensure patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals. **Regulation 12(2)(a)(**b)
- The service must ensure that care is provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed. **Regulation 12(2)(a)(b)**
- The service must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. **Regulation 12(2)(b)**
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding identification and reporting. **Regulation 13 (1)(2)**
- The service must ensure that there is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines. **Regulation 17(2)(a)(b)**
- The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care. **Regulation 18(1)**

Action the provider SHOULD take to improve

- The service should ensure that patients waiting to be admitted or transferred have the appropriate care including access to a bed when they are in the emergency department overnight.
- The provider should investigate and carry out further analysis to understand the reasons for high staff turnover.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients were not being triaged in line with the national standard. We did not see that there was a dedicated triage nurse in the department. The department did not provide care in line with national standards and risks to protect adults and children. The flow of patients through the department was poor and patients were not assessed, treated, admitted and discharged in a safe and timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment We found evidence where best practice safeguarding processes were not always followed.

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

This section is primarily information for the provider

Requirement notices

We found not all mental health patients had appropriate and timely risk assessments completed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found there were not sufficient numbers of appropriately qualified nursing and medical staff.