Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

Queen Alexandra Hospital
Southwick Hill Road
Cosham
Portsmouth
PO6 3LY
Tel: (023) 9228 6000
Website: www.porthosp.nhs.uk

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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)	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth. The main site provided by this trust is the Queen Alexandra Hospital, which is a 975 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 610,000 people. The trust provides specialist renal services to a population of 2.2 million people across Wessex.

We carried out an unannounced inspection of the Queen Alexandra Hospital on 16, 17 and 28 February 2017, where we inspected the medical care services and the emergency department. We returned on 10 and 11 May 2017 and inspected the key question of 'well led' for Portsmouth Hospital NHS Trust. As part of this later inspection in May 2017 we visited the emergency department, four medical care wards and the Acute Medical Unit (AMU) to review ward to board governance arrangements. During our May 2017 inspection we identified concerns in both the emergency department and medical care wards and AMU, which have been reported on in this February 2017 report. To view our findings and report from the inspection of 'well led' for the Portsmouth Hospital NHS Trust please refer to our website.

We inspected and rated urgent and emergency care and medical care. Urgent and emergency care has been rated as requires improvement overall, and medical care has been rated as inadequate overall.

Our key findings were as follows:

Urgent and emergency care:

- The hospital was not performing well against the national four hour A&E standard, with 67-71% of all patients in the ED being seen within four hours.
- Twelve hour Decision to Admit (DTA) trolley breaches had risen rapidly with 226 recorded between January and March 2017.
- Not all incidents were reported within urgent and emergency care were graded correctly, or investigated thoroughly. Which meant opportunities to learn from incidents were missed.
- The service did not consistently adhere to duty of candour legislation and ensure patients and their families were given open communication when incidents occurred.
- Risk assessments had not been completed or updated for patients who had been in the department for more than 12 hours.
- Patients with mental health conditions were only assessed for their risk of deliberate self-harm which meant other risks may not be identified.
- Staff knowledge of mental health conditions and the Mental Health Act (MHA) 1983, was not sufficient to be able to safely care for patients in mental health crises.
- Staff did not observe patients with a mental health problem often enough, meaning patients had the opportunity to leave the department without challenge.
- There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients who attended the department with a mental health problem. Staffing was not always adjusted according to acuity and demand at any given time.
- Young people (as young as 15 years old) were admitted to the EDU with patients with mental health conditions without additional safeguards being applied.

Summary of findings

- We were not assured that the processes for safeguarding children were effective, or that the bruising protocol for actual or suspected bruising was being followed.
- There were missed opportunities to improve the service. Whilst some improvements with regards to the effectiveness of the area had been noted there were many risks within the department which had not been addressed, or had worsened. The governance system was not addressing these concerns in the emergency department.
- There had been some improvement initiatives in the ED such as the navigator nurse and pitstop and some good areas of practice noted.However, ED performance was showing a downward trend for some areas of performance.
- Staff did not always complete daily checks on emergency equipment within the ED.
- Some specialty consultants were resistive to the medical take model which meant there were delays in patients receiving specialist assessment and/or treatment in the ED.

Medical Care:

- Overall, the quality of care on the medical wards in relation to emergency medical care was very poor.
- Not all incidents were categorised correctly. The quality of investigations was poor, and lessons to be learned or care and service deliver problems were not always identified.
- The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.
- Medicines management policies were not always followed in the acute medical unit and medical wards to protect the safety and wellbeing of patients.
- Patient confidential information was not stored securely and documentation was not always accurate or updated in a timely manner.
- Staff did not always consistently follow infection control procedures on medical wards.
- Consent to treatment was not always obtained in line with the Mental Capacity Act (2005).
- Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and physical restraint.
- The inspection team had significant concerns about the safety and care of vulnerable people such as frail older persons or patients living with dementia.
- Staff caring for patients living with dementia did not always carry out a dementia assessment or use the dementia pathway.
- Staff did not always recognise or act appropriately in response to serious safeguarding concerns. Staff did not have sufficient knowledge of essential legislation and procedures in order to safeguard patients.
- Staff we spoke with did not have knowledge of the trust's pain assessment tool for patients who could not verbalise their pain.
- There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores.
- Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.
- The trust did not always declare mixed sex breaches as they occurred in line with current guidelines.

Summary of findings

- There were significant concerns regarding the flow of patients throughout the urgent medical pathway. The acute medical unit (AMU) had bed occupancy significantly higher than the England average and escalation areas were consistently in use. This affected waits for cardiac and renal day case procedures.
- Patients were moved both during the day and night for non-clinical reasons to aid bed availability.
- Some staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend.
- Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.
- Department risk registers did not always reflect the current risks or demonstrate risks were effectively reviewed or managed.
- Although some strategies were in place to improve the acute medical pathway, there was no evidence to show these had been embedded or had a significant impact on patients' care. . We could not evidence any significant or sustained improvements in medical care since our previous inspections.
- There were shortages of junior medical staff and consultants on AMU. Nursing shifts were not always filled which meant unwell or vulnerable patients did not receive the appropriate level of care and supervision. Staffing was not always adjusted according to acuity and demand at any given time.

We found the following areas of good practice:

- Patients and their relatives told us they generally felt they were well cared for while in the ED.
- Patients were given hot food and drinks if their transfer from the ED was delayed.
- Patients arriving at the ED were seen and assessed quickly by a senior doctor or nurse.
- Staff in the ED followed infection control procedures to reduce the risks cross-contamination.
- ED staff felt more connected with senior managers than on previous inspections and were engaged with initiatives to drive improvements.
- Staff in the ED treated patients and their relatives with dignity, respect and compassion.
- TARN data showed better than national average outcomes for patients with severe or life threatening injuries.
- Between November 2016 and March 2017 93% of patients said they would recommend the A&E service to family and friends, higher than the national average of 87%
- The introduction of pitstop provided a rapid assessment and treatment to patients who attend the Emergency Department.
- The trust had an identified pathway for patients living with dementia that included assessment, liaising with the older persons' mental health team and discharge planning

For the areas of poor practice the trust needs to make the following improvements.

Importantly, the trust must:

- Staff working with patients must have sufficient knowledge and skills to care for patients presenting with mental health condition.
- Staff within the emergency and medical areas must have sufficient knowledge of the Mental Health Act (MHA), 1983, so they understand their responsibilities under the Act.

Summary of findings

- Ensure that all clinical staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Systems must be in place to ensure that the risks of detained patients, including the risk of absconding, are fully assessed and mitigated where possible.
- Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively across all services.
- Safeguards must be put in place when children or young people are admitted into adult environments such as the EDU to ensure they are sufficiently safeguarded from avoidable harm.
- Ensure the Local Safeguarding Children Board protocol for the management of actual or suspected bruising must be followed in all situations where an actual or suspected bruise is noted in an infant that is not independently mobile.
- Staff mandatory training should be above the hospital's own target of 85%.
- Patients should not be transferred from ambulance trolleys in the corridor outside pit stop.Staff should move the patient to a more discreet area before attempting transfer, unless urgent transfer is required due to the patient's clinical condition.
- Patients waiting in the corridor for a space to become available in the 'pit stop' area should be either observed by staff at all times or have means of summonsing immediate help if required.
- Staffing numbers and skill mix of staff working in all areas must reflect patient numbers and acuity which should be adjusted according to variations in need.
- Staff in the medical services must follow the trust's medicines management policy to ensure that medicines and prescribed, stored and administered appropriately.
- Patients in the ED must be seen by a senior medical doctor in a timely way following referral to medical services.
- The acute medical model must be immediately reviewed to ensure that patients are seen by a treating physician and treated at the earliest opportunity.
- Equipment must be checked as per individual ward protocols to ensure it is safe and ready for use.
- Risk assessments must be completed to assess the range of risks to patients being cared for in escalation areas. These must take account of environmental factors such restricted access to curtains, call bells and oxygen. These risks must be mitigated where possible.
- Improve quality of incident grading and classification to ensure that they are escalated and investigated appropriately.
- Improve the undertaking of duty of candour and being open following incidents.
- Improve flow through the hospital to prevent patients being cared for in the ED for longer than necessary.
- Patients must not wait on trolleys for more than 12 hour periods in line with national standards.
- The hospital must declare mixed sex breaches as they occur in line with Department of Health guidance.
- Improve processes to enable staff to safely speak up about concerns. All staff must know how to raise issues regarding bullying and harassment.
- Protect patient's confidentiality through safe storage of records.

Summary of findings

In addition the trust SHOULD ensure:

- Conversations between the navigator nurses should be held in a private area to preserve the patient's dignity and respect.

Following the inspections of the Queen Alexandra Hospital in February and May 2017 we took immediate action to ensure the safety of patients. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so. Details of this action are included at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The emergency department has been rated requires improvement overall. With effective and caring rated as good, responsive and well led rated as requires improvement and safety rated as inadequate. Incidents were not always thoroughly investigated which meant actions were not identified and lessons were not being learnt. Some daily checks on emergency equipment were not routinely carried out. Staff compliance with mandatory training requirements fell short of the hospitals target of 85%. Staff knowledge of mental health conditions and the Mental Health Act (MHA), 1983, was not sufficient to be able to safely care for patients in mental health crises and meet the needs of all patients in this area. There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients with a mental health condition. Staff did not observe patients with a mental health condition often enough, which meant that patients had the opportunity to leave the department without challenge. Patients were assessed only for their risk of deliberate self-harm. This meant patients were experiencing other psychiatric disorders may not have their risks accurately identified. Vulnerable young people were admitted into the EDU with adult patients, many of which were in mental health crises. We were not assured that the processes for safeguarding children were effective within the emergency department or that the bruising protocol for actual or suspected bruising was being followed. Patients waiting in the corridor were not always observed by staff and had no means of summoning urgent help if required. Flow through the department was often compromised by a lack of available hospital beds. The hospital was not performing well against the national four hour A&E standard, with 67-71% of all patients in the ED being seen within four hours. Twelve hour trolley decision

Summary of findings

to admit breaches had risen rapidly with 226 recorded between January and March 2017. There were delays for patients referred to acute medical services to be seen by a senior medical doctor.
However,
Patients and their relatives told us they generally felt they were well cared for while in the department.
Patients arriving at the department were seen and assessed quickly by a senior doctor or nurse.
Staff were aware of infection control procedures.
Security staff were the only staff group who demonstrated excellent knowledge and understanding of the Mental Health Act, 1983 and the Mental Capacity Act, 2005.
TARN data showed better than national average outcomes for patients with severe or life threatening injuries.
There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings.
The development of the new pitstop area had reduced the number of patients who had to wait in the corridor and helped to reduce the amount of time it took for patients to see a doctor.

Medical care (including older people's care)

Inadequate

Medical care has been rated Inadequate overall.
With safe, caring, effective and well led rated as inadequate and responsive rated as requires improvement.
Overall the care provided within this service was very poor. Staff did not always recognise and act appropriately in response to serious safeguarding concerns. Consent to care and treatment was not always obtained in line with the Mental Capacity Act (2005). Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and/ or physical restraint.
Staff did not robustly assess, monitor or manage risks to patients. Risk assessments had not been completed or updated for all the escalation areas and additional beds in use. Vulnerable patients such as frail older persons and patients living with dementia did not have their needs appropriately assessed and risks for those patients were not sufficiently mitigated.

Summary of findings

Medicines management policies were not always followed in the acute medical unit (AMU) and medical services. Patient confidential information was not stored securely. Staff did not always consistently follow infection control procedures. Staff did not always respond to patients when they asked for assistance. On some occasions, the inspection team had to request that staff intervene to maintain patients' safety. Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.

The trust did not always declare mixed sex breaches in line with current guidelines. Not all incidents were reported, and some were categorised incorrectly. Care and service delivery failures were not always correctly identified during investigations of incidents. The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.

AMU had bed occupancy significantly higher than the England average and escalation areas were consistently in use. Patients were moved both during the day and night for non-clinical reasons to aid bed availability. Patients did not have timely access to discharge from hospital.

Staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend. Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.

Governance processes were not effective at identifying risks and improving the safety and quality of care and treatment. There was no clear or formal strategy to improve the urgent medical pathway and we could not evidence any significant improvements since our inspection in September 2016. The urgent medical pathway was still medically led and not all consultants were supporting necessary changes in the urgent medical pathway.

Not all staff had completed their mandatory training and the compliance for some staff groups was significantly lower than the hospital target. Not all

Summary of findings

staff completed safeguarding adults training to the appropriate level. Competency assessments for both permanent and agency nursing staff were not always in place.
However,
There was a standardised pain assessment tool was consistently in use which supported the management of pain in patients who could communicate verbally. Some patients and relatives praised the care they received on the renal day unit (RDU) and AMU.

Queen Alexandra Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care)

Detailed findings

Contents

Our inspection team

This inspection was overseen by Leanne Wilson, Interim Head of Hospital Inspection, Care Quality Commission.

How we carried out this inspection

This was a focussed inspection undertaken specifically to review the care provided patients within the acute medical pathway.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

Queen Alexandra Hospital is the acute district general hospital of the Portsmouth Hospitals NHS Trust. The emergency department (ED) at Queen Alexandra Hospital is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment such as lacerations and suspected broken bones. There were 141,957 attendances at its Urgent and Emergency Care services from April 2015 to March 2016.

Although this ED was a recognised trauma unit, major trauma patients went directly to the nearest major trauma unit. The department had a four-bay resuscitation area, with one bay designated for children. There were two major treatment areas, Majors 1 with 18 bays and three cubicles, Majors 2 with six bays and four chairs (with a trolley for clinical examination). There was a separate 'pit stop' assessment area with six trolleys and four chairs. Additionally, there were trolleys that were used for patients waiting in the corridor area if pit stop was full. There was a nine bedded Emergency Decision Unit (EDU). This area was comprised of two 4 bedded bays and a single bedded side room.

The minor treatment area had four treatment cubicles and a consultation room used by an experienced general practitioner to provide an urgent care service. The urgent care service was for patients that presented with a condition that required immediate treatment, but which could be carried out by a GP. The department had a separate children's treatment area with its own waiting room secure from the main waiting room. This consisted of an observed play area, an isolation room and five cubicles.

We carried out an unannounced inspection of the Queen Alexandra Hospital emergency department on 16, 17 and 28 February 2017, We carried out a further announced inspection of the corporate and leadership functions of Portsmouth Hospital NHS Trust on 10 and 11 May 2017. This inspection was carried out in response to concerns received regarding culture, governance and leadership within the trust. The specific concerns required us to visit the emergency department in May 2017 to review ward to board arrangements. During this inspection we identified concerns in all areas visited and we have included these findings in this report.

During this inspection we spoke to approximately 24 members of staff, 14 patients and three relatives. We looked at 10 sets of care records as well as policies and other relevant documents.

Urgent and emergency services

Summary of findings

We have rated the emergency department as requires improvement overall. We found:

- Incidents were not always thoroughly investigated which meant actions were not identified and lessons were not being learnt.
- Staff knowledge of mental health conditions and the Mental Health Act (MHA), 1983, was not sufficient to be able to safely care for patients in mental health crises.
- There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients who attended the department with a mental health condition.
- Staff did not observe patients with a mental health condition often enough, which meant that patients had the opportunity to leave the department without challenge.
- Staff did not assess patients presenting in mental health crises against a range of indicators. Patients were assessed only for their risk of deliberate self-harm. This meant patients were experiencing other psychiatric disorders may not have their risks accurately identified.
- Some patients detained under the MHA were at high risk of absconding and this risk was not being mitigated.
- Vulnerable young people were admitted into the EDU with adult patients, many of which were in mental health crises.
- We were not assured that the processes for safeguarding children were effective within the emergency department or that the bruising protocol for actual or suspected bruising was being followed.
- Patients waiting in the corridor were not always observed by staff and had no means of summonsing urgent help if required.
- Flow through the department was often compromised by a lack of available beds. This led to patients being nursed in ED for long periods of time.
- The hospital was not performing well against the national four hour A&E standard, with 67-71% of all patients in the ED being seen within four hours.
- Twelve hour trolley breaches had risen rapidly with 226 recorded between January and March 2017.
- There were delays for patients referred to acute medical services to be seen by a senior medical doctor.
- Some daily checks on emergency equipment were not routinely carried out.
- Staff compliance with mandatory training requirements fell short of the hospitals target of 85%.

However,

- Patients and their relatives told us they generally felt they were well cared for while in the department.
- Patients were given hot food and drinks if their transfer from the department was delayed.
- Patients arriving at the department were seen and assessed quickly by a doctor or senior nurse.
- Staff were aware of infection control procedures.
- Security staff were the only staff group who demonstrated excellent knowledge and understanding of the Mental Health Act, 1983 and the Mental Capacity Act, 2005.
- TARN data showed better than national average outcomes for patients with severe or life threatening injuries.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

We have rated safe as inadequate. We found:

- Incidents were reported by staff but not always investigated thoroughly and, as such, did not always result in learning or sufficiently mitigate against future similar incidents.
- We were not fully assured being open or duty of candour was being undertaken in all cases.
- Patients waiting in the corridor outside the 'pit stop' area were not always directly supervised by staff. These patients also had no means of calling for assistance when the staff could not directly see them.
- There were insufficient numbers of staff in the Emergency Decision Unit (EDU) to provide safe care and treatment.
- Staff attendance at mandatory training did not achieve the trust target of 85% in several key subjects such as children's safeguarding.
- Care for patients with acute mental health problems was poor and they were not adequately supervised. Staff did not have sufficient training to enable them to care for patients in a mental health crises appropriately.
- Staff did not assess patients presenting in mental health crises against a range of indicators. Patients were assessed only for their risk of deliberate self-harm.
- In the EDU we found that young people were nursed in bays with adults in mental health crisis, which did not safeguard or protect young people.
- Patients detained under the Mental Health Act (MHA), 1983, were not sufficiently safeguarded from absconding from the unit, and this risk was not mitigated.
- We were not assured that the processes for safeguarding children were effective within the emergency department or that the bruising protocol for actual or suspected bruising was being followed.
- There was evidence that checks were made on equipment for resuscitation but these were not always completed within expected timescales.
- Staff did not complete risk assessments for pressure ulcers and the use of bed rails as patients were not expected to stay long in the department. Some patients were cared for in the ED for over 12 hours so they may have missed opportunities to identify such risks and plan care accordingly.
- Sepsis screening was being undertaken; however compliance rates with providing treatment for sepsis were lower than expected and could place patients at risk of harm.

However:

- With the exception of the Emergency decision unit area, there were appropriate staffing levels for medical and nursing staff.
- Staff knew how to report incidents and received feedback from managers when they reported incidents.
- Medicines, including controlled drugs were securely stored and managed correctly.
- Records we reviewed were complete and were available to staff that needed access to them.
- TARN data showed better than national average outcomes for patients with severe or life threatening injuries.

Incidents

- The trust reported no never events for the emergency department between December 2015 and January 2017. A never event is defined as 'A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'.
- Information from the Strategic Executive Information System showed that there were 93 serious incidents reported across the department between December 2015 and November 2016. Of these the most common type of incident were related to emergency preparedness, resilience and suspension of services due to a lack of flow through the department.
- The department had increased its reporting of incidents. Staff knew when and what should trigger them to report an incident.
- We saw evidence that staff received feedback and learning from incidents that had been reported. Staff we spoke with told us they felt safe to report incidents and near misses and understood the reasons why incident reporting should always happen. For example, feedback from an incident led to changes for patients waiting by

the main automatic doors. If people stand to close to these can remain open causing patients to get cold, a red line on the floor indicated where it was possible to wait so that the doors remained closed.

- Some incidents were not investigated thoroughly enough to drive improvements. For example, we reviewed the investigation record that followed staff raising an incident with regard to a 15 year old child being admitted to the Emergency Decision Unit (EDU). The lessons learned identified from this stated 'Thank you for reporting this safety event' with no actual lessons learnt detailed or corresponding actions identified.
- Similarly, staff had raised an incident after a patient on a section 5(2) absconded from the EDU in February 2017. The lessons learnt were that closer observation were needed and earlier escalation of deteriorating behaviour. There were no actions identified other to place the management of patients with mental health conditions on the risk register so it was not clear how this would mitigate against future incidents of a similar type.
- We reviewed a range of incidents and found examples where investigation outcomes were not appropriate. One patient attended the emergency department with a chest complaint. The outcome was that the patient required urgent review on the cancer pathway. The patient was asked by the emergency department doctors to go to their GP and ask to be referred into the pathway. The patient was not seen urgently and this resulted in a delay of several months. The investigation outcome stated, 'I believe the actions taken on the day by ED staff were appropriate'. This was not an appropriate outcome given the impact on the patient's clinical condition.
- Another example evidenced a misdiagnosed and delayed reported fracture between the emergency department and radiology, was recorded on the incident record as a 'low' impact. The learning action said, 'No lessons to be learned by ED at this time', which was not appropriate as a fracture was missed and lessons could be learnt.
- Data reviewed by the commission in May 2017 highlighted there had been a suicide in December 2016 of an individual who had left the EDU whilst awaiting an assessment by the mental health trust's liaison team. The patient was considered to be high risk of suicide and was reported in the Serious Incident Requiring Investigation (SIRI) report, which went to the Registered provider's internal final SIRI panel on 16 March 2017, as having 'absconded' from the EDU. The SIRI report stated that the patient was for consideration of application of the Mental Health Act, 1983, if they wished to leave the hospital. The patient left the hospital without staff awareness and was sadly found hanged by the police in their own home the following day. Although there were clear potential opportunities for learning, the SIRI report identified no care or service delivery problems.
- The clinical director was responsible for the department's clinical governance activities. This included mortality and morbidity meetings. These meetings happened monthly, and details of incidents and deaths were discussed and learning shared, this was confirmed in meeting minutes we reviewed.
- There was a process in place for the management of incidents that included the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the duties required by the duty of candour. We saw examples where details of investigations had been shared with families that indicated duty of candour responsibilities had been applied.
- However, we were not assured that all opportunities to undertaken duty of candour or being open were taken. Through the incident reporting system we looked at incidents reported by the emergency department between 1 February and 30 April 2017. We identified four incidents which had been incorrectly graded, and there was no evidence duty of candour or being open was undertaken in these cases. For example, a misdiagnosed fracture was graded as 'low harm', a missed tendon injury was graded as 'low harm', and there were no identified learning actions and no evidence of duty of candour or being open recorded.

Cleanliness, infection control and hygiene

- There was a cleaning schedule for the resuscitation room and checks on this area were made during the day. There was disposal for sharps that was seen to be less than half full.
- The department overall was visibly clean and uncluttered. There were sufficient handwashing facilities for staff.

- We observed staff washed their hands between patients' contacts. There were also sufficient supplies of disinfectant hand gels and personal protective (PPE) equipment, such as gloves and aprons for staff to use. We saw that staff used this PPE appropriately and changed it before attending to other patients.
- A patient admitted with a potential infection was kept isolated from others in the major treatment area, and appropriate steps were taken to stop the spread of infection. Cubicles were deep cleaned when patients moved out of them.

Environment and equipment

- The department had a four-bay resuscitation area, one bay was equipped for children and adults. There were two major treatment areas; Majors 1 consisted of 18 bays and three cubicles, Majors 2, six bays and four chairs (with a trolley for examinations). There was a separate 'pits top' assessment area that had six trolleys and four chairs.
- There were trolley spaces indicated on the walls of the corridor outside the ambulance assessment area. One space in trolley space three had a sign which explained to patients why they were waiting in a corridor, and asked them to tell a member of staff if they needed anything. However, there were no call bells to summon help if no staff were present.
- In the children's ED and the Emergency Decision Unit (EDU), there were relative's rooms.
- Resuscitation equipment was stored correctly to ensure it was ready for use. In the major treatment area and resuscitation room there were four emergency grab bags. These had checklists and tamper proof tags. These contained the emergency equipment needed when transferring a critically ill patient to another area in the hospital. There were checklists for each individual bag, and the records of checking were completed in three of the four bags we checked.
- The layout of the department had changed with the creation of the 'pit stop'; this area had six cubicles and four chairs for patients. One cubicle was retained empty as it was required for examinations of patients in chairs chair patients.
- There was sufficient and appropriate seating in the main waiting area. This area was overseen by streaming / triage nurse, known as the navigator.
- The EDU had two four bedded bays and a side room. This area was used for patients that required short term observation or were waiting for the results of tests. It was also regularly used to accommodate patients with acute mental health problems. There was an interview room for patient assessment in the EDU. Staff could not view all patients within the EDU and the doors were not secure so patients, visitors and staff could freely go on and off of the ward. This posed a risk to vulnerable patients such as those detained under the MHA or those awaiting psychiatric assessment. After our inspection the trust informed us they have secured the entrance and exit to this department.
- The department had access to hospital beds to allow elderly patients to be nursed on appropriate pressure relieving devices, such as alternating pressure air mattresses in the major's treatment area. We saw that up to 14 patients had been transferred onto beds with pressure relieving mattresses while in Majors 1.
- There was a consistent system for checking equipment and supplies in each bay in the resuscitation room. We found that checks were generally completed and recorded daily.
- Disposable equipment was stored appropriately and was found to be in date and suitable for use.
- There was an anaesthetic machine in the resuscitation room, which was checked weekly by operating department practitioners from the intensive care unit that were familiar with the machine. The records of checks were kept by that department. On review of the record of checks this equipment was checked once in the previous month. Staff were aware that this machine should be checked weekly, but did not have access to the records to check this.
- There was a separate ambulance entrance for children and a specially equipped resuscitation room.

Medicines

- Minimum and maximum temperature recordings of medicines refrigerators in the resuscitation room were carried out daily. They were not all found to be within the expected range, this had not been reported to pharmacy which did not follow the trust's own medicines management policy. Staff we spoke with were unclear what action to take if refrigerators for storing medicines were out of range. Medicines not stored at the temperature recommended by the manufacturer could become less effective as a result.
- Medicines stored in the department were spot checked and found to be in-date and stored securely. Controlled

drugs were stored securely and appropriately. A review of the controlled drugs register found that medicines administered had been correctly completed and reconciled with the stock level.
- Patient allergies were recorded on the prescription charts we reviewed.
- There was a departmental protocol for the prescribing of antibiotics that staff adhered to.
- In the children's emergency department we found that medicines were securely stored in a locked room. There was a refrigerator for medicines that required temperature controlled storage, minimum and maximum temperatures were recorded daily.

Records

- When a patient was registered, their details were entered onto a computer system that tracked how long people had been waiting, and the investigations they had undergone. Patient records and information stored on trust computers was protected by passwords and backed-up to keep it secure.
- The department had staff known as patient 'trackers' who were responsible for printing off patient records from the electronic system to ensure they were complete and transferred with the patient. Clinical staff told us they valued this role as it freed up their time to care for patients.
- Staff entered all clinical information onto the computer system. When patients were admitted to a ward a paper copy of their treatment record was printed out and taken with them.
- We reviewed six sets of patient records within the main department; these were complete and included observations and pain assessment scores.
- In February and May 2017 staff had not completed risk assessments for pressure ulcers and the use of bed rails in the clinical records we reviewed on inspection. The ED staff did not see it as their role to complete these assessments as they did not expect patients to stay long in the department. However, patients sometimes spent over 12 hours in the department. This meant that risks to patient safety may not be recognised at the earliest opportunity.

Safeguarding

- Staff were aware of the process to make a referral to the trust safeguarding team and also the local authority. Staff were aware that there was a statutory reporting process in cases of female genital mutilation and could find this information on the hospital intranet if required.
- There was also information for staff about processes to follow if they suspected a patient had been subject to, or was at risk from domestic violence.
- We were not assured that the processes for safeguarding children were effective within the emergency department. We were informed of two cases that occurred in the week prior to our inspection where children under the age of one year old were sent home despite bruising of unknown origin being found.
- The 'Protocol for the management of actual or suspected bruising in infants who are not independently mobile', states, 'This protocol must be followed in all situations where an actual or suspected bruise is noted in an infant who is not independently mobile'. However, on discussion with the safeguarding team they informed us that the bruises were "open to interpretation" by the medical staff. Therefore we were not assured that the protocol was being adhered to.
- The 'Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document' sets out required safeguarding training levels for healthcare staff. The training rates for medical staff in the emergency department for level three children's safeguarding was 66.6%. Emergency Nurse Practitioners, who see and treat children, had not received level three safeguarding children's training. This was not in line with the intercollegiate guidance.
- Staff told us that young people aged 16 to 17 years were frequently admitted to the Emergency Decision Unit (EDU) in bays with adult patients, many of who were in mental health crises or detained under the Mental Health Act (MHA), 1983. During our inspection we saw that a vulnerable 16 year old patient was being nursed in the Emergency Decision Unit (EDU) with six patients presenting with mental health needs. This included two patients detained under the MHA and one patient who was assessed as acutely suicidal. Staff caring for this young person did not recognise their inherent vulnerabilities as a young person and there had been several missed opportunities by senior staff to put in sufficient safeguards to protect them. This was raised to the executive team at the time of our inspection.

- The trust supplied data which showed that 20 young people aged 15 to 17 years old had been admitted to adult environments (mainly the EDU) within the ED during January and February 2017. Of these, one fifteen year old child had been admitted. Trust data also showed that during January and February 2017 and average of 27.57% of all patients admitted to the EDU presented with mental health conditions. This figure did not include patients with primary alcohol or illicit drug related presentations. During our inspection, we saw that no additional safeguards were routinely considered to protect young people being nursed in these often volatile adult environments.
- Staff did not sufficiently safeguard patients detained under the Mental Health Act (MHA), 1983. During this inspection, on 17 February we were made aware that a patient detained under section 5(2) of the MHA had absconded from the EDU, without challenge from staff. Similarly, on 10 May 2017, during inspection we were made aware that a patient under section 2 of the MHA left the EDU freely without challenge or intervention from staff. The patient, at that time, was awaiting admission to a psychiatric intensive care bed. The patient returned safely within 30 minutes but staff responsible for the patient did not have oversight of the patient's wellbeing or whereabouts to sufficiently safeguard the patient from avoidable harm.
- Of the 17 consultants in the emergency department, only one had not completed the children's safeguarding level 3 training. This was improved since the last inspection.
- Staff had completed training on adult and children's safeguarding. Hospital data from January 2017 reported that over 97% had completed safeguarding adult's training and 77% had completed all levels of children's safeguarding. Children's safeguarding training compliance was below the trusts' 85% target.
- The number of staff that had completed training on deprivation of liberty safeguards was above the trust target at 89% in January 2017.

Mandatory training

- Staff attendance at mandatory training did not consistently achieve the trust target of 85% in December 2016 and January 2017. Eighty one percent of staff had completed adult basic life support; 74% bulling and harassment awareness; 64% conflict resolution training; 71% Mental Capacity Act (MCA) and 79% information governance training. This meant there was a risk that staff lacked knowledge and skills in these key areas that the trust had identified as essential for all staff.
- However, staff compliance was over the trust target in Blood awareness training (90%); Complaints (95%); Dementia care (94%); Deprivation of liberty safeguards (89%); Equality diversity and human rights (91%); moving and handling (98%) and Infection control (85%).

Assessing and responding to patient risk

- Patients admitted to the department with a mental health condition were quickly assessed for their risk of self-harm and this was documented. However, we were not assured that these checks were on-going throughout the patients stay on the ward. Similarly, the initial risk assessment was based solely on the risk of self-harm and therefore did not assess against a range of risks associated with all mental health conditions. For example, we saw where one patient presented with psychosis and whilst they were not expressing a want to self-harm, they were evidently very unwell and requiring urgent psychiatric intervention. This risk had not been accurately assessed.
- We found the assessment of ambulance patients had been improved by the trust introducing a rapid assessment and treatment process in the 'pitstop' area. During the day, this was carried out by a team which comprised a senior doctor, nurse and a healthcare support worker. Staff carried out this process quickly in order that subsequent ambulance patients did not have to wait. This also meant that patients were quickly assessed by a doctor and were located quickly in the correct area of the department.
- The department had introduced a navigator nurse in October 2016 and this role was now embedded. However there was no standard operating procedure for the role to list the responsibilities and experience required. The navigator was a senior qualified nurse based in the main waiting room of the department, assisted by a healthcare support worker.
- This nurse carried out a brief clinical assessment of patients as soon as they arrived and they were able to quickly reassess patients if they showed signs of deterioration. The navigator nurse had access to a panic

button for their own safety and to quickly access support if needed. We observe red the navigator nurse triaging a walk-in patient with suspected sepsis to majors for urgent medical assessment.

- The navigator nurse was able to stream patients directly to the major treatment area if needed, and also to minor treatment area and the minor illness service. The navigator nurse was able to book patients in and record basic observations and they moved patients directly to the resuscitation room or the 'Pit Stop' area if they felt this was clinically indicated. Patients we spoke with told us they felt the navigator role ensured they were able to discuss their reason for attending with a nurse immediately when they arrived.
- The median time to initial assessment was seven minutes the same as the England average.
- The department used the national early warning system (NEWS) to detect patients that were at risk of deterioration. In records we reviewed these were used appropriately. Staff felt able to escalate NEWS scores to senior nurses or medical staff and did so.
- National CQUIN data for Sepsis (for the period October to December 2016) showed the 98.35% were screened for sepsis. However, 42.69% received treatment following screening where sepsis was indicated, and 47.04% received treatment at triage for sepsis.
- The trust board meeting minutes from February 2017 have included a risk on the assurance framework which includes a moderate graded risk of 'Not compliant with administration of antibiotic within 1 hour of first triage.' The control cited on the assurance framework was 'sepsis six pathway'.
- The department took action to improve their sepsis performance and undertook a gap audit comparing the results from January and April 2017. The time taken from identification to administration of antibiotics in under 60 minutes improved from 74% in January to 95% in April 2017. Triage to antibiotic time also increased from 84% to 95%.
- The service had identified further learning as part of the audit to maintain these improved standards. This included further training, increasing awareness, and regular audits.

Nursing staffing

- In February 2017 there were insufficient staff to meet the needs and ensure the safety of patients with mental health conditions in the Emergency Decision Unit (EDU). We saw that there was one band 5 registered nurse in charge of the EDU each night. This one nurse was responsible for up to nine patients. On the nightshift of 16 February 2017, one nurse was responsible for seven patients, five of which were presenting in mental health crisis and two were detained under the Mental Health Act, 1983 and one was only 16 years old.
- We raised this with the executive team during the inspection who implemented the addition of an agency registered mental nurse each night to support the nurse in charge in caring for patients with mental health conditions. However, we saw that these staffing numbers did not vary according to the numbers of patients or the level of acuity they presented with.
- When we returned in May 2017, staff told us that the RMN had made little impact on patients within the EDU as they were agency RMNs who were not invested in the overall running of the ward and one member staff said the RMN was being used just to 'satisfy the CQC'.
- In May 2017 we reviewed staffing allocated to the EDU from 1 to 8 May 2017 which confirmed a range of demand and acuity of between two and five patients detained under the Mental Health Act, 1983, being managed with the same number and skill mix of staffing. We saw no evidence of any formal consideration of demand or acuity.
- There were mostly sufficient numbers of qualified nurses to staff the main department safely; however, nurse staffing had been identified as a risk and on-going recruitment was taking place. A safer staffing acuity tool was in use to help ensure there were sufficient nursing staff. Where gaps in rotas were identified this was discussed with senior managers at daily operational meetings to ensure they were aware of increased risk in the emergency department.
- Staffing rotas confirmed that there were some gaps in staffing that were unable to be filled. Staff sometimes worked flexibly to fill these shifts. Agency staff could be requested if there was a staffing deficit.
- The nursing staffing of the department appeared on the risk register as there was a shortage of children's nurses to staff the children's emergency department. The service was not able to run over 24 hours and the children's service continued to be run from the main department after 2am. There were plans in place to provide additional training and rotate adult nurses through the children's ED to increase staff experience.

- Handover procedures were observed and provided an effective overview of activity within the department. However, handovers were conducted separately between medical and nursing staff. This meant that there was no single overview of the department or awareness of pressures or risk across disciplines.

Medical staffing

- In September 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average, and the proportion of junior (foundation year 1-2) staff was lower than the England average.
- The trust employed 47 whole time equivalent doctors within the emergency department. The department had 14.7 whole time equivalent consultants. There was a smaller group of senior doctors that were not consultants (15% of medical workforce) and a larger group of junior doctors that made up 54% of the workforce.
- There was a senior doctor on duty in the pitstop area between 10am and 10pm every day.
- There was consultant cover in the department for more than 16 hours per day. This was in line with Royal College of Emergency Medicine recommendations on consultant workforce (2010) However; consultants told us that they were often not always able to leave the department on time at the end of their shift.
- There were insufficient junior medical staff on the medical staffing rota due to vacancies. This made it necessary for consultants to 'act down' in order to fill these roles.
- The mental health liaison team which was provider by a neighbouring NHS trust provided a consultant psychiatrist that was based in ED.
- The Frailty Interface Team (FIT) had a consultant in elderly medical services that supported the medical staff across the ED.
- Staff from the intensive care unit were available at all times to support the ED staff in the resuscitation room should patients require urgent anaesthesia. There were cover arrangements in place from on-call anaesthetists.

Major incident awareness and training

- The Emergency Department had an escalation policy (dated October 2016) that provided staff with guidelines for the delivery of safe and timely care for patients. The policy described best practice with regard to providing clinical capacity when the hospital was in escalation. This policy worked in conjunction with the Capacity Escalation Policy and the Full Capacity Policy. These policies were intended to work with the escalation policies throughout the hospital to ensure risk sharing could be achieved and the admission of patients into hospital beds in wards to enable the normal functioning of department. Staff had awareness of changes in escalation policies that had been made since the inspection in February 2016.
- The trust had agreed escalation plans across the Portsmouth system in May 2016.
- The department had an up-to-date major incident plan, and arrangements were in place with the local ambulance trust to manage mass casualties.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We have rated effective as good. We found:

- The Royal College of Emergency Medicine (RCEM) audit showed that patient outcomes were better than many other hospitals. The rate of unplanned re-attendances within seven days was better than the England average.
- There were easily accessible evidence based guidelines for the treatment of urgent and emergency patients.
- The department satisfied the requirements of the national 'Standards for children and young people in emergency settings'.
- Patients' pain was assessed promptly and appropriate pain relief was administered quickly.
- Teaching and staff development was a priority in the department. There was a structured competency framework for nursing staff.
- There was good multi-disciplinary working with the frailty intervention team, the psychiatric liaison team, the stroke unit and intensive care staff.
- TARN data showed better than national average outcomes for patients with severe or life threatening injuries.

However;

- Only 80% of nursing staff within the ED had received an annual appraisal which was below the trust's own target of 85%.
- Staff working within the Emergency Decision Unit (EDU) had not received training in caring for patients with mental health conditions and reported they were not competent or confident in this aspect of their work.
- Staff did not record fluid input and output for some elderly patients to ensure they were receiving the correct treatment.

Evidence-based care and treatment

- The emergency department used a combination of clinical guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) to determine the treatment that was provided. Guidance was regularly discussed at monthly governance meetings, disseminated and acted upon as appropriate.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE. These included treatment of strokes, asthma, feverish children, multiple traumas and the prevention of deep vein thrombosis. At monthly governance meetings any changes to guidance and the impact that it would have on clinical practice was discussed.
- The department satisfied the requirements of the national "Standards for children and young people in Emergency Care settings".
- The ED participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM).
- There was also a local audit programme which included topics such as compliance with insulin prescribing, sepsis, trauma care and standards of record keeping. The results of the audits led to refinements and changes in treatment protocols and improvements in the clinical computer system. Updated protocols were shared with all staff the department.

Pain relief

- In the CQC A&E Survey 2014, the trust scored about the same as other trusts for the question "How many minutes after you requested pain relief medication did it take before you got it?"
- The trust scored about the same as than other trusts for the question "Do you think the hospital staff did everything they could to help control your pain?"
- We observed that nurses administered rapid pain relief when they assessed patients who had arrived by ambulance or on foot.
- Patients we spoke with told us that they had been given pain relief quickly on arrival at the department.
- Although formal pain scores were not always assessed in the minor treatment area, three of the four patients that we asked told us that they had been offered pain relief. Records showed that this had been administered promptly and in line with hospital policy.
- Pain scores were recorded in the major treatment and resuscitation areas as part of the national early warning system (NEWS).

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated. Intravenous drug charts showed that these were recorded completely and accurately.
- However, we noted that some elderly patients were not started on a fluid input and output chart which meant they staff could not accurately assess the fluid balance or effectiveness of this treatment.

Patient outcomes

- The Royal College of Emergency Medicine (RCEM) carried out three national clinical audits in 2015/16 and this service submitted data to all three.
- The first was the measurement of vital signs in children. Standards at the hospital were similar to the majority of hospitals in England.
- Standards were better than most other hospitals in the prevention of blood clots in immobilised lower limbs and procedural sedation in adults.
- The third audit for the completion of safety documentation before discharge was significantly better than the majority of hospitals in England (82% of patients compared to 3%).
- In the previous year the department had achieved better results than the majority of hospitals in clinical audits regarding initial management of the fitting child, mental health in emergency settings and the assessment of cognitive impairment.
- We observed two patients with sepsis being treated promptly and in accordance with national guidelines.
- There was a local audit programme which included topics such as compliance with insulin prescribing,

sepsis, major trauma and examination of feverish children. The results of the audits led to refinements and changes in treatment protocols and improvements in the clinical computer system. Updated protocols were shared with all staff the department
- The department was currently contributing to three national research projects regarding the treatment of head injuries, heart failure and childhood sepsis.
- The rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. At the Queen Alexandra hospital unplanned re-attendances were on average 7.5% since August 2015 against the national average of 8%.
- The service submitted data to the Trauma Audit and Research Network (TARN) for the 2015/16 year. The data showed there were 0.8 survivors more per 100 patients than the national average. Though this is a reduction from 1.5 survivors per 100 patients in 2013/14.
- TARN recorded for 2016 the Median Time to receiving a CT scan (hrs) was 1.18 hours against a national average of 0.55 hours.
- TARN recommends that patients with severe head injuries or focal signs should be transferred to the care of neurosurgery units regardless of whether they need surgical intervention. Between January 1st 2013 and December 31st 2016 28% of these patients were transferred from this hospital to a neurosurgical unit.
- The BOA standards for trauma (BOAST) results for injuries to the limbs and pelvis recorded an average time to theatre of 12.87 hrs, which was better than the national average of 14 hours.
- For the 2015/16 'National Confidential Enquiry into Patient Outcomes and Death – Sepsis' the trust submitted 55% of available cases.
- The quality account reports for 2015/16 identified that there were areas of improvement required in the management of sepsis at the front door. This included the 'need to improve time compliance with 1 hour antibiotics for all patients suspected of having Sepsis in emergency corridor and direct admission units.'

Competent staff

- Staff we spoke with told us that access to training about the needs and risk of patients with a mental health problem was limited since the mental health lead nurse had left the department several months prior to our inspection. The trust had not recruited to the post of mental health lead since then as the previous lead took a lead role as it was an area they were interested in, not a formal part of their job description. Post inspection, we were informed by the trust that the department's mental health lead was a consultant who had been in the role for the past 10 years but staff we spoke with during the inspection were unaware of this.
- In May 2017 we were informed the trust were seeking to offer the past post holder bank work to deliver training but this was not a formalised plan and there was no scheduled start date. Staff we spoke with who were working on the Emergency Decision Unit (EDU) reported they did not have sufficient competence or confidence in supporting patients with mental health conditions.
- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process. At the time of our inspection 80% of nursing staff had taken part in an appraisal in the last year against a target of 85%.
- Nurses explained that, when the department became crowded, all "office activities" were cancelled to enable staff to look after patients. The head of nursing was aware of the shortfall and had arranged appointments for outstanding appraisals.
- Teaching and staff development was a priority in the department. Nursing shift times were flexible in order to allow for formal teaching sessions two or three times a week.
- Junior doctors told us that two hours of teaching time each week was protected regardless of the pressures on the department. They told us that the ED consultants offered excellent learning support.
- Staff told us that there was a structured competency framework so that nurses and their managers knew when they were ready for increased levels of responsibility. These had recently been updated in order to reflect changes in practice.
- We spoke with doctors who were new to the department. They told us that they received regular supervision from the emergency department consultants, as well as twice weekly teaching sessions.
- Nurses we spoke with told us that they had undertaken the Resuscitation Council's Intermediate Life Support course and others had also attended paediatric resuscitation training.

- Nursing staff were supported by an ED practice educator who was a senior member of staff who also worked clinically. This role co-ordinated the activities of student nurses within the department and helped to develop competency assessments for qualified staff.
- A recent education audit by the University of Southampton and the Nursing and Midwifery Council had shown that the department provided a supportive and well-informed learning environment.
- Physicians working in ED were supported with the maintenance of anaesthetic skills by staff in the intensive care unit.
- There were security staff in the department at night, from 9pm-5am. These staff had an excellent knowledge of the Mental Health Act that included the most applied sections of the act, as well as the Mental Capacity Act.

Multidisciplinary working

- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- There was a good working relationship with the children's safeguarding team and with the community paediatric team.
- The psychiatric liaison team had recently been expanded by the NHS trust that provided the service. The team consisted of nine mental health nurses and a consultant psychiatrist. We observed a good working relationship between this team and ED staff. ED nurses told us that the emergency mental health pathway was now more effective and patients did not wait so long to be seen. The mental health liaison team also assessed patients who had attended as a result of substance or alcohol misuse.
- The two main pathways for avoiding unnecessary admissions were referrals to the Ambulatory Emergency Care centre and to the frailty interface team (FIT).
- Referral criteria for ED patients that could be treated in the Ambulatory Emergency Care Centre was not well established. Referral rates in the six weeks prior to our inspection had varied from 25 patients a week to 49 patients which were similar to the numbers on our previous inspection. An ED doctor told us that acceptance of referrals depended on the type of staff working in the Ambulatory Emergency Care Centre on any given day. We later learnt that nurses and doctors rotated from the Acute Medical Unit and that their number and experience was variable.
- The frailty interface team was comprised of clinical nurse specialists, healthcare support workers, occupational therapists, physiotherapists and a consultant in elderly medical services. The team carried out a specialist assessment of all frail elderly patients attending the department. They worked closely with clinical and support teams in the community in order to prevent the need for hospital admission.
- We observed a very proactive approach from the team. There were computer screens in their office which showed details of patients in the department and those that were expected to arrive by ambulance. This enabled the team to assess frail patients as soon as they arrived and they were able to suggest and discuss treatment options with ED staff.
- Staff we spoke with reported that integration with the rest of the hospital had improved in recent months. Other specialties were beginning to accept that effective treatment of emergency admissions required action from a number of different hospital teams, not just those in the emergency department.

Seven-day services

- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when needed.
- There was an on-call pharmacy service outside of normal working hours.
- Emergency department consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.
- The new psychiatric liaison service worked seven days a week from 8am to midnight. Outside of these hours, staff could access the neighbouring mental health trust's crisis team if they required urgent advice or support.
- There was always an anaesthetist on-call to assist with resuscitation if required.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.

- The computer system alerted staff when vulnerable children or adults arrived in the department.
- Discharge letters were clear and comprehensive and were sent to GPs on a daily basis.
- The computer systems provided up-to-date information about patients' condition, investigations and progress within the ED.
- Computer systems in the department were protected by password to prevent unauthorised persons accessing patient information.
- There were several whiteboards in the major treatment area, these identified patients by initials only and recorded the patients whereabouts in the department. The boards were also used for staff allocation and the progress of any investigations or tests that patients needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of their children.
- The staff we spoke with had sound knowledge about consent and mental capacity and knew when formal mental capacity assessments needed to be carried out.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

Are urgent and emergency services caring?

Good

We have rated caring as good. We found:

- We observed patients and those close to them receiving compassionate care from staff across the emergency department.
- The emergency department (ED) staff were welcoming and did all they could to provide patients with privacy when booking in. We witnessed staff treating distressed patients with kindness and compassion.
- Staff in the department treated patients and their relatives with dignity and respect. Consent was sought from patients before staff carried out observations, examinations or provided care. Staff met the needs of patients promptly.
- Emotional support was provided for patients and their relatives in the department. There was a room that could be used to accommodate the relatives of critically ill patients brought into the major treatment area. Staff told us that families using the room were given regular updates on their family member.
- The chaplaincy team were available across 24 hours, to provide additional support for patients and their relatives.

However,

- Patients' conversations with the navigator nurse were not private and could be easily overheard by other waiting patients.
- Patients' were sometimes transferred from ambulance trolleys in the corridor, despite the new pitstop area and another available room. We observed patients that were transferred in this way were always covered to preserve their dignity.

Compassionate care

- The trust's Urgent and Emergency Care Friends and Family Test performance (percentage that would recommend the department) was better than the England average between December 2015 and November 2016. In the latest period, November 2016 the trust's performance was 93.3% compared to an England average of 86.1%.
- We observed caring interaction from the navigator nurse when seeing patients that walked into the department. Patients could be heard talking with the navigator nurse, although there were privacy screens in place. For example, we observed a patient with a mental health problem discussing their crisis with the navigator nurse, the people in the waiting room were aware of this

vulnerable patient's presenting problem. There were plans to give more privacy to patients when talking to the navigator nurse but it was unclear how this would be achieved.
- The CQC A&E survey (2015) showed that the trust performed similar to other trusts for the question about how long it took for a patient to speak to a nurse or doctor.
- The A&E survey results from 2015 in response to the question about privacy and dignity, rated the department about the same as other trusts'.
- Patients were treated with dignity and respect, where possible staff tried to maintain confidentiality of conversations. However, due to the layout of the department, particularly in the major treatment area with chairs this was difficult. Staff were aware of this and spoke quietly to patients when receiving information about their reasons for attending the department.
- We observed two patients being moved from ambulance trolleys to ED trolleys in the corridor area, the patient was not asked if they would find this acceptable. The patients were covered with blankets; however there was a room available for transferring patients between trolleys privately, which was not used on these occasions. On one of these occasions there was also an empty bay in the pit stop that could have been used for this transfer to ensure the patients privacy and dignity was maintained.

Understanding and involvement of patients and those close to them

- The results of the CQC A&E survey (2014) showed that the trust scored about the same as other trusts in 24 of the 24 questions relevant to caring.
- Family members were allowed to stay with their relatives in the resuscitation room if this was appropriate and were given information and supported by staff. Relatives waiting with patients in the major treatment area were given refreshments by staff.
- Data from the A&E survey (2014) for the question relating to patient confidence and trust in the doctors and nurses in the department was about the same as other hospitals. Patients also rated the ability to get attention from a member of staff if they needed something the same as other trusts'.
- Patients we spoke with told us that they were involved in decisions about their care and treatment as much as they wanted to be.

Emotional support

- We saw emotional support given to a patient and their relatives when they were admitted to resus very unwell. The nurse explained everything that was being done to monitor the patient and kept their relatives well informed throughout.
- Staff had access to the hospital chaplaincy team and could contact them at any time to support patients with religious or cultural needs as well as provide emotional support.
- The A&E survey results for the question about staff responding to patients being distressed rated the department about the same as other trusts.
- Staff could access additional support from the mental health liaison team when caring for very emotionally distressed patients to ensure the patients received appropriate emotional support.

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

(for example, to feedback?)

Requires improvement

We have rated responsive as requires improvement. We found:

- The hospital was not performing well against the national four hour A&E standard. They only assessed and either discharged or admitted 64-71% of all patients in the ED within four hours during January and March 2017. This was well below the national standard of 95%.
- Patients waiting between four and 12 hours between decision to admit and admission had risen between March 2016 and March 2017 and was significantly higher than the national average.
- We observed long delays before speciality assessment and treatment by on-call specialist medical teams.
- There were delays of up to 48 hours for patients with mental health problems who needed to be admitted to a hospital.

Urgent and emergency services

- Service planning and delivery for the department did not take account of the demographics of the local population.
- There was a high percentage of patients being treated for mental health conditions in the Emergency Decision Unit (EDU), without appropriate support in place to meet their needs.
- The percentage of ED attendances that resulted in admission was higher than the England average

However,

- The trust had implemented an urgent care improvement programme that had started to improve patient flow through the department. Senior medical review in the 'pitstop' area was working well.
- Staff were knowledgeable about the care and treatment of patients from specific vulnerable groups such as patients living with dementia and individuals with learning disabilities. They were committed to meeting those needs.
- Learning from complaints was discussed at clinical governance meetings and disseminated to staff via the governance newsletter.

Service planning and delivery to meet the needs of local people

- Changes had been made in the delivery of care to meet the needs of local people. Senior staff had visited other well performing emergency departments in order to understand how different ways of working could enhance patient safety and experience.
- Service planning and delivery on the Emergency Decision Unit (EDU) did not take account of the high percentage of patients being treated for mental health, alcohol or drug related conditions in the department despite the demographics of the local population.
- Portsmouth is in the worst performing 10% of local authorities nationally for indicators relating to alcohol. The rate of self-harm hospital stays is worse than the average for England. There had been no formal service planning that takes account of these issues.
- During January and February 2017 and average of 27.57% of all patients admitted to the EDU presented with mental health conditions so this patient group represented a significant proportion of the patient population.
- The layout of the department had changed since our previous inspection with a new 'pitstop', which had room for six patient trolleys and four chairs. This had reduced the numbers of patients having to wait in the corridor, and helped the department reduce the amount of time it took for patients to see a doctor.
- The urgent care centre was staffed by a dedicated GP (with a minimum of five years' experience) every day from 10am to10pm.
- The trust had implemented an urgent care improvement plan that improved patient flow through the department. This had helped to reduce the severe crowding that had previously taken place. An example of the new arrangements was that medical patients, whose admission had been arranged by a GP, went directly to the acute medical unit, rather than being assessed and treated in the emergency department.
- There was now a hospital escalation policy which described the actions to be taken if the emergency department was full and ambulances were no longer able to handover patients. The policy was detailed and logical and ED staff were aware of the current escalation status.

Meeting people's individual needs

- The waiting room had sufficient seating for the people waiting. Children had their own waiting area which included appropriate toys, and was accessed via a secure door operated by reception staff.
- There was a spacious relative's room that could be used for family members of critically ill patients in the resuscitation room.
- Patients admitted to the emergency department that were likely to die were relocated to a side room, to allow families to spend time with the patient. During the inspection a patient that had died remained in a side room in the department to allow further family members to get to the hospital.
- There was a lack of privacy for ambulance patients when they were waiting in a corridor before being transferred to a treatment area. However, we saw staff making every effort to ensure that corridor waits were as short as possible. Patients spent less time in the corridor than during previous inspections.
- Nurses had received training in the care of people with a learning disability. They were able to speak confidently about the differing needs of people with a learning disability and prioritised their care where possible.

Urgent and emergency services

- The majority of staff had recently undertaken training in the specific needs of people living with dementia. All patients over the age of 65 were assessed for signs of dementia. If they were found to be vulnerable they were referred to a specialist team before being discharged.
- We observed the care of a patient that had been admitted from home by the out of hour's service. However, on arrival in the department it was identified that they had a do not attempt cardio-pulmonary resuscitation in place as well as an advanced directive stating that they wanted to die at home. There was effective coordination between the FIT team, social services and the palliative care team which ensured the patient was discharged into the care of the community team that allowed them to die in their place of choice.
- There was a well-equipped and designed children's emergency department that was secure and separate from the adult area. This included areas for children to wait with age appropriate toys and also allowed observation of children with head injury. Treatment rooms for triage and treatment of children were also separate from adult facilities. This had a secure door from the main waiting room that was controlled electronically.
- In the CQC A&E Survey 2014, the trust scored 6.7 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as than other trusts.
- Patients that were allowed to eat while waiting in the major treatment areas were provided with sandwiches and snacks. Hot meals were also provided for patients that required them on an as needed basis.
- There was full level access with automatic doors and, toilets with disabled access. Baby changing facilities were available within the children's emergency department.

Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between December 2015 and November 2016. The trust attained between 64% and 71% of all patients being admitted, transferred or discharged within four hours between January and March 2017 which is well below the national standard and meant patients were staying too long in the ED.
- Data provided by the trust shows there has been a significant number of 12 hour decision to admit trolley breaches in the ED since January 2017. Twelve hour trolley breaches occur when the period of time between a patient arriving in the ED and them being discharged, transferred or admitted exceeds 12 hours. The trust had 44 trolley breaches in January, 87 in February and 95 in March 2017. Prior to January 2017 there had been no 12 hour trolley breaches in November or December 2016. This showed that the trust were not sustaining previous improvements in relation to flow through the ED.
- In October 2016 the median time to treatment was 44 minutes compared to the England average of 59 minutes.
- The trust's performance had consistently met the standard and had been better than the England average. The trust's median time to treatment had shown a decrease from May 2016 (57 minutes) to October 2016 (44 minutes) demonstrating an improvement.
- Between April 2016 and March 2017 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was 39%. This was worse than the preceding year which was at 29% and worse than the national average of 12%.
- We observed long delays in responses from medical and surgical specialists during our inspection. There were also delays in patients being assessed by a speciality doctor. Emergency medical staff were often involved with prescribing patients routine medicines and treatment. Patients that had been referred to specialist doctors were not always seen on ward rounds if they were had to remain in the ED due to a lack of flow through the department.
- Delays in specialist assessment and care for patients with mental health conditions had been reduced due to an increase in the number of psychiatric liaison nurses (provided by another NHS trust). However, there were frequent delays if mental health patients needed to be admitted to a psychiatric unit. They were nursed in the Emergency Decision Unit (EDU) and were cared for by ED nurses with input from the mental health liaison service.
- Staff on the EDU told us there were frequently delays of over 12 hours for patients awaiting a psychiatric bed. On 10 May, we observed a patient had been waiting over 72 hours for a psychiatric intensive care bed.

Urgent and emergency services

- The children's emergency department was open between 7am and 2am. Outside of these hours the service consolidated to the main department.
- The percentage of ED attendances that resulted in admission was 28% in 2015/16; this was higher than the England average of 22.2%.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make a comment or complaint staff would direct them to the nurse in charge of the department. If the concern could not be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS) that logged their complaint and attempted resolution within a set timeframe. Information on contacting PALS was available within ED.
- Formal complaints were investigated by a consultant or senior nurse and replies were sent to the complainant within the agreed timeframe. The number of complaints and learning from them were discussed at ED governance meetings. For example, patient comfort rounds had recently been changed to hourly, rather than two hourly in response to a complaint that had been investigated.
- The department had received complaints from patients about being cold when waiting by the main doors from the ambulance bay. There was a red line marked on the floor that meant that the electronic doors would remain shut to reduce heat loss as much as possible.

Are urgent and emergency services well-led?

Requires improvement

We have rated well led as requires improvement. We found:

- There had been areas of improvement within the leadership of this service. Emergency department staff had been supported to make independent decisions about service improvements but this was at an early stage and required further development.
- Long-standing members of staff had doubts about the sustainability of recent improvements in patient flow and safety.
- The Urgent Care Improvement Plan was reported to be losing pace as the Director of Emergency Care was being pulled into operational work.
- There was a lack of consistent leadership to drive improvements in areas of known risk within the department.
- Governance issued were not discussed at the sisters; or nurses' meetings.
- All focus and poor indicators were being linked to flow through the department by staff. However, whilst it was acknowledged that flow was a challenge for the ED, the identified risks associated with care provision were locally owned and should have been addressed by the department.
- There were missed opportunities to improve the service. Whilst some improvements with regards to the effectiveness of the area had been noted there were many risks within the department which had not been addressed, or had worsened.

However,

- Emergency department leaders described increased support from board members.
- There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings. This had helped to reduce the culture of "learned helplessness" that we had found during the previous inspection, though it was still an apparent culture.
- Staff were enabled to be more pro-active in effecting positive changes in patient care.
- There was a quarterly clinical governance newsletter was detailed and informative.
- Staff spoke positively about recent changes in leadership within the department. Staff we spoke with said they felt well supported by the colleagues and immediate line managers.

Leadership of service

- A clinical transformation lead (Director of Emergency Care) had been appointed following external advice and agreement; they had taken up the newly-created post in July 2016.
- The emergency department leadership team consisted of the chief of service (a senior consultant), head of nursing and general manager.
- All reported that they had received increasing levels of support from senior staff in the trust in recent months.

In the written foreword to the urgent care improvement programme document, the interim chief executive made it clear that all staff in the trust needed to work together in order for the programme to be successful.

- Nurses expressed respect for the matron and head of nursing and told us that they were approachable and supportive.
- The general manager had been in post for 20 months and had a good understanding of the challenges facing the department and the improvements that were required.
- The chief of service was clinically active and we observed him providing clinical leadership on a daily basis. Doctors and nurses confirmed that he had the skills, knowledge and experience required to lead the department.
- We observed a good rapport between the director of emergency care and senior staff within the ED. Some staff expressed a feeling of optimism that the new role would "make things happen".
- However, there was a lack of consistent leadership to drive improvements in areas of known risk within the department. There was a learned helplessness that the risks associated with ED are regarding the flow through the hospital, with all focus and poor indicators being linked to this. However, whilst it was acknowledged that flow was a challenge for the ED, the identified risks associated with care provision were locally owned and should have been addressed by the department.

Vision and strategy for this service

- An emergency care improvement programme had been agreed by the trust board and this was underway. There was a sense of determination from the leaders of this programme that it would be adhered to and that any obstacles would be overcome. This was at risk by the director of transformation becoming involved in operational management of the acute medical pathway.
- External specialist organisations were providing six weeks of intensive support to the trust at the time of our inspection and reported that progress with improvements had stalled.
- Senior staff in the emergency department acknowledged that the involvement of the external organisations were not a long term commitment. However, it was still seen as essential step towards a more sustainable long term strategy.
- A risk summit held in September 2016 reported that improvements in the emergency care pathway were beginning to take place and that the trust had started to work effectively with external advisers.
- The concerns with flow through the department had been apparent in the service for some time. Whilst work trust wide had begun with different specialties throughout the hospital to involve them when patients required emergency admission, there was no strategy to support patients who required input in the interim period until this was in place.

Governance, risk management and quality measurement

- The interim chief executive chaired a weekly urgent care improvement meeting. This examined the impact the urgent care improvement plan was having on the quality and safety of patient care.
- Detailed information about waiting times and patient safety in the emergency department was collected in real time and presented to board members on a weekly basis. The data (including ambulance waiting times, initial patient assessment, delays in treatment and admission to a ward) accurately reflected patient flow through the emergency department.
- Monthly governance and quality meetings were held within the department and these were well attended. Complaints, incidents, audits and quality improvement projects were discussed. We saw that governance issues were discussed at consultants meetings although not at sisters or nurses meetings. This meant there was a risk that nurses would not be aware of current governance and safety issues.
- The ED chief of service published a detailed quality and governance newsletter once a quarter. It contained items such as learning from incidents, safeguarding alerts and compliance with infection control measures. The newsletter was posted on the staff noticeboard and was sent to each member of staff by e-mail.
- When patients waited more than 12 hours for admission following a decision to admit staff, in the emergency department reported it as a serious incident. All of these incidents had a root cause analysis investigation completed, however all of these were on generic templates and the majority had the same outcome. There was no consideration to review overall harm to the patient over the longer term.

- There were missed opportunities to improve the service. Whilst some improvements with regards to the effectiveness of the area had been noted there were many risks within the department which had not been addressed, or had worsened.
- The department was aware that compliance with sepsis treatment, mental health care, risk assessing patients who had been in the department for more than 12 hours was a risk, however these risks had not been sufficiently addressed. Basic requirements such as the checking of the resuscitation trolley and patient records were also not being undertaken as expected.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.
- There was a strong sense of teamwork which was centred on the needs of patients and their families. Staff told us that the support that they received from their colleagues helped them cope with the pressure which resulted from a department that was often severely crowded.
- During our last inspection staff had described a culture of "learned helplessness". In recent months managers from the emergency care improvement programme had arranged staff engagement sessions where staff had been supported to make decisions that would improve patient care. At one session nurses had identified that frequent movement of patients from the ambulance assessment area to the major treatment waiting area and, ultimately, to the major treatment area was upsetting for patients and reduced safety. A healthcare assistant suggested that the major treatment waiting area could be changed to a second treatment area so that patients care was always managed by the same team. Other staff agreed with this proposal and managers supported it. This change took place within a month.
- Staff supported each other on a day-to-day basis. However, they reported there had been little opportunity in the past to sit down together in order to develop improvements in patient care. Managers had recently addressed this issue by arranging multi-disciplinary staff engagement sessions. Originally facilitated by members of the NHS emergency care improvement programme, these sessions were now led by hospital staff.
- We asked a number of ED nurses and doctors if they thought that recent improvements in patient flow through the department would be continued, and if they were optimistic about the future. Staff that were relatively new were optimistic and enthusiastic about the changes. Staff that had been in post for several years were more cautious. They explained that they had been through a series of new ways of working in the last few years. Even when patient flow had improved initially, improvements had rarely lasted for long. They felt that it was too early to say whether the latest changes would become embedded throughout the hospital.

Public engagement

- The department sought comments from the patients. They were engaged through feedback forms, comment cards, the friends and family test. Posters were displayed throughout the department asking for their comments in an effort to improve the service.

Staff engagement

- Nursing staff at band 5 we spoke with told us that there were regular meetings for this group. They felt that their opinions were heard by managers. We were told that communication across the department had improved since the new matron had come into post.
- There were also separate meetings for band 6 and 7 staff as well as support workers.
- Medical, nursing and support staff across the department made reference to how staff were supportive of each other. This factor was sighted by four staff for why they had chosen to stay working in the department despite the problems with flow.
- There were staff meetings during lunchtimes to support resilience, these were organised by one of the consultants.
- Letters of thanks and praise for staff were displayed on the staff noticeboard. Excerpts from some letters were published in the governance and quality newsletter.

Innovation, improvement and sustainability

- Sustainability of the service is a key challenge for the department. Risks identified through previous inspections were being addressed, and we noted there had been some improvement in these areas during this inspection.
- However, was felt that risks associated with ED were all associated with the flow through the hospital. This did

not show an innovative approach to improvement because risks associated with care provision are locally owned and should have been addressed by the department. This did not demonstrate assurance that improvements within the department could be sustained without regulators identify the concerns for the department to address.

Medical care (including older people's care)

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

Information about the service

The Acute Medical Unit (AMU) at Queen Alexandra Hospital is a 58 bedded unit which receives admissions from the emergency department, Ambulatory Emergency Care unit and directly from GP referrals. Within the AMU there is also a seven bedded escalation area. The unit is open 24 hours a day.

The medical services care for a range of patients within specialities such as cardiology, respiratory, general internal medicine and gastroenterology. Medical care services were inspected on 29 and 30 September 2016 where there was no evidence of significant improvement and medical services were rated as 'requires improvement'.

We carried out an unannounced inspection of the Queen Alexandra Hospital medical care services on 16, 17 and 28 February 2017, We carried out a further announced inspection of the corporate and leadership functions of Portsmouth Hospital NHS Trust on 10 and 11 May 2017. This inspection was carried out in response to concerns received regarding culture, governance and leadership within the trust. The specific concerns required us to visit the medical areas in May 2017 to review ward to board arrangements. During this inspection we identified concerns and we have included these findings in this report.

During this inspection we visited all areas of the acute medical unit (AMU), 10 medicine wards including care of the elderly and five outlier and escalation areas including the discharge lounge, cardiac day unit (CDU) and the renal day unit (RDU). We spoke with 35 members of staff including medical staff, nurses, therapists, porters and senior department managers. We also reviewed 22 patient records and reviewed data both prior to, and following our inspection.

We completed a SOFI observation on the Acute Medical Unit and D2 ward during the morning shift when the ward appeared busy, and sat in a bay where several staff were present. Short Observational Framework for Inspection (SOFI) is a specific way of observing care to help us understand the experience of people who use the service, including those who were unable to talk with us.

Medical care (including older people's care)

Summary of findings

We have rated medical care as inadequate overall. We found:

- Not all incidents were categorised correctly. The quality of investigations was poor, and lessons to be learned or care and service deliver problems were not always identified.
- The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.
- Medicine management policies were not always followed in the acute medical unit and medical wards to protect the safety and wellbeing of patients.
- Patient confidential information was not stored securely and documentation was not always accurate or updated in a timely manner.
- Staff did not always consistently follow infection control procedures on medical wards.
- Consent to treatment was not always obtained in line with the Mental Capacity Act (2005).
- Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and physical restraint.
- The inspection team had significant concerns about the safety and care of vulnerable people such as frail older persons or patients living with dementia.
- Staff caring for patients living with dementia did not always carry out a dementia assessment or use the dementia pathway.
- Staff did not always recognise or act appropriately in response to serious safeguarding concerns. Staff did not have sufficient knowledge of essential legislation and procedures in order to safeguard patients.
- A pain assessment tool was available for patients who could not verbalise their pain. However, none of the staff we spoke with knew about this tool and we did not see it being used for patients living with dementia and learning disabilities.
- There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores.
- Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.
- The trust did not always declare mixed sex breaches as they occurred in line with current guidelines.
- There were significant concerns regarding the flow of patients throughout the urgent medical pathway. The acute medical unit (AMU) had bed occupancy significantly higher than the England average and escalation areas were consistently in use. This affected waits for cardiac and renal day case procedures.
- Patients were moved both during the day and night for non-clinical reasons to aid bed availability.
- Some staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend.
- Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.
- Department risk registers did not always reflect the current risks or demonstrate risks were effectively reviewed or managed.
- Although some strategies were in place to improve the acute medical pathway, there was no evidence to show these had been embedded or had a significant impact on patient care. We could not evidence any significant or sustained improvements in medical care since our previous inspections.
- There were shortages of junior medical staff and consultants on AMU. Nursing shifts were not always filled which meant unwell or vulnerable patients did not receive the appropriate level of care and supervision. Staffing was not always adjusted according to acuity and demand at any given time.

However,

Medical care (including older people's care)

- A standardised pain assessment tool was consistently in use which supported the management of pain in patients who could communicate verbally.
- Some patients and relatives praised the care they received on the renal day unit (RDU) and AMU.

Are medical care services safe?

Inadequate

We have rated safe as inadequate. We found:

- Staff did not sufficiently protect patients from avoidable harm or abuse. Safeguarding concerns were not always recognised or escalated in a timely way and three safeguarding cases were currently under investigation by the police.
- Incidents were not always reported appropriately in all areas. Where incidents were reported, they were not always categorised correctly and, as such, were not always investigated fully or in a timely manner. Learning from incidents did not always correctly identify care or service delivery problems.
- There was inconsistent compliance with Duty of Candour (DoC) regulation. We found serious incidents where there was no evidence Duty of Candour had been applied.
- From our observations on the Acute Medical Unit (AMU) and medical wards we visited during inspection, and review of data supplied by the trust, we found the wards were not compliant with the Health and Social Care Act Code of Practice on the prevention and control of infections and related guidance (2015). Linen was not managed safely in all areas, sharps were not stored safely and compliance with hand hygiene audits was significantly below the trust's target of 95% compliance. Staff did not always check emergency equipment.
- We found resuscitation trolleys in the AMU and the discharge lounge were not checked daily in line with trust policy.
- Management of medicines did not protect the wellbeing of patients. Medicines reconciliation was not always carried out in a timely manner. Medicines were not always stored securely and we found intravenous and oral medicines unsecured in clinical areas. Staff in AMU did not consistently monitor fridge temperatures or take action when the fridge temperature was recorded as out of range.
- Not all escalation areas had appropriate risk assessment to accommodate medical outliers or additional patients when the hospital bed capacity was

full. Wards which were required to accommodate an extra bed using the 'one up' system did not all have risk assessments and the bed spaces used did not have wall oxygen or call bells.

- Management of records did not protect patient confidentiality. Patients' medical records were left on desks or underneath notes trolleys and the notes trolleys on four wards we visited were unlocked.
- Staff did not consistently complete risk assessments for patients to identify risks such as falls, pressure ulcers and malnutrition. Patient records did not have individualised care plans to enable staff to plan and deliver their care and treatment appropriately and act on any identified risks.
- Not all staff completed mandatory training. Medical staff in the medicine clinical service centre (CSC) achieved 77% compliance and nursing staff achieved 83% compliance which did not meet the trust target of 85%. The trust did not provide level 2 or 3 safeguarding adults training which meant not all staff were trained to the appropriate level.
- Patients did not always receive timely physiological observations. Audits of the early warning score showed only 69% to 78% of patients had their observations recorded on time from December 2016 to February 2017.
- AMU and ward staffing levels did not meet the required levels for the number and acuity of patients on the ward. The AMU had 14 vacancies across the unit and relied heavily on agency staff to cover shifts. Patients who were sectioned under the Mental Health Act or had high dependency needs did not receive the level of nursing support indicated by their risk assessments.
- During our February 2017 inspection we found there was no allocated staffing to care for patients in the GP triage area of AMU. Two patients with cardiac conditions were waiting in the area with no allocated nurse responsible for their care. There was no policy in place for staff to escalate concerns of staffing, deteriorating patients or overcrowding during the inspection
- Although medical services carried out mortality and morbidity reviews, these were only carried out on low percentage of patients.
- There were concerns about the resilience of the urgent medical pathway. At the time of our inspection all available escalation areas were open which meant there was limited capacity for further patients to be admitted.

Incidents

- At our previous inspection, we identified concerns that not all incidents or near misses were reported and staff did not always receive feedback from incidents.
- On this inspection, all the staff we spoke knew how to report an incident via the electronic reporting system and could give examples of when they had done so. However, staff did not consistently report all incidents. Staff in the Acute Medical Unit (AMU) told us that not every member of staff reported incidents where the ward was short staffed. This was supported by the matron who told us that only two incidents of staff shortages had been reported in the week before our inspection which was significantly lower than the number of shifts with staff shortages. We also found an incident where the Ambulatory Emergency Care unit was opened to accommodate medical outliers meaning Ambulatory Emergency Care patients could not be cared for in the unit was not reported as an incident. This meant the trust could not monitor the level of risk and the impact on patients.
- Information provided by the trust showed there were no 'near misses' reported as incidents since our last inspection in September 2016. This was highlighted as a concern in our last inspection report; however no action had been taken. Senior staff told us this was because all near misses were re-categorised as no harm incidents and therefore were being categorised incorrectly. A near miss incident is an event which may have resulted in harm but was recognised before reaching the patient.
- Staff reported mixed experiences in receiving feedback from incidents. Junior medical staff told us they received feedback from incidents and were involved in the investigation process. One nurse told us they received feedback after reporting a patient fall which stated, 'be more attentive'. The nurse told us the fall was due to staffing issues so the future risks were not sufficiently mitigated. Two members of staff from different ward areas told us there was a local and trust newsletter sent out detailing incidents which had occurred but this was not consistent across all staff groups.
- Information provided by the trust showed the medical services reported 775 incidents from 01 December 2016 to 28 February 2017. Of these, 747 were categorised as

causing no harm or low harm to patients and 22 caused moderate harm to patients. There were three incidents with resulted in severe harm to patients and three incidents which resulted in death.

- At the time of our inspection there were 84 incidents awaiting investigation in AMU and 494 in the process of being reviewed. Senior staff confirmed that there was a backlog in reviewing incidents and they were trying to manage this backlog by working on a Saturday.
- Incidents were not always categorised correctly according to the level of harm caused to the patient. We reviewed all incidents reported by the medical services and AMU from December 2016 to February 2017 and found incidents which were categorised as 'no harm' but clearly show harm was caused to the patient. For example, in AMU an incident was reported that due to a shortage of trained nurses on the ward, the deterioration of an unwell patient was not highlighted to the medical team. The patient required aggressive fluid replacement to prevent further deterioration. This incident was categorised as low harm meaning the patient only required extra observation or minor treatment. Similarly, an incident on C7 ward where a patient fell due to staff shortages was categorised as no harm. This meant the trust could not monitor the impact and risk to patients effectively to prevent similar incidents reoccurring.
- The medical services CSC had not reported any 'never events'. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The medical services held mortality and morbidity reviews for medical patients. The trust submitted presentations of these meetings which showed learning had been identified. However, we found that a significant proportion of deaths were not reviewed through this process. From November 2016 to April 2017, there were a total of 384 deaths, however only 52% of these were reviewed through a mortality peer review panel and 23% reviewed at a formal mortality and morbidity meeting. In elderly care, only 48% of deaths had been reviewed and in AMU, only 23% of deaths had been reviewed. Mortality and morbidity meetings allow health professionals to discuss individual cases to determine if there could be any shared learning. This posed a risk that learning would not be identified and shared appropriately.
- The trust had started a new initiative in November 2016 where all respiratory deaths were reviewed at a daily mortality review panel. This was a new pilot, with plans to implement across the hospital if successful. Data submitted by the trust showed from November 2016 to February 2017 over 130 cases had been reviewed. The department had identified learning and reoccurring themes from these incidents. However, no action plan was provided to show how the department intended to address these.
- We found variable compliance with the Duty of Candour legislation. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Some staff had a good knowledge of Duty of Candour and could give examples of when they had used it in practice. For example, a ward sister on a medical ward told us there had been an incident whereby a doctor's handover sheet containing confidential information about 37 patients had been found in the hospital restaurant. The ward sister told us the trust had written to all 37 patients to inform them of the incident and then conducted follow up calls to all patients. The meant that although confidential information had not been kept secure the ward took appropriate steps to ensure all patients were informed of the incident and provided follow up calls to ensure patients received appropriate support.
- However, we found other serious incidents where there was no evidence that Duty of Candour legislation had been applied. For example, we found an incident where a patient had been moved from the emergency department to the AMU without the cervical spine being secured. The patient had progressive changes in how much they could move their limbs during this time. However, the identification of a cervical spine injury was delayed for four hours. The incident was incorrectly categorised as low harm and the event was not reported as a serious incident. There was no evidence of duty of candour on the incident record.
- We could not be assured all incidents were investigated in an effective manner. We found a serious incident

where a patient with learning disabilities was admitted to the hospital following an unresponsive episode. Two doctors with differing opinions saw the patient, one felt the patient had sustained a stroke and one did not. The patient as subsequently discharged from the hospital but admitted again four days later with a stroke. The investigation outcome was recorded as, 'it does not appear that particular blame can be given'. The focus of incidents should be in regard to learning to prevent future reoccurrences and not blame. There was also no evidence Duty of Candour was undertaken in this case.

Safety thermometer

- The trust used the NHS safety thermometer as one of the methods of monitoring safety performance. . The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms. It also provides a means of checking performance and is used alongside other measures to direct improvements in patient's care. This included pressure ulcers, falls, venous thromboembolism (VTE) and catheter related urinary tract infections (UTI).
- At our previous inspection, we highlighted concerns that safety thermometer data was not visible to staff, patients and relatives. At this inspection, safety thermometer data was displayed on a board in the main corridor of AMU and included information on number of admissions, amount of days since last pressure ulcer and days since last fall with harm. However, staff did not know about the safety thermometer in their unit and what the information meant for staff and patients. We did not find any evidence that the results of the safety thermometer were being used to promote learning and protect patients from harm.
- Staff in the Renal Day Unit (RDU) did not have any knowledge of the safety thermometer and told us they did not collect data despite accommodating medical outliers overnight on a consistent basis. However, the trust subsequently submitted data to show safety thermometer information was collected on the RDU.
- We reviewed the safety thermometer data for AMU from December 2016 to February 2017, which showed 94% to 97% of patients received harm free care.

Cleanliness, infection control and hygiene.

- At our previous inspection in September 2016 we identified staff did not always follow the trust's infection control policies and procedures to safeguard patients from the risks of cross infection.
- From our observations throughout the medical services we visited during our inspection in February 2017, we found the wards were not compliant with the Health and Social Care Act Code of Practice on the prevention and control of infections and related guidance (2015).
- Observations during our inspection showed staff did not always comply with infection control policies. We found a full clinical waste bag and domestic waste bag left on the floor at the entrance to orange area of AMU and observed patients, staff and visitors walking past. On an elderly care ward, we found three clinical waste bags on the floor in the clinical area and on another elderly care ward we observed night nursing staff eating pizza at the nurse's station. Staff eating on the ward could pose an infection control risk.
- In lilac area of AMU, we found several linen bags with used linen in, left open, and stored next to the clean linen trolley. This meant that clean linen was coming into contact with used linen which posed a risk of cross infection. In red area of AMU we found bags with used linen left on the floor. We also observed a nurse carrying a used bedpan without wearing appropriate personal protective equipment (PPE) and a member of staff removing gloves but not washing their hands before delivering care to another patient. These actions posed a high risk of cross infection between patients.
- We also found tissues contaminated with blood had been left on the end of a patient's bed. We highlighted this to staff who removed and disposed of them immediately.
- We inspected all the sluice areas of AMU, which were visibly clean and tidy. All sluices had commodes which were visibly clean, however, no equipment had labels detailing when it had been cleaned. This posed an infection control risk as staff could not be assured equipment had been cleaned before use.
- On the red area of AMU one sharps bin was over three quarters full and open enough for a patient to place their hand in and one sharps bin outside room 9 had no lid and contained used needles. We found a further three sharps bins which did not have lids and contained

sharps. On orange AMU, we found another sharps bin which was three quarters full and open enough for a patient to place their hand in. This bin contained used syringes, needles and medicine vials.

- Hand hygiene audits from the general medical wards for December 2016, January 2017 and February 2017 showed compliance with hand hygiene was not consistent across all wards. Data was supplied from 12 medical wards, In December 2016, four of these wards did not submit any data, three met the trust's target of 95% compliance and five wards did not meet the 95% target. In January 2017 all wards submitted data, 10 wards achieved the 95% compliance target and two did not. In February 2017, three wards did not submit data, five wards met the 95% target and four wards were below the 95% target. Ward E6 and E7 consistently did not meet the trust's 95% compliance target achieving 93% in December 2016 and January 2017 and 90% in February 2017. The trust did not provide any additional information to show how they were addressing this.
- Results from the hand hygiene audit on AMU showed medical staff achieved 81% compliance in January 2017 and 86% compliance in February 2017. The intensive support metrics for AMU showed on the week commencing 16 February 2017, medical staff compliance with hand hygiene was only 59%.This was significantly lower than the trust target of 95% compliance. There was no information on what action the trust was taking regarding this low compliance with hand hygiene from medical staff. This posed a risk that patients were not protected from the risk of cross contamination. The AMU patient safety board displayed compliance with hand hygiene as 93% on 16 February 2017, which did not meet the trust target of 95%.
- There was no consideration for the infection control risk of using the 'one up' system and placing and additional bed in a ward where space was limited. We did not see any evidence that staff had consulted the infection prevention and control lead nurse to provide advice and guidance.

Environment and equipment

- During our previous inspection we identified the environment and equipment did not consistently protect the safety of patients in medical services. Staff did not comply with the trust's policy for checking and servicing equipment. Staff in several areas did not check the resuscitation equipment on a daily basis and we found some emergency equipment was checked but not correctly identified as broken and/or dusty. We found 14 cardiac monitors on the cardiac day unit (CDU) had not been serviced yearly as recommended and cleaning fluids were not stored securely.
- On our inspection in February 2017, staff told us the trust held a central database for all equipment and details of the service history. We found all the cardiac monitors in CDU had been serviced and we saw evidence of labels showing when the next service was due.
- We found resuscitation equipment on the renal day unit (RDU) and E7 was checked daily and all equipment was in good working order. However, on AMU we found a resuscitation trolley which had not been checked on three occasions between 26 December 2016 and 06 February 2017. We also found the resuscitation trolley in the discharge lounge had not been checked on 16 days in January and seven days in February 2017. The discharge lounge accommodated medical outliers overnight in addition to patients ready for discharge during the day. The posed a risk that resuscitation equipment may not be ready for use in an emergency. The discharge lounge was also located away from other wards and therefore, this posed a greater risk as it would take longer to source replacement equipment.
- We asked the trust to provide risk assessments for day units, the discharge lounge and theatre recovery being used as an escalation area for outlying medical patients and they were unable to provide this.
- The AMU senior management team had placed pink area of AMU on the department risk register stating 'the ward area is not fit for purpose' and 'despite risk assessments for 5 beds, 1-2 additional beds are frequently used due to operational pressure'. The team had identified a refurbishment of this area was required to ensure an appropriate environment. This area did not have adequate washing facilities for patients and we had highlighted this in our last report.
- The hospital used a 'one up' system when needed for creating extra beds. This meant there were identified wards where an additional bed space would be made available when the hospital was on red or black alert status. We carried out a night visit to the operations centre and the medical services wards and visited four wards where additional beds were in use.
- We visited these areas and saw an additional bed space was created by a screen. However, there was no call bell

and no power points in the bed space. Staff told us that before being used as a one up bed the space was used for storage. However, it was now consistently used as an additional bed space and had not been changed to account for one up bed.

- The trust submitted a risk assessment template used for the additional bed on D2/D3 ward which prompted staff to consider the patient, staffing and equipment. However, we did not receive any risks assessments for the other areas where additional beds were used. We also reviewed incidents which had been submitted by staff stating 'one up' beds were used when staffing did not meet the required level.

Medicines

- At our previous inspection we identified medicines management did not always protect patients' wellbeing. We found that medicines reconciliation did not always occur within 24 hours of admission. Medicines reconciliation is the process of identifying an accurate list of medicines for the patient on admission. We also found some patients had gaps in their medication administration chart and staff did not know if patients had received their medicines. Medicine administration charts were not always signed and dated and did not always document the patient's allergies.
- Data submitted by the trust showed compliance with medicines reconciliation within 24 hours did not always meet the hospital target. National Institute of Clinical Excellence (NICE) guidelines recommend all patients should receive medicines reconciliation within 24 hours of transfer of care. In December 2016 and January 2017, the average overall compliance across eight identified medical wards was 79%. In February 2017, the compliance decreased to 70% but was only measured four medical wards. In other wards compliance was significantly lower for example, C6 ward achieved 61% compliance in December 2016 and 59% compliance in January 2017. Results for C6 ward were not provided for February 2017. The trust told us the decline in patients receiving medicines reconciliation within 24 hours was due to 'winter pressures'.
- During our inspection in February 2017 we reviewed 22 patient records, 14 of these had not had medicines reconciliation within 24 hours. This posed a risk that patients may not continue to receive all their medicines as prescribed prior to their admission which impact on their overall health and wellbeing.
- From December 2016 to February 2017, staff reported 34 incidents involving the storage, prescription and administration of medicines in AMU. Of these 34 incidents, 10 related to prescription errors. This included two occasions where patients had been prescribed other patient's medicines. There were also seven incidents where patients had missed a dose of medicines including insulin, antibiotics and medicines to prevent blood clots.
- From December 2016 to February 2017, staff on the general medicine wards reported 108 incidents involving medicines. Of these 108 incidents, 69 were recorded as no harm, six recorded as causing low harm to patients and three recorded as causing moderate harm to patients.
- Medicines were not always stored securely. In February 2017 on RDU, we found a medicines trolley unlocked and two shelves of stock medicines in an unlocked cupboard and other items in unsecured open baskets. The trust was failing to ensure that medicines were stored safely and securely which posed a risk of unauthorised access and/or tampering with medicines. We raised this with the nurse in charge of the ward who told us the number of medicines kept on the ward had increased to support the medical outliers who were inpatients. We raised our concerns to staff on the ward and they secured all the medicines immediately.
- During our inspections in February 2017, we found three bags of intravenous infusions which had been prepared for patients left unattended on the side in red AMU. We also found four ampoules of intravenous medicines and one full bottle of oral antibiotic left unattended. There were no staff present in the area where patients could access these medicines for at least 11 minutes. We also found intravenous fluid unattended in blue area of AMU. In orange area of AMU, we found eight bags of intravenous fluid in a disposable wash bowl mixed with tape measures, unopened intravenous giving sets and dressing. This posed a high risk that unauthorised people could access prescription only medicines and putting patients at risk. Staff were failing to follow the trust's policy on safe management of medicines and good practice guidance.
- Staff did not always ensure medicines were kept at the correct temperature. We found the temperature of the medicine fridge in AMU was not recorded on seven days in January 2017 and was recorded as outside the recommended temperature range on 11 days in January

2017. In February 2017, staff had recorded the fridge was below the minimum temperature of 2 Celsius every day and above the maximum temperature of 9 Celsius on eight days but had not taken any action to rectify this. The drug fridge temperature should be maintained as between 2 and 8 degrees Celsius in line with the Royal Pharmaceuticals Society guidelines.

- The trust's medicine management policy states fridge temperatures must be checked daily and if outside recommended range pharmacy must be contacted. We saw no evidence that this had been reported when the fridge temperature was out of range. The efficacy of medicines could be affected if they are not maintained according to the manufacturer's recommendations. This meant staff could not be assured patients were receiving medicines that were fully effective as they were not stored at the manufacturers recommended temperature. This had been highlighted as an area of concern during our previous inspection in September 2016.
- A member of the leadership team for AMU told us that senior band 7 nurses co-ordinating AMU had a daily checklist to complete and one of the areas was to ensure the fridge temperature had been checked. However, we found although this checklist was in place during January and February 2017 senior staff had not ensured the fridge temperature was effectively monitored.

Records

- At our previous inspection, we found that the storage of medical records had improved and patients' medical records were stored in locked notes trolleys. However, we found some wards displayed patient information on whiteboards, which were easily visible to patients and visitors. We found although risk assessments had been completed, staff did not always follow this up with a documented plan of care to show how the risks to that patient had been mitigated. We also found some records where the writing was illegible or difficult to read.
- During our inspections in February 2017, we reviewed 22 medical and nursing records. With the exception of patients' observations and some assessments, all records were paper records.
- During our February 2017 inspections, we found patient medical records were not stored securely across all medical wards. On D1, E4 and G1 we found patient records left on counters or underneath notes trolleys. On D2, D3, G2, and G3 we found the notes trolleys were unlocked. This meant there was a risk unauthorised people could access patient's confidential medical records.
- Staff did not take sufficient steps to ensure patient information was not shared. In AMU lilac area, we found a computer screen left unlocked displaying patient test results facing outwards onto a corridor used by other patients and visitors. The screen showed the patient's name and hospital number along with test results. We also found two handover sheets on the nurse's station with names and clinical details of patients on the ward.
- On the Ambulatory Emergency Care unit, we found one set of notes and a list of patients on AMU facing outwards at the nurses station. Our inspection team were able to pick up the document without staff being aware.
- On D2, D3, E7 and G1 we found whiteboards clearly displaying patients' personal information such as patients who were terminally ill, those at risk of falls and others who required a specific diet. When we reviewed notes for these patients, we saw no evidence that staff obtained consent from patients to enable their personal information to displayed for public view.
- We reviewed a sample of 22 patient's documents across all medical areas inspected. These showed that risk assessments, such as risk for falls, malnutrition and pressure injuries were not always consistently completed. Where risk assessments had been completed there was not always a plan of care documented outlining how staff would mitigate the risks for that individual patient.
- Documentation audits from December 2016 to February 2017 showed on average over the three months 78% of patients records had documented evidence that their care had been evaluated. The audit also showed, on average only 10% of patients' medical records had evidence of changes in the patient's condition.
- We found, at times there were duplication of records due to different record systems. For example, assessments to determine the patient's risk of developing a blood clot could be written in three different places; on a chart in the patients nursing notes, on a pharmacy chart and on an electronic patient observation system. We found on one patient's notes, a malnutrition assessment had been completed in two

places but the assessments did not correlate with each other. This posed a risk that staff were not always working with the most accurate and up to date risk assessment.

- Documentation audits for the medicine CSC showed that in February 2017 out of 30 records, all were signed, dated and legible. However, only 67% of entries were timed and only 63% of records had been completed within 24 hours of the event occurring. This posed a risk as all professionals were not documenting the patient's care and treatment in their medical records.
- On AMU orange ward we reviewed a set of notes where the night nursing entry was written at 0600 on 16 February, however, the next entry was written at 0300 and dated 16 February 2017. We raised this with a member of staff who agreed the notes were not in time order but could not provide an explanation for this.
- During our inspection on 28 February 2017 in orange area of AMU, two members of the inspection team observed the breakfast tray of a patient who was living with dementia being removed without the patient eating any of their breakfast. We raised this to the nurse in charge, who reviewed the patient's food chart which showed the patient had eaten half a bread roll. This meant we could not be assured that clinical records were always maintained accurately.

Safeguarding

- The trust had safeguarding policies and procedures and staff told us these were available on the staff intranet.
- Whilst there was a clear safeguarding process in place, we were not assured that all staff could accurately identify vulnerability. We saw this evidenced in a wide range of areas in our inspections in February 2017 and May 2017 where protective measures for vulnerable patients were not in place to safeguard them from avoidable harm. These examples are detailed throughout this report.
- On D2 ward, we received information about three serious safeguarding incidents which occurred between December 2016 and May 2017. All the incidents have been referred to the police for investigation due to the trust's failure to safeguard patients. However, one of the incidents was not identified by staff as a safeguarding until the patient raised the complaint with CQC and the inspection team submitted a safeguarding referral to the local authority. This posed a risk that not all safeguarding incidents are reported by the trust. All three incidents remained under police investigation at the time of writing this report.
- In the medicine CSC, 95% of medical staff and 99% of nursing staff had completed safeguarding adults level one training. This met the hospital target of 85%. The hospital did not provide level 2 or 3 safeguarding adults training. The trust provided enhanced training on the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). However, this training did not meet all the requirements of level 2 safeguarding adults training. The intercollegiate document for adult safeguarding (2016) states that level 2 should be the minimum level of competence for all qualified healthcare staff. At level two, practitioners should be able to report on information which may indicate possible harm.

Mandatory training

- On our previous inspection, we identified that some groups of staff within the medical directorate did not meet the trust's mandatory training target.
- During this inspection we found, the trust provided training for staff in mandatory topics such as basic life support, information governance, manual handling, risk management and safeguarding adults and children.
- The trust provided data for the entire medical clinical service centre which included medicine wards. The data showed that medical staff in the medicine CSC achieved 77% overall compliance and nursing staff achieved 83%. This was lower than the trust target of 85%. Some staff reported being unable to attend mandatory face-to-face training due to staff shortages and told us it would get cancelled.

Assessing and responding to patient risk

- At our previous inspections we found that patients did not have appropriate care plans to meet identified risks and to ensure care was provided in a consistent and safe manner.
- At our inspection in February 2017, we found that although some patients had care plans, these were not individualised to meet their needs. We found several examples of patient care plans which were standard and

did not outline appropriate or individualised care for that specific patient. This posed a risk that staff would not receive consistent care based on their individual and assessed care needs.

- We reviewed the care plan of a patient who had diet controlled diabetes in red area of AMU. The care plan stated 'no special diet, loss of appetite recently'. We reviewed another care plan of a patient with diabetes, obesity and lymphedema. The nutrition part of the care plan stated 'to assist with meal selection and ensure drinks are offered regularly'. There was no documentation of the management of diabetes or obesity. Patients with diabetes, particularly diet-controlled diabetes require a carefully managed diet to help control their blood sugar.
- Another patient, on E7, medical records stated they required assistance with food and fluids. However, the nutrition section of the care plan was not completed. This posed a risk that staff, particularly new or agency staff would not be aware of the patient's need for assistance or their particular needs at mealtimes.
- We reviewed records for a patient who had been admitted with confusion, decreased mobility and decreased appetite. This patient did not have any care plan to reflect measures to meet their needs and putting them at risk of receiving inconsistent or inappropriate care.
- A patient that had been identified as a risk of falling had a care plan that stated they had been moved bays and the goal of care was to prevent falls. Another patient on E7 had been assessed as a high risk of falls and they were also blind in one eye. The care plan stated the patient should have footwear when walking and staff to assist the patient to be mobile. The patient was also nursed in a single room which was not visible from the nurses' station. There was no detail on the care plan of how to prevent falls or the particular risks for either of these patients which meant staff were not acting on the risk assessment to prevent harm to patients.
- When we raised these issues with nursing staff they told us the care planning documents were new and staff had not been trained to use these. Staff told us band 6 sisters in the AMU were responsible for providing teaching to junior staff but this had not been implemented at the time of our inspection. We also raised these concerns with senior staff who also told us band 6 staff were responsible for providing teaching on these care plans.
- The medicine CSC documentation audit for February 2017 submitted by the trust stated 100% of the 30 records reviewed had an individualised core care plan and 97% of the care plans had a clear goal stated. However, the percentage of patients who had a revised care plan documented was marked as 'N/A'. There was no explanation to why this indicator was not applicable to the audit.
- Risk assessments were not always carried out consistently. Of the 22 records we looked at, 10 patients should have had a falls risk assessment completed, however only six patients had completed assessments. We also found pressure ulcer assessments were not always re-evaluated and malnutrition assessments were not always completed. This posed a risk staff would not identify and manage risks to patients appropriately.
- Staff within medical services did not always recognise that patients with mental health needs present with increased risk and did not do all that was reasonably practicable to reduce such risks. We found a patient who had acute mental health needs and was admitted to the ward with a significant neck wound had no assessment of their mental health needs. Nursing staff providing direct care to the patient did not fully understand the risk or the needs of the patient. For example, they did not know whether the patient was subject to detention under the Mental Health Act, whether the patient was a known risk to themselves or others or whether the patient used illicit drugs or alcohol.
- Documentation audits for the medicine CSC from December 2016 to February 2017 showed 99% of pressure ulcer assessments and 96% of manual handling assessments were completed. In the same time period, 93% of patients had falls assessments completed and only 82% of patients had malnutrition assessments completed.
- The medicine CSC had completed an action plan to minimise the risk of falls for patients. This was due to be reviewed in March 2017. The action plan showed the directorate had completed some actions such as reviewing all falls which caused patient harm and implementing ward based training for staff. The action plan indicated some actions still needed to be completed such as carrying documentation audits for patients at risk of falls.

Medical care (including older people's care)

- The trust used a recognised tool to assess the risk of patients developing a pressure ulcer. The trust also used recognised documentation which required staff to complete a series of care tasks at every care opportunity to minimise the risk of pressure sores for that person.
- We found staff did not always act on pressure ulcer risk assessments that had been carried out. During our inspection we found five examples on G2, AMU and E4 where patients at high risk of pressure ulcers did not have appropriate care documented to reduce their risk of developing pressure ulcers. For example, a patient on G2 was deemed 'very high risk' of developing pressure ulcers but when we reviewed their pressure ulcer documentation there was six to eight hourly gaps indicating staff had not completed the care tasks. We also reviewed the notes of a patient on AMU who had a large friction burn; we could not find any evidence that any pressure area or personal care had been carried out that day.
- Staff used an electronic early warning score (EWS) to record routine physiological observations such as blood pressure, temperature, and heart rate. The EWS system was used to monitor patients and prompt staff to call medical staff to review patients when required. Staff in AMU told us they found it easy to contact the medical team if they had concerns over a patient's EWS.
- The EWS audit for the medicine CSC submitted by the trust showed from December 2016 to February 2017 on average 69% to 78% of patients observations were recorded on time. However, this was significantly lower on some wards for example E8 only performed 49% to 55% of patients' observations on time from December 2016 to February 2017. The cardiac day unit performed better completing 80% to 90% of patient's observations on time.
- The trust told us they had started a patient safety initiative called 'stop the red clock campaign' which aimed to improve staff compliance with recording vital signs. Data submitted by the trust showed there had been an increase in compliance with recording vital signs from 70% in February 2015 to 85% in July 2016. There was no breakdown available for the medicine CSC.
- The trust submitted investigation reports from three serious incidents, two of which occurred in January 2017 and one which occurred in February 2017. In all three of these serious incidents, staff did not follow the correct policy for repeating observations as determined by the EWS tool. The trust submitted an action plan stating they were introducing training for health care support worker to carry out observations and upload to the electronic system and remind staff of the importance of undertaking observations.
- Information in trust board papers showed from November 2016 to January 2017, the trust achieved 97% compliance with screening inpatients for sepsis. This was above the trust target of 90%. However, in the same time period only 57.6% of patients requiring antibiotic treatment for sepsis received antibiotics within 60 to 90 minutes. This did not meet the trust target of 66%. This meant that although staff were recognising and screening patients for sepsis they did not always provide timely treatment.
- Not all wards completed an effective assessment of risk to patients when they were being cared for in the additional 'one up' beds and escalation areas such as the discharge lounge. Some 'one up' bed spaces did not have access to power points, piped oxygen and call bells. Staff told us they placed low risk patients in these beds. There was a patient risk assessment template in use for D2 / D3 ward but there was no evidence of risk assessment on any other ward.
- The trust told us there was no standard operating policy (SOP) in place for the accommodation of medical outliers in the discharge lounge although patients were regularly accommodated in the lounge. There was an agreed SOP in place for outliers in recovery with clinical checklist to determine the patient's suitability to be accommodated in the recovery area overnight. The trust had drafted a SOP for the use of the cardiac day unit (CDU) and this was awaiting consultant approval. This included a list of patients who were to be classed as suitable to be an outlier to the CDU and patients who were not suitable. The CDU had been in use for a number of months since 2016 where outliers had been accommodated and risks had not been identified.
- In the discharge lounge staff told us they occasionally received patients who were not suitable for the unit. A senior member of staff told us patients would only be transferred to the discharge lounge as a medical outlier if they were confirmed for discharge. However, staff gave us an example of a patient who was transferred to the discharge lounge and still required intravenous antibiotics.
- The AMU waiting area was used to accommodate patients who had been referred by their GP until a bed

was available on AMU. However, we found during our February 2017 inspection, the unit had not assessed the risk to patients and there was no protocol in place to ensure the safety of patients waiting in this area. We spoke with three members of staff about this area and all staff confirmed there were no plans in place to escalate patients' safety concerns or crowding in this area. Following the inspection, CQC imposed conditions on the trust's registration. One of the conditions imposed on the trust was to ensure a clearly defined procedure was in place for escalating crowding and patient safety concerns. The trust submitted a copy of the procedure to CQC in March 2017.

- During our inspection on 28 February 2017, we found two patients, both with cardiac conditions waiting to be seen in the AMU waiting area. The only member of staff present was a receptionist. These patients had not been assessed by a member of staff and therefore staff would not be aware if the patient was at risk of deterioration. Members of the inspection team raised this concern with a senior member of staff and both patients were assessed immediately.

Nursing staffing

- At our previous inspection we found staffing levels met or exceeded the planned staffing levels. However, we found there was 116 vacancies across the medical services and therefore the wards had to rely on agency staff to cover shifts. We had concerns that agency staff were not familiar with the ward and this impacted patient care for example patients were often not being washed or assisted to get out of bed until lunchtime.
- From 20 December 2016 to 15 February 2017, staff in AMU had submitted nine incidents reports relating to poor nurse staffing levels and risks to patients care. One of these was categorised as low harm and the remaining eight were categorised as no harm. The incident reports described delays in patient care for example assisting patients with feeding, administering medication and carrying out patient observations. One patient had a decreasing blood pressure which was not highlighted to the medical team; this led to the patient requiring urgent fluid resuscitation.
- From December 2016 to February 2017, staff in the medical services had submitted 32 incidents reports relating to poor nurse staffing levels. Of the 32 incident reports, 21 were categorised as causing no harm to patients and 11 were categorised as causing low harm to patients. The incidents reports described patients did not receive medications, observations and turns on time. Staff could not provide one to one care for patients on enhanced care observations and one report stated a patient had a fall as a result of poor staffing.
- We spoke with nursing staff of all grades across AMU and medicine services during our inspection. Staff told us expected staffing levels were frequently not met and commented, 'it gets ridiculous', 'we are so short of staff it is difficult to manage'. Staff told us agency staff were used to cover shifts. One nurse in AMU told us on the prior to the inspection team arriving on site one nurse was left on her own to manage an area of AMU and three patients were climbing out of bed. The displayed staffing for the morning shift on AMU was five registered nurses and one health care assistant short of the expected numbers.
- We carried out a night visit on 16 February 2017. During this visit we observed red area of AMU had no staff present for at least 11 minutes between 10.17pm and 10.28pm. During this time call buzzers were not answered and medicines were left unattended.
- One nurse on D1 told us they were frequently short staffed and the numbers of staff did not increase to take account of the extra bed in use from the one up system. Staff told us they were frequently one registered nurse short or the registered nurse was changed to a health care assistant. On the evening we visited the ward there was no nurse in charge on ward D1 and D2 ward was short of one health care assistant.
- There were areas of the hospital where staffing was reported by staff as sufficient. For example, staff on the renal day unit (RDU) told us staffing was not a major concern and they used agency with permanent members of staff from other renal wards to cover the unit at night.
- Staff on E6 and E7 told us there was an increased amount of staff sickness which caused a lack of staffing. On the day of our inspection the ward was one nurse and one health care assistant short for the shift. The number of shifts filled on ward E6 and E7 were the lowest out of all the medical services. In January 2017 the ward filled 90% of RN shifts and 83% of care staff shifts during the day. Night shifts for RN staff were filled 98% of the time and 85% of care staff night shifts were filled. This showed that staffing for E6 and E7 ward did not meet the expected levels which posed a risk that patients were not receiving high quality care.

- The trust submitted information on staffing for medical services in January 2017. This showed not all staffing gaps were able to be filled with agency staff. Out of seven medical services wards and AMU, all wards filled less than 93% of registered nurse shifts and five wards filled less than 90% of shifts registered nurse shifts. The data showed a higher number of shifts for care staff and overnight workers were filled. On AMU the data showed during the day only 90% of RN and care worker shifts were filled. At night both RN and care worker shifts were filled to 100%.
- Data submitted in February 2017 showed there were 55 vacancies for nurses and care staff across medical services. Of these 55 vacancies, 14 were from AMU.
- On 28 February 2017 we found two cardiac patients were in the GP triage area but no staff had been allocated to care for them. We raised this with a senior member of staff who arranged for a nurse to care for the patients immediately.
- Staffing did not always reflect the needs of the patients who were on the ward. The AMU had a total of 58 beds which could be used at any one time. A further five beds were available in the GP referral area. The number of staff required to meet the needs of all patients was calculated using a recognised dependency tool. We reviewed staffing in AMU on the morning of 28 February and calculated the staffing requirements to be 19 registered nurses (RN) and nine health care support workers based on the acuity and dependency needs of the patients. However, the unit was staffed with 16 RNs and eight HCSWs in the morning and 14 RNs and six HCSW's in the afternoon.

Medical staffing

- At previous inspections we found there were insufficient numbers of speciality medical doctors to ensure all patients received timely reviews. It was highlighted at both previous inspections that the pink area of AMU did not have allocated medical cover.
- During our inspection in February 2017 we found medical cover in AMU remained a concern for staff. Senior medical staff told us there was insufficient consultant cover on AMU. The expected number of consultants was 11 but the unit were only staffed with eight consultants.
- Junior doctors provided medical cover on medicine wards from 0730 to 2230 in a mixture of day and twilight shifts. The trust did not provide a breakdown of the numbers and grades of doctors on shift during the day. The on call team consisted of doctors in their first year post graduating (FY1), senior house officers (SHO's) and registrars. The trust did not provide information on how many FY1's and SHO's were on the on call team.
- The trust informed us there was one on call registrar to support emergency admission 24 hours a day.
- Across the cardiology, general medical and respiratory team, there were a total of 75 vacant shifts for FY1's and SHO's in December 2016, 10 of these shifts were not filled. For the same time period, there were 36 vacant shifts, all of which were filled by agency staff.
- In AMU there were two night shifts not filled by FY1 doctors in December 2016. In the same time period 38 SHO shifts and three registrar shifts were not filled. This posed a risk that patients were not assessed and treated in a timely manner to ensure their safety.
- All medical wards had a daily consultant ward round Monday to Friday. Some speciality medicine wards, for example respiratory and cardiology, held a daily consultant ward round at the weekend and also reviewed patients within their speciality in AMU.

Major incident awareness and training

- At our last inspection we found some individual clinical areas were in the process of developing business continuity plans. The inspection team also had concerns about the resilience of the urgent medical pathway as all escalation beds were open which meant there was limited capacity for patients to be admitted in the event of a major incident locally.
- At our inspection in February 2017 we found respiratory, cardiology and endoscopy had all completed individual business continuity plans. These detailed actions staff should take in the event of staff shortages, IT systems failing, and lack of available beds and failure of essential equipment.
- We requested a copy of the AMU business continuity plan; however the trust informed us this had not been completed and was still in draft form. The trust told us they have employed a senior project manager to oversee the AMU and allocated them the task of completing the business continuity plan. The trust told us they expected a new draft to be presented to the CSC board for ratification at the end of June 2017. This

posed a risk that if a major incident or other unexpected event such as major staff shortages occurred in the AMU staff would not have a clearly defined action plan in place.
- The inspection team found there were still concerns about the resilience of the urgent medical pathway. All escalation areas were open at the time of our inspection and the trust was in either red or black status for the duration of our inspection. This meant there was still limited capacity to admit patients to the hospital in the event of a major incident locally.

Are medical care services effective?

Inadequate

We have rated effective as inadequate. We found:

- Staff did not demonstrate sufficient knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) procedures. Consent to care was not always obtained and staff were observed administering medicines covertly.
- In the renal service a procedure was undertaken on patients that was not in accordance with best practice recommendations. The undertaking of these procedures did not go through an ethics committee approval. Patients were not informed or consented about the procedure not conforming to best practice prior to the procedure being undertaken.
- Although the trust told us there was a pain assessment tool available for patients who could not verbalise their pain. None of the staff we spoke to knew about the pain score and we did not see it being used in practice. Staff did not consistently complete the Malnutrition Universal Screening Tool (MUST) to assess patients' risks of malnutrition. This had been identified as a concern during the February and March 2016 inspection but improvements were noted in September 2016.
- Patients did not always receive the assistance or engagement from staff they needed at mealtimes to reduce the risk of malnutrition, poor hydration or choking. Food and fluid charts were not consistently completed.
- Overall, annual appraisal rates were below the trust target of 85%. Nursing staff rates were very low with only 62% of nursing staff in the medical service having had an annual appraisal.
- On acute medical unit (AMU) and D2, there was no assurance in place to evidence that bank and agency staff administering intravenous medicines had been assessed as competent to do so.
- As previously highlighted in the September 2016 inspection, AMU was medically led and nursing staff reported poor communication between medical and nursing staff which did not fully support patient care.
- On medical wards the discharge rate at weekends was lower than the weekday average. Therapy staffing numbers were significantly reduced at weekends. The trust told us they had formed a new weekend discharge team with a senior nurse and junior doctor who supported discharges on the ward at weekends from 8am to 1pm. However, this had not improved the average rate of weekend discharges at time of our inspection.

However:

- A standardised pain assessment tool was consistently in use which supported the management of pain in patients who could communicate verbally.

Evidence based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines were available for staff to refer to. This included information about assessment and management of pressure ulcers and care of patients with diabetes.
- Patients' records showed most were assessed on admission for their risks venous thromboembolism (VTE) in line with clinical guideline [CG92]. Depending on the level of risks, patients were prescribed treatment for the prevention of blood clots.
- Concerns were raised to us regarding a procedure that was being undertaken in the renal centre. We followed up on these concerns and found that in renal services a procedure was being undertaken on patients not in accordance with best practice recommendations from NICE. The undertaking of these procedures did not go through an ethics committee for approval. Patients were not informed or consented about the procedure not conforming to best practice prior to the procedure being undertaken.

- Care pathways were in place for specific conditions or sets of symptoms. These included pathways for acute kidney injury, parenteral nutrition, falls prevention and management, neutropenic fever and sepsis, malnutrition, and sepsis.
- During the February 2017 inspection, we found staff did not meet the guidelines outlined in NICE clinical guideline 32 'nutrition support in adults: oral nutrition support, enteral tube feeding and parental nutrition'.
- The trust undertook a range of national audits in respect of medical care services. The local teams and specialties also undertook a range of local audits.

Pain relief

- At our previous inspection we found staff did not always record the outcome of pain assessments and the effectiveness of pain control. We also had concerns there was no specific tool used to assess pain in patients who were unable to verbalise their pain.
- On this inspection we found nursing staff assessed patients pain using a verbal reporting scale of zero to three and recorded this on the patient's early warning score (EWS) chart. We found that a pain score was documented for patients with every set of observations.
- However, as this tool relied on patients being able to understand the question and verbalise a response it was not a reliable pain tool for non-verbal patients or patients who could not understand the question. We had concerns over the pain assessment and management for patients who could not verbalise their pain such as patients living with dementia or learning disabilities.
- The trust was not compliant with the Faculty of Pain Medicines core standards for pain management (2015). Standard eight states, 'assessment tools must be standardised and available in an appropriate range of languages for adults, children and vulnerable individuals, such as the elderly with dementia and patients with learning difficulties'.
- The trust told us a behaviour pain tool designed to assess pain in patients who could not clearly articulate their needs was implemented in 2012. We found clear guidelines on the staff intranet on how to use this pain tool and document pain scores for patients who could not verbalise their pain. However, the staff we spoke with on AMU and on care of the elderly wards did not know about this pain score. Staff told us there was no specific pain score available for patients with dementia or learning disabilities and they would use 'clinical judgement' or just 'get to know the patient'. This posed a risk that patients who could not verbalise their pain would not have effective pain assessment and management.

Nutrition and hydration

- At our previous inspection we raised concerns that staff did not consistently complete malnutrition assessments in AMU. We also highlighted concerns that patients did not receive the assistance they needed at mealtimes to reduce the risk of malnutrition and food and fluid charts were not consistently completed.
- During our inspections in February 2017, we found staff did not consistently complete the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. We found four patients who did not have evidence of a malnutrition risk assessment and one patient who although it was completed, the assessment conflicted with another nutritional assessment.
- The documentation audit from December 2016 to February 2017 across medical services wards showed only 82% of patients had a documented malnutrition risk assessment. This meant that patients at risk of malnutrition were at risk of not being identified and therefore not receiving the appropriate treatment, care and support.
- Medical services had a protected mealtime's policy in place. The protected mealtime's policy aims to allow patients to eat their meals without unnecessary interruptions from staff interventions or visitors and allows staff to focus on providing assistance to patients who are unable to eat independently. We found some staff did not know what protected mealtimes meant and we observed staff carrying out non-urgent tasks during mealtimes. This meant that staff were not consistently following the trust policy for protected mealtimes.
- The AMU and medical services wards had a 'red tray system' in place to identify patients who required assistance with meals. For patients who could not eat independently, meals were placed on a red tray so staff could clearly identify the patients who required assistance.
- Staff did not accurately monitor and act on patients' nutrition and hydration needs. Out of 22 records we reviewed, we identified eight patients who required a food or fluid chart. However, none of the records we reviewed for these patients had a fully completed food

chart and some were left blank. For example on G2 ward we reviewed the notes of a patient whose care plan stated maintain food and fluid chart. However no food or fluid chart had been completed. On E7 ward we found reviewed an elderly patient's medical records which stated they needed assistance with food and fluids; however the patient did not have a food chart or nutritional care plan completed.
- The documentation audit submitted by the trust for February 2017 showed 90% of food charts and 100% of fluid charts were completed daily.

Patient outcomes

- The trust were an outlier for pleurisy, pneumothorax and pulmonary collapse. This meant there were more deaths from pleurisy, pneumothorax and pulmonary collapse than the national average.
- We asked the trust for to provide an assessment of their understanding for the high mortality rate for this group of patients and to submit evidence of their investigation into these cases. The trust told us they could only locate 23 out of the 29 medical records and 14 of the 29 patients had an underlying malignancy. We have requested further information through the mortality outlier panel from the trust about these cases, due to the quality of the response not being of the standard we would expect.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Between February 2016 and March 2017 the sentinel stroke national audit programme (SSNAP) scored the trust at level C, apart from August 2016 to November 2016 where the trust scored level B. The SSNAP audit is measured on a scale where level A is the highest and E is the lowest level.
- The trust was part of a national CQUIN to reduce Acute Kidney Injury (AKI). Between July 2016 and January 2017 the trust had achieved 90% compliance with the mandated items on the discharge summary for an Acute Kidney Injury (AKI).
- The endoscopy unit was accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training.

Competent staff

- Staff did not consistently receive appraisals. Data submitted by the trust In March 2017 showed the overall compliance in the medical assessment directorate for appraisals was 75% which did not meet the trust target of 85%. Although 96% of medical and dental staff received an appraisal, only 68% of nurses and 40% of science, technical and therapy staff received an annual appraisal.
- The medicine Clinical Service Centre (CSC) achieved 72% compliance overall, 93% of medical and dental staff and 89% of science, technology and therapy staff received an appraisal. However, only 62% of nursing staff had received an appraisal. This meant not all staff had the opportunity to identify their work based objectives or reflect on their competence or confidence in their role.
- During our inspection in May 2017, senior staff on AMU and ward D2 told us agency staff employed by NHS professionals or other agencies within an agreed contract framework could administer medication both orally and intravenously. The Trust policy for medicines management states these nurses must have been assessed against the trust's intravenous medication competency to the required level and can provide evidence of theoretical teaching. The policy also states ward and department managers are responsible for ensuring that all of their staff are informed as to which members of the team are competent to accept delegation of duties.
- However, we requested the competencies for agency staff working on AMU and D2 to administer intravenous medicines and senior staff were not able to provide this. Staff told us that the agency held all information and they was an assumption that all staff from framework agencies held competencies to administer intravenous medicines. This meant staff were not following the trust's medicines management and posed a risk that staff who were not deemed competent could administer intravenous medicines to patients.
- We also asked senior staff on AMU and D2 to provide competencies for permanent registered nurses working on the wards to administer intravenous medicine. The staff told us they did not keep evidence of competency assessment and staff completed the trust's e-learning module and kept the certificate themselves. We reviewed three members of staff folders on D2, none of

which held any up to date competency assessments. The trust's medicine management policy states all practitioners must complete a yearly medicines administration update and have completed the intravenous drug administration competency before administering intravenous medicine. This meant that staff were not following the trust policy on medicines management.

- The agency staff members we spoke with during our inspection had received an orientation and induction to the ward area. Staff in AMU confirmed the nurse in charge of each area was responsible for giving agency staff an orientation at the start of each shift. However, there was no robust framework in place for checking the identification, qualification or competency of agency staff when they arrived on the ward. This posed a risk that unauthorised or unqualified people could be allowed to work on wards.
- One of the nurses in charge of an area on AMU had only been qualified for five months but had been taking charge of shifts since she had been qualified for 3 months. There were clear gaps in their knowledge base such as the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) procedure. This posed a risk that the member of staff in charge of the ward did not have sufficient knowledge in order to ensure patients were protected and lead new staff.
- The inspection team were also concerned about the support for the newly qualified member of staff. We raised our concerns with a senior member of AMU leadership who told us they were not aware of the situation. The member of staff told us they did not believe this was a satisfactory situation based on the information given and would investigate this.

Multidisciplinary working

- At our previous inspection we found multidisciplinary working was not consistent in AMU and some of the medical wards. Staff reported the model of working in the AMU was medically led rather than multidisciplinary and we found there was a lack of nursing and therapy input during patient board rounds.
- On our inspection in February 2017, we attended a bed meeting which was attended by two AMU consultants, several junior doctors, two medical technicians and one specialist nurse and one senior nurse. There was no representation from ward nurses or therapy staff in the meeting.
- Junior nursing staff on AMU told us that doctors do not involve the nurses or inform them of outcomes of ward rounds. Several nursing staff told us they consulted the patients' medical records to get information from the medical team.
- Staff on AMU told us they could contact the therapy teams and specialist nurses for advice and support if required.
- Units accommodating medical outliers did not always have easy access to members of the multidisciplinary team. Staff on the cardiac day unit and renal day unit told us they did not have access to a pharmacist, therapy staff or phlebotomy service as the ward was a day unit but accommodated medical outliers overnight. Staff told us they could request support from neighbouring wards and that support from allied health professionals had improved in the last year.
- Staff across the medical wards could access specialist mental health assessments, advice and support for working age adult patients through the provision of a mental health liaison team (MHLT). The MHLT was provided through another NHS trust and could be accessed between 8am until 5pm, seven days per week. Outside of these hours, urgent psychiatric advice could be accessed through the mental health crisis team but they were based off site and staff we spoke with said they were rarely called.

Seven-day services

- At our inspection in February 2017 we found there was minimal occupational therapy service across medical wards and AMU at the weekend. Rotas indicated the weekend provision was two occupational therapists for the medical wards and one occupational therapist and one occupational therapy assistant for AMU and D2 on Saturday. There was no provision for occupational therapy on Sundays for medical wards; however an occupational therapist and occupational therapy assistant was provided for AMU.
- Data submitted by the trust showed out of hours' provision for physiotherapy and occupational therapy was not always met. Rotas submitted by the trust indicated there should be four physiotherapists and two physiotherapy assistant on duty on Saturday and Sunday to provide cover for the medical wards, the short stay ward (D2) and AMU. From December 2016 to

February 2017 the full physiotherapy staffing requirement was not met on any of the weekend days for D2 and AMU. The physiotherapy staffing requirement was only met on 4 occasions for the medical wards.

- The speech and language therapy team provided cover Monday to Friday 0900 and 1700 but did not provide any weekend cover in AMU or the medicine wards.
- The average weekend discharge rate (including transfers) from AMU was slightly lower than the average weekday discharge rate. From December 2016 to February 2017, the average discharge rate from AMU on was 13% on Saturday and 12% on Sundays compared to 15% on weekdays.
- On medical wards the discharge rate at weekends was lower than the weekday average. From December 2016 to February 2017, the average discharge rate was 11% on Saturday and 8% on Sunday compared to a weekday average of 16%. The trust had acknowledged this and told us they had formed a new weekend discharge team with a senior nurse and junior doctor who supported discharges on the ward at weekends from 8am to 1pm. However, this had not improved the average rate of weekend discharges at time of our inspection.

Access to information

- Clinical staff had access to patients' medical records. The trust used an electronic system which had the facility to update patients' medical, nursing and social status and was used to produce handover sheets for medical and nursing staff. Staff told us they valued this as it ensured all the patients' information was available on the handover sheet.
- The trust used a separate clinical record system to the mental health liaison team. To ensure clinical information was available the MHLT would update the trust's clinical records with a handwritten summary of their contact with the patient.
- We had concerns that not all staff had access to the electronic system for recording patients' physiological observations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our previous inspection we identified staff did not always have sufficient knowledge in regard to their responsibilities under the Mental Capacity Act (2005). We also found the trust did not always plan and deliver care in accordance with the Mental Capacity Act (2005), particularly in regard to the Deprivation of Liberty Safeguard (DoLS) process.
- On our inspection in February 2017 and May 2017 we found staff within AMU and some medical wards did not demonstrate sufficient understanding or working knowledge of the Mental Capacity Act (MCA), 2005 or Deprivation of Liberty Safeguards (DoLS). DoLS allows restraint and restrictions to be used in a hospital setting but only if the person being deprived does not have capacity to consent to the restriction and the restraint or restriction are evaluated to be in a person's best interest. Hospitals must ask a local authority if they can deprive a person of their liberty.
- During our inspection in February 2017 we found a widespread lack of understanding of DoLS, For example, one nurse on AMU told us they did not understand the process and said that the 'doctors do that (DoLS) and the consultant signs it off'. On D1 one nurse said that if a patient lacked capacity they would 'get a registrar to complete the DoLS process.
- We found patients being nursed on AMU and ward G2 in beds with bed rails in use without the correct DoLS authorisation in place. One patient on G2 had bed rails up on the right side of the bed and was actively trying to get out of bed. There was no bed rail assessment or record of the patient having consented to the use of bed rails and there was no DoLS in place. On our inspection in May 2017 on D2 ward, we reviewed the records of five patients who had both bed rails in place. Four of these patients did not have a completed bed rails assessment.
- During our February 2017 inspection, on E4 ward we reviewed the records of a patient who was deemed to not have capacity and detained in hospital for their own welfare. However, there was no evidence that the patient's family had been involved in this decision and no best interest meeting had been held. This posed a risk that staff had not considered the best interests of the patient.
- On AMU, we observed a patient had been sedated without their consent. The patient had become aggressive and had injured a staff member and therefore staff acted to maintain the safety of the patient and others on the ward. However, the patient remained at risk of further episodes and it was thought likely they would require further physical and chemical restraint. We found no documented plan of care which would

support both the patient and staff during further incidents. This meant that although staff had acted appropriately in response to an urgent situation, there was a risk that the patient could be restrained again without the appropriate plan of care and legal framework in place.

- During our inspections in February 2017, we observed patients being administered medicines covertly without the patient's knowledge in food. During our inspection on 16 and 17 February 2017, we observed a patient being given an antibiotic tablet covertly in ice cream. Staff told us the patient had a DoLS in place but we found no documentation in the patient's record to support this practice. This was raised to the executive leadership team on the day of our inspection.
- However, on 28 February in AMU we observed nursing staff giving patients medicines covertly to two patients. On one of those occasions, a senior nurse was observed instructing two junior nurses to administer medicine covertly in the patient's breakfast. We found no documentation in either of these two patients to support the practice.
- The trust medicines management policy clearly stated the decision to administer medicines covertly must not be considered routine. It sets out there must be a broad and open discussion with the multidisciplinary team, preferably including a pharmacist and, where possible, the carers and or family. The decision and action taken, including names of all parties involved must be documented in medical and nursing notes with a review date set. However, staff we spoke with were not aware that the administration of medicines covertly was covered in the medicines management policy.

Are medical care services caring?

Inadequate

We have rated caring as inadequate. We found:

- There was deterioration in the compassionate care staff provided for patients since our last inspection. We found a poor care culture had become normalised across AMU and some medical services wards.
- Staff did not always provide compassionate care to patients and did not always respond to patients when they called out for assistance.
- Staff did not always take appropriate measures to protect patients' privacy or dignity.
- The care of very vulnerable patients was of particular concern. We observed situations where vulnerable patients were at risk of harm and the inspection team had to request staff intervene to maintain the patients' safety.
- Staff did not always provide emotional support to patients. We observed a member of staff assessing an elderly patient who had been assaulted and had intense facial bruising. The member of staff did not offer the patient any reassurance or emotional support.
- Throughout medical services, we observed patients living with dementia becoming upset and agitated and staff not acknowledging them or providing reassurance.
- AMU was a particular concern. We observed a patient choking on their meal; two members of staff were in close proximity but did not attempt to help the patient. Our inspection team intervened in order to ensure the safety of the patient.
- On AMU we observed another patient living with dementia and calling out for assistance. A member of staff stood next to the patient did not respond to these calls, and as a result the patient was incontinent.
- Staff did not always protect patients' dignity and did not always keep personal information about patients confidential.
- Results of the friends and family test for the acute medical unit (AMU) and some medical services wards were consistently low.
- Patients and their families were not always involved in planning and making decisions about their care. The documentation audit for February 2017 showed that only 27% of patients on medical wards had their care record discussed with them or a relative

However, we observed the following areas of good practice:

- Some patients and relatives praised the care they received on the renal day unit (RDU) and AMU.

Compassionate care

- On the inspections in February and May 2017 we found deterioration in the compassionate care staff provided

to patients, since our last inspection in September 2016. We found there was a culture of poor care and behaviour which had become normalised for staff within the AMU and some medical services

- We completed a SOFI observation on the Acute Medical Unit in February 2017 and D2 ward in May 2017. These were undertaken during the morning shift when the ward appeared busy, and sat in a bay where several staff were present. Short Observational Framework for Inspection (SOFI) is a specific way of observing care to help us understand the experience of people who use the service, including those who were unable to talk with us.
- In February 2017 On AMU we observed a patient choking on their meal; two members of staff were in close proximity but did not attempt to help the patient. Our inspection team intervened and requested staff assist the patient in order to ensure their safety. The staff did not close the curtains around the patient's bed to ensure privacy and dignity.
- On AMU lilac area we observed another patient living with dementia and calling out for assistance. A member of staff stood next to the patient did not respond to these calls, and as a result the patient was incontinent. The patient's care plan clearly stated they required assistance with toileting.
- On E7, we observed a female patient living with dementia from a neighbouring ward. The patient was walking towards the exit in a short nightdress which did not preserve their dignity. The patient walked past two members of staff who were sitting at the nurses' station and did not attempt to help the patient. The inspection team intervened and asked staff to assist the patient to ensure their safety, privacy and dignity.
- On G1 we found room number 4 and the 'one up' bed space did not have curtains. Therefore, staff or patients could not close these to ensure privacy and dignity.
- In May 2017, On AMU orange, we observed a member of staff walking away from an elderly patient living with dementia who was clearly distressed and calling out for assistance. We also observed a patient left without a blanket or clothing on the lower half of their body as nursing staff did not support them to remain covered. Another patient in AMU orange was sat in their chair in mesh underwear with their incontinence pad exposed.
- On yellow, red and orange areas of AMU we found staff standing over patients while assisting them with their meals.
- We also observed staff did not attempt to encourage patients or make eye contact while assisting them at meal times.
- Throughout our inspection in February and May 2017 we observed the majority of patients were not dressed in their own clothes across medical services. . We also observed in AMU red, none of the patients who were sat out in hospital nightgowns had privacy blankets to ensure their privacy and dignity.
- During our inspection in May 2017 on D2 ward, we observed a member of staff clearly telling a patient the diagnosis and prognosis of another patient. We raised this with the ward manager who ensured they would address the issue with the member of staff concerned.
- However, on the renal day unit (RDU) two of the patients we spoke with during our February 2017 inspection, described the medical and nursing staff as 'caring' and providing 'superb care'. We also spoke to a relative of a patient on AMU who told us the staff took time with their mother and did not rush the patient even when they were busy.
- Medical services took part in the friends and family test. The friends and family test is an important tool that asks people if they would recommend the services they have used. Data submitted by the trust showed, on average from November 2016 to January 2017, 89% of patients would recommend the ward to friends and family and 3.5% of patients would not recommend the service.
- The medical services wards received mixed feedback, some wards such as the respiratory day unit, E7 and C7 received a consistently high percentage of patients who would recommend the ward. However, wards D2 and D3 received the lowest scores consistently. On average from November 2016 to January 2017, 92% of patients would recommend D2 and D3 ward.
- The trust provided an action plan detailing how they planned to address the feedback from patients. The action plan stated the ward would ensure all patients who are discharged are offered an opportunity to complete the survey and the ward manager to inform staff of the analysis of data. However, the action plan did not look to identify any reoccurring themes in order to address the reasons patients would not recommend the ward to friends and family.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- At our previous inspection we found patients and their representatives were not involved in planning and making decisions about their care and treatment.
- The documentation audit for February 2017 submitted by the trust showed out of 30 patients on medical services wards only 27% had their care record discussed with them or a relative. During our inspection in February 2017, we reviewed 22 patient's medical records and none of them had evidence the patient or their family had been involved in their care planning.
- We observed a relative asking to speak to doctors about their mothers care as her mother did not speak English. The relative had been waiting 45 minutes to speak to a member of staff. Staff told the relative to return in the evening, the relative had concerns and told staff, 'when I come back this evening, the shift has changed and nobody will know'. The nurse in charge of the ward gave the relative an update on their mothers care.

Emotional support

- At previous inspection in September 2016 we saw some examples of staff providing emotional support to patients. However, we did have concerns that in some areas patients had limited opportunities to discuss any concerns or anxieties with staff.
- At our inspection in February 2017, we observed staff did not always provide emotional support to patients. We observed a member of staff assessing an elderly patient who had been assaulted and had intense facial bruising. The member of staff did not offer the patient any reassurance or emotional support.
- Throughout medical services, we observed patients living with dementia becoming upset and agitated and staff not acknowledging them or providing reassurance.

Are medical care services responsive?

Requires improvement

We have rated responsive as requires improvement. We found:

- The Acute Medical Unit (AMU) had an overall occupancy rate of 105% which was significantly higher than the England average of 88%.
- The use of escalation beds was widespread across the hospital and significantly impacted upon waiting times and cancellations in some areas. Patients were waiting longer for cardiac and renal day procedures as a direct consequence.
- Overnight bed moves were frequent with 842 overnight bed moves between November 2016 and January 2017.
- The Integrated Discharge Service (IDS) was not reported by staff to be impacting upon discharge rates at the time of our inspection. There were frequent delays for assessment by IDS.
- Mixed sex breaches were not always recognised by staff and not reported correctly in line with Department of Health guidelines.
- Patient's and relatives told us that the trust did not always respond to complaints in a timely or satisfactory manner.
- The needs of people living with dementia were not fully considered across all wards. There was an electronic dementia assessment available; however this did not inform care planning.

However:

- Some staff on AMU had received training specifically in caring for patients living with dementia and other mental health conditions.
- The trust had an identified pathway for patient's living with dementia which included assessment, liaising with the older persons' mental health team and discharge planning.

Service planning and delivery to meet the needs of local people

- At our previous inspection we found patients were not consistently cared for in same sex accommodation in the escalation areas. We also found the trust were not following the correct guidelines issued by the Department of Health for declaring mixed sex breaches.
- Data submitted by the trust following our February 2017 inspection showed four mixed sex breaches from December 2016 to February 2017 had been reported by the trust. The Department of Health guidance on mixed sex accommodation (2009) sets out that male and female patients should not be cared for in mixed sex accommodation in hospitals and breaches are reportable.
- The breach occurred when recovery was used as an escalation area and the ward nurse caring for the

patients did not know male and female patients needed to be segregated. Male and female patients were placed opposite each other and the situation was resolved when the operational manager for theatre arrived in the department. The trust told us four patients were affected by the breach.

- The trust told us additional learning was put in place for the member of staff involved and improved education was put in place for nurses who may care for outlying medical patients in the recovery area.
- Data submitted by the trust also stated there were six incidents reported by staff as potential mixed sex breaches between December 2016 and February 2017. These were reviewed at a panel and agreed they were not mixed sex breaches due to the use of screens. However, whilst staff used screens to preserve patient's dignity this should have still been declared as a mixed sex breach. In escalation areas such as RDU and CDU, staff used screens on a daily basis to manage mixed sex breaches. The trust told us the single sex accommodation policy had been updated to incorporate updated guidance for day units when used as escalation areas and this was approved in March 2017.The use of screens was not covered in the trust's clinical policy for delivering same sex accommodation.

Access and flow

- Data submitted by the trust showed from October 2016 to March 2017 the average occupancy rate on the acute medical unit (AMU) was 105% and there was a general upward trend over the last year. This occupancy rate was significantly higher than the national average of 88%.
- Data submitted by the trust showed the average length of stay on AMU from October 2016 to February 2017 was 0.9 to 1.1 day. This met the trust target to ensure patients did not stay longer than 72 hours on AMU.
- The trust told us there were approximately 35-75 medical outliers at any one time and approximately 20% of inpatients were cared for on wards which were not medical wards such as surgical wards, day units and the discharge lounge.
- At the time of our inspection, there were 230 medically fit for discharge patients in the hospital.
- The trust undertook a range of measures to try and improve the flow through the emergency medical pathway. There was a trust-wide hospital bed meeting held four times daily which aimed to identify potential early discharges and any deteriorating patients that may require transfer to a higher intensity ward or hospital.
- Senior staff had also implemented 'stranded patient meetings' which varied in frequency and had not been consistently held in the months prior to our inspection. Stranded patients were described as those patients who could not return home until a suitable package of care or placement could be identified. Several staff members said these stranded patient meetings had been effective and, as such, had been stopped until the numbers of stranded patients had risen again which led to the meeting being re-introduced.
- We requested the minutes of these bed meetings and the trust submitted an operations report for 03 March 2017 to 06 March 2017. On two out of three of these days the hospital was on black status which is the severe level of occupancy within the hospital. However, the action log for patient safety concerns was not completed on any of these days.
- During our February 2017 inspection, we visited the operations centre in the hospital at approximately 10pm. Staff told us there was nine patient bed moves taking place at that time. Staff informed us patient bed moves could not have occurred earlier as the escalation areas such as recovery, surgical wards and day units were not able to take additional patients until later in the evening. For example, surgical ward rounds occurred at 5pm to identify patients who could be discharged and patients would not be discharged until approximately 8pm onwards. A matron on AMU we spoke with said that they routinely provided a list of patients who could be outlied to the hospital's site operations team. Patient bed moves in the late evening and overnight were seen as a normal occurrence.
- The discharge lounge closed at 6pm each evening as a discharge lounge then re-opened as an escalation area. Staff told us that ideally the patients who were accommodated in the discharge lounge were ones who would likely go home the next day. On the evening we visited the discharge lounge there were four patients admitted as in-patients to that area. We visited the lounge the following day in the afternoon and found two patients had been discharged but two were awaiting medicines to take home.
- Staff in the cardiac day unit (CDU) told us they now expected the day unit to be opened each night as an

escalation ward. Staff expressed frustration that the cardiac day procedure waiting lists were increasing as a result. Data supplied by the trust showed that the CDU had accommodated an average of 14 patients each night since 1 January 2017 but escalation plans detailed they were to take only between seven and 10 patients each night, depending on the hospital's capacity status.

- The Ambulatory Emergency Care unit told us they sometimes accommodated medical outliers although 'they were not supposed to'. Staff told us the week before our inspection the unit had to accept medical outliers and as a result could not accommodate Ambulatory Emergency Care patients. Staff told us medical patients were accommodated on the ward for 2-3 days. The staff had since been informed a decision had been taken not to place medical outliers on Ambulatory Emergency Care due to the impact on Ambulatory Emergency Care patients.
- Staff on wards which accommodated additional patients as part of the 'one up' system expressed frustration at having to move patients who had undergone an operation to the additional bed to allow room for a medical patient. Staff told us the beds were in constant use and 'could not remember the last time the one up bed was not used'.
- Data submitted by the trust as part of the respiratory mortality and morbidity panel showed that from November 2016 to February 2017 10% of cases reviewed had been declared medically fit for discharge but patients were not discharged. It is not clear how many of these patients died from hospital acquired infections. We reviewed an incident where a patient was medically fit for discharge but could not be discharged due to lack of availability of care packages in the community. The patient died of hospital acquired pneumonia before being discharged.
- From December 2016 to February 2017, 73 patient's cardiac procedures on the cardiac day unit (CDU) were cancelled due to lack of bed availability. Data submitted by the trust showed that in January and February 2017 the CDU was used consistently as an escalation area compared to 90% in December 2016. In January 2017, 10 or more of the 14 beds on CDU were in use every day for medical outliers, this reduced slightly to 93% in February 2017.
- We reviewed data submitted by the trust on incidents which had occurred in the medicine CSC. We noted an incident where a cardiac patient was seen in outpatients in May 2016 and the decision was made to schedule a surgical cardiac procedure. The procedure did not take place and the patient was admitted in January 2017 with a myocardial infarction (heart attack). It was not clear if the procedure was not carried out due to waiting times.
- From December 2016 to February 2017, 17 patients had their procedures cancelled on the renal day unit (RDU) due to lack of bed availability. The renal department told us they managed patients across all renal wards to avoid cancellations if possible.
- The trust operates a multiagency integrated discharge service (IDS) from this hospital site. The IDS is made up of multidisciplinary staff from neighbouring local authorities, community NHS trusts, commissioning and staff directly employed by the trust. The IDS is comprised of teams that previously would have had frequent interface regarding patient discharges but had been co-located on site for only a few months prior to our inspection.
- Staff within the IDS said they were co-located but not fully integrated at the time of our inspection. One bed manager told us they had yet to feel any real impact arising from IDS. One senior nurse from AMU said flow was worse since IDS had been on site.
- We saw there were frequent delays for social care assessment by the IDS. For example, we saw where one patient had been referred on 7 February 2017 but was not actually seen until 16 February 2017.
- Staff within the IDS reported that some discharges within the hospital were delayed due to poor ward care. For example, they described securing complex care packages for the patient to not be discharged as medicines were not supplied in time by ward.
- From November 2016 to January 2017, 842 bed moves occurred overnight between the hours of 9pm and 7am, 323 of these moves occurred between midnight and 7am. None of these patients were moved due to their clinical condition. The trust also submitted data which showed From December 2016 to February 2017, a total of 2557 non-clinical bed moves occurred. These meant patients were being moved to manage bed availability, which can cause interruptions in care and disorientation for confused patients.
- In lilac AMU we observed a patient living with dementia appearing very distressed at approximately 2.30 in the

afternoon. At approximately 9.30pm it was identified that the patient needed to be moved from AMU to an elderly care ward as they were disturbing two other patients. The patient was moved at 2.30am.

- We found incidents reported of patients becoming distressed after being transferred to another ward in the early hours of the morning. For example, one incident described a patient who had been identified to move beds at 3pm and had been woken at 1am to inform they had to move to another ward. At 2am the patient was transferred and became very distressed because they thought they were in a concentration camp. Another patient was moved to an oncology ward in the early hours of the morning, they became distressed as they believed they had cancer due to being on an oncology ward.
- Some staff told us they did not agree with the frequency of bed moves overnight. One charge nurse said they had escalated their concerns to senior managers but that the managers only think about the bed moves and not individual patient outcomes. Several porters told us they were very busy 'moving patients all night' and described it being unpleasant having to move people at times they should be encouraged to sleep.
- Other staff we spoke with was not concerned about moving patients at night. One nurse on AMU said patients were only transferred at night from AMU when they needed to transfer a patient in from the emergency department. Another nurse from AMU said that bed moves were not ideal but they had to prioritise ensuring patients conditions were stable. One nurse in charge in AMU said they were not concerned about vulnerable bed moves.

Meeting people's individual needs

- The trust had an identified pathway for patient's living with dementia which included assessment, liaising with the older persons' mental health team and discharge planning.
- The dementia pathway referenced the use of booklets which documented key information about the patient such as likes and dislikes, family members and how to communicate. However, staff on the wards and AMU told us this was not completed in practice. We reviewed the records of four patients who were all living with dementia and should have had this booklet completed. However, none of the patients had a completed booklet. This meant that staff may not have known key information about the individual patient which would inform their care and treatment plan.
- The needs of people living with dementia were not fully considered across all wards. There was an electronic dementia assessment available; however this did not inform care planning. For example in February 2017, we reviewed a patient's medical records which showed a behaviour chart. However, no action had been taken to use this information in a care plan for example, to show triggers of behaviour such as time of day.
- We also saw examples on E7 and AMU red area of when patients had communication care plans but they did not adequately meet the needs of the patient. Nursing staff had written a care plan for a patient on E7 who presented as confused which said staff should 'optimise verbal communication to adequately ensure understanding, procedures or care'. There were no references to non-verbal communication methods or specific, individualised measures to truly support the patient.
- The trust provided staff with training to meet the needs of patient's living with dementia. From October 2016 to January 2017 the average compliance rate with the training for medical services and care of the elderly staff was 94% to 96%.
- The trust provided mental health awareness and mental health update training for staff. Information submitted by the trust in March 2017 showed 11 nurses and one member of medical staff in the medicine Clinical Service Centre had completed the training. This was a significantly low percentage of the total staff group.
- We found patients were not always supported with their meals. On red area of AMU we observed a patient who had a red tray to identify that they required assistance with their meal. Though the patient was given their meal without assistance to eat from staff. The patient started choking and our inspection team requested the staff on the ward intervene immediately to maintain the patient's safety.
- We carried out a Short Observational Framework for Inspection (SOFI) on AMU orange area and yellow area. We saw examples of staff not assisting and supporting patients with their meals. On AMU yellow area we observed a patient living with dementia who had been admitted due to an eating disorder. Although the patient had a red tray to indicate they required

assistance, staff did not attempt to help the patient sit up and when the patient called out to staff they did not respond. We raised our concerns to nursing staff who then assisted the patient.
- We also observed staff standing over patients while feeding them and poor engagement between staff and patients. This was also reported on during our last inspection in September 2016.

Learning from complaints and concerns

- Prior to our last inspection in 2016, we received information from patients and stakeholders which indicated the trust did not always respond to patient complaints in a timely manner. However, during the inspection, there was evidence to show that AMU was responding to complaints and concerns.
- Prior to this inspection we continued to receive evidence to indicate patient complaints were not dealt with in a satisfactory or timely manner. We received four complaints from patient's or their relatives prior to our inspection in May 2017. All of these complaints raised serious concerns and all had written to the trust and had not received a satisfactory response. One of these patients and one relative had raised concerns with the patient advice and liaison service (PALS) at the trust but not received any response.

Are medical care services well-led?

Inadequate

We have rated well led as inadequate. We found:

- There was a disconnected relationship between senior trust leadership and staff in clinical areas. Staff felt they were not listened to or consulted in changes in their own areas of work.
- A number of concerns identified by CQC at previous inspections had not been addressed. These included serious issues such as medicines management, infection control practices, documentation and incident reporting.
- Staff throughout AMU and the acute medical pathway were frustrated and demoralised due to the pressure created by the flow problems throughout the pathway.
- Staff did not have knowledge of the speak up policy for the hospital and did not know how to raise concerns without contacting their line manager.
- The AMU department risk register did not include all serious risks to the department.
- Although staff were focussed on addressing areas of concern using the AMU improvement plan, there was no clear, long-term strategy to direct improvement and progress of the acute medical pathway.
- There was new head of nursing and matron in AMU which lead to staff feeling unsettled at such a significant change in leadership.
- There were concerns that senior band 7 nursing staff did not demonstrate the level of leadership expected.
- Not all medical services consultants were engaged with plans for the future across the acute medical pathway and this was a barrier to progress.
- There had been a significant increase in the staff turnover rate on AMU which had risen to 14.61% in January 2017. Staff sickness in AMU was consistently above the national average.

Vision and strategy for this service

- Staff we spoke with described a vison to improve the areas of identified concern. Since our last inspection the trust had placed the acute medical unit (AMU) in an intensive support programme, aimed at providing support to resolve the identified areas of concern. Senior staff told us they were focused on participating in the intensive support programme.
- AMU had an improvement plan in place called the, 'AMU 30 day plan'. This detailed tasks for improvement over a specific month. For example, some tasks listed for June 2017 were agree and implement safer staffing for AMU and introduce AMU safety huddles. However, there was no clear overarching strategy to address the significant issues and concerns which had been consistently highlighted throughout our inspections and reports.
- There were flow challenges throughout the hospital, high numbers of medically fit for discharge patients and an increased number of medical outliers throughout the hospital. Since June 2016, the trust had been working on implementing a new medical model. The aim of this model was to reduce the amount of time patients waited to see a senior medical doctor when admitted to

the hospital and improve the consistency of discharge. However, this model had still not been successfully implemented by our February 2017 or May 2017 inspections. .

- One of the senior leadership team of AMU told us there were new strategy meetings taking place. This allowed the senior team to meet with the executive team to look at general care and brainstorm ideas to improve care and treatment for patients.

Leadership of service

- At our inspection we found there was variable leadership in the urgent medical pathways services. At the time we found there was clear local medical leadership on the AMU and senior nurse leadership on all wards inspected. However, there was variable leadership from medical consultants throughout the trust and we found not all medical consultants were engaged with plans for the future. Senior hospital mangers did not have oversight of the urgent medical pathway and at bed meetings managers did not work together to forward plan to ensure availability of beds.
- In our last inspection report the medical care service was rated as 'requires improvement' and clearly identified areas where improvement was required. Since that inspection, the medical service had deteriorated and a number of our concerns had not been addressed. Therefore, there was no evidence to suggest the leadership team were effectively influencing change within the department.
- At our last inspection, although we identified the leadership for urgent medical care had been strengthened by the introduction of a transformation lead, we could not evidence significant improvements. We found that the leadership on AMU was medically led and there was a poor working relationship between nurses and medics.
- At our inspection in February 2017, we found the senior leadership team of the AMU and the medicine clinical service centre (CSC) was made up of a Head of Nursing, Chief of Service and General Manager. The senior leadership team talked positively about their working relationship and felt it was the correct team to make improvements in AMU.
- The head of nursing for the emergency department had also taken on the role of head of nursing for AMU and this had become a joint role. At the time of our inspection the head of nursing had been in the new role for two weeks. There was also a new matron who had been in post approximately four weeks at the time of our inspection in February 2017 at was responsible for quality and operational leadership. Therefore, the nursing leadership was new and staff told us they were feeling unsettled at such a significant change of leadership.
- The matron told us they had been working with the band 7 senior nurses to develop their leadership skills. Each band 7 nurse had an area of AMU they were responsible for and the matron was working with them to empower them to manage this area. There was also a senior band 7 to act as a co-ordinator on each shift. The co-ordinator was responsible for the management of the unit for that day and also had additional responsibilities such as ensuring safety checks and patient documentation was completed. However, we found that despite the implementation of these additional checks, some essential safety checks such as the medicine fridge temperature had consistently not been carried out.
- The Emergency Care Improvement Programme (ECIP) had worked with band 7 nurses to develop their leadership skills. The trust had also implemented band 7 development days which included topics such as coaching and mentoring, leadership, leading a serious incident investigation and peer review. However, the inspection team had concerns over the band 7 leadership and felt they did not always demonstrate the level of leadership expected. For example they did not understand that staff shortages would impact quality of care for patients and one senior member of staff told us they were not responsible for governance as it was the senior leadership team's responsibility.
- We found there was tension between the band 7 nurses and the senior leadership team. Senior staff told us the team did not always work together and one senior member of staff told us, 'everyone thinks they know what is best for AMU'.
- On the day of our inspection in February 2017, we found a band 5 nurses in charge on every area we visited on AMU. One nurse in AMU had been left in charge of a shift but had only been qualified for seven months. The nurse was still completing their preceptorship programme and had been taking charge of the ward since being qualified for three months. We discussed this with the matron of AMU who agreed this was not appropriate.

Following our inspection, the trust provided information showing a senior nurse was available to support the junior nurses at all times. However, during our inspection we did not see evidence of this.

- We found there was still variable leadership from medical services consultants throughout the hospital and not all medical services consultants were engaged with plans for future change.
- There was a disconnected relationship between the executive team and staff working in clinical areas. A member of senior management told us the recent CQC report had, 'brought to the front lots of issues that had already been raised but not listened to'. The member of staff also told us the nursing leadership in AMU had previously been 'weak and non-visible' but had improved with the new nursing leadership in post.

Governance, risk management and quality measurement

- We found governance processes were still not effective at ensuring the quality and safety of care delivered to patients. A number of concerns raised at our previous inspection had not been sufficiently addressed such as medicines management, documentation, incident reporting and infection control practices. We also had serious concerns about the care and treatment of vulnerable people and staffing levels in AMU.
- Due to significant concerns we took urgent enforcement action following our inspection which imposed conditions on the trust in relation to staffing in the AMU and the GP triage area. The risks associated with safety in this area had not been identified by the trust through governance processes, which demonstrated that risk was not being effectively monitored.
- The trust had placed AMU into an intensive support programme following our last inspection. This meant the AMU senior management team met with the Director of Nursing for a weekly overview of the essential areas of non-compliance identified in our previous report. This included incident reporting, compliance with infection control practices and complaints. A quality 'scorecard' was produced on a weekly basis which monitored the unit's performance against the areas of non-compliance. In addition, the Director of Nursing received notification of all incidents graded at moderate harm or above.
- The scorecard and recording of metrics had only been in place for a few weeks and therefore we were not able to evidence any significant improvement. However, some nursing staff did not feel the intensive support programme was providing support to staff, one member of staff commented that it was a, 'two minute conversation in passing'. Another member of staff told us, 'we audit up to the hilt, sadly we do not pass a lot of those audits'.
- The head of nursing held the overall responsibility for governance in the AMU and was supported by two part time band 7 Registered Nurses. There was a monthly urgent care governance meeting held which included AMU. This was attended by a multidisciplinary team, including a patient representative. Minutes of these meetings show discussions about incidents themes for example falls. There was also evidence of reviewing themes from complaints. Actions on the risk register were reviewed at these meetings.
- The matron and governance leads in AMU told us they had started a quality and governance newsletter for AMU and the emergency department. The purpose of this newsletter was to keep staff informed of governance issues within the departments such as serious incidents, quality indicators and risks. However, this newsletter had not been embedded and did not have a set frequency to be sent out.
- The AMU held a department risk register. The risk register included risks such as junior medical and consultant staffing, the use of escalation areas, the risk of outlying patients and non-compliance with CQC requirement notices. In our last inspection report we identified some key risks which had not been included on the risk register.
- At this inspection there were still risks which had not been included on the risk register such as staff's knowledge and implementation of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) legislation. This was added to the risk register after our inspection. There was no business continuity plan for AMU which had been identified as an area of concern in our previous inspection report. Although this meant the unit did not have a clear plan to follow in the event of a major incident or disruption to the service, this was not included on the risk register.
- The trust told us they were aware not all the risks for AMU were included on the risk register and staff and meetings had been booked with speciality teams during March 2017 to update the register.

- The risk register also documented non-compliance with CQC requirement notices for governance processes, privacy and dignity of patients, documentation and safe care and treatment of patients. This was rated as a moderate risk and risks were not identified individually. Therefore, we could not be assured there was effective oversight of individual risks, all of which were serious and impacted on the safety and quality of care for patients.

Culture within the service

- At our previous inspection, we found demoralised staff in all areas where medical patients were cared for. Staff described 'change fatigue' and felt changes happened at senior management level but had not filtered down to clinical areas.
- At our inspection in February 2017, we found staff were demoralised and frustrated. Staff in AMU described a culture of 'going round in circles' and told us staff were under massive pressure following our last inspection report. They told us there was very little positive improvement since our last inspection. One senior nurse told us, 'we escalate issues up to senior management but no one actually listens'.
- The senior leadership team told us they acknowledged morale was low in AMU Senior staff acknowledged that AMU was a difficult area to work in due to the recent changes in leadership, lack of bed availability and the recent CQC report. However, the senior management team did not discuss any plans to address staff morale.
- Staff, of all grades from porters to senior management were frustrated by the number of patient bed moves and the consistent use of escalation areas. Staff made comments such as, 'we are moving patients all night, it is not nice moving patients in the early hours of the morning' and 'we constantly have to apologise because we are moving patients'.
- Staff on CDU told us they were frustrated the unit was constantly being used as an escalation area which impacted the ability to carry out day case cardiac procedures. Staff on wards which accepted additional patients using the 'one up' system told us having the additional bed open all the time lowered staff morale.
- One senior member of staff told us, 'risks have been normalised' and we saw evidence of this throughout our inspection across medical services.
- During our inspection in February 2017, we saw several examples of a poor care culture and behaviour which had become normalised by staff. This meant staff poor care for patients had become a day to day occurrence and will we did not find evidence that this was challenged by staff or managers.
- Prior to our inspection we received whistleblowing allegations of bullying and harassment taking place within medical services. One of the allegations we received stated that staff were being asked openly if they had raised whistleblowing concerns to CQC. Due to the seriousness of these concerns, we contacted the trust to raise our concerns.
- The trust told us there was a 'speak up' policy in place and a hospital speak up guardian who could be contacted by staff. However, the staff we spoke with during our inspection did not know about the speak up policy or speak up guardian. Staff told us they would report bullying to their line manager but if their line manager was bullying them, they would not know who to contact.
- The trust submitted minutes of consultant meetings on AMU. These minutes showed the consultants on AMU had drafted a letter to the CEO and NHS trust board detailing their concerns about the serious issues in AMU. We did not have details of the concerns raised in this letter.
- From August 2016 to January 2017, the average turnover for the medicine CSC was 10%-12% which was below the national average of 12.6%. The staff turnover rate for nurses working in the AMU from March 2016 to March 2017 ranged from 4.8% to 14.61%. There was a significant increase in staff turnover from October 2016 where the rate was 10% compared to 6.4% the previous month to March 2017 where the turnover ate had risen to 14.61%. The trust did not provide an action plan to show how they were planning to address these issues.
- The trust reported 0% sickness in the medicine CSC for medical and dental staff from July 2016 to October 2016. However, we were not assured by the accuracy of this data. For nursing staff in the medicine CSC, the sickness rate ranged from 3.1% to 3.8% from July 2016 to November 2016 and increased to 5.2% in December 2016. The average staff absence for acute hospitals in England from December 2016 to January 2017 was from 3.69% to 4.66%.
- This meant for all months apart from December 2016, the sickness rate of nursing staff in the medicine CSC was below the England average. The AMU sickness rate from February 2016 to February 2017 ranged from 4.33%

to 10.29%. This was above the England average for every month recorded. We received correspondence from the trust stating that due to gaps in the AMU management team sickness rates have not been maintained. Therefore, we cannot be assured the data submitted is correct.

Public engagement

- The trust encouraged patients and their relatives to give feedback on their care using the NHS Friends and Family Test (FFT).
- Some wards displayed feedback from patients and the action they had taken in response. For example on E4 ward patients had said they received good care until discharge but their discharge was too quick and not very pleasant. The ward displayed that they were working on providing better communication prior to discharge.
- There was no evidence of public engagement to design or improve the AMU. The services did not use focus groups or patient user groups.

Staff engagement

- At our previous inspections we found the trust did not fully engage with staff about changes in the urgent medical pathway.
- At our inspection in February 2017, we found staff still felt the trust did not engage with them regarding the challenges and changes taking place in the urgent medical pathway.
- Senior staff told us it was difficult to engage staff on AMU. Staff told us that junior staff had been allowed to take time off in lieu if they attended the engagement session but only three members of staff attended the last session.

Innovation, improvement and sustainability

- At the previous inspections we found the way of working across medical services wards was not sustainable. During the inspection all escalation areas were open which meant there was a risk that the trust would not manage if the workload suddenly increased.
- During our inspection in February 2017, we found several areas of concern which had been identified in previous inspection reports but had not been resolved.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Staff working with patients must have sufficient knowledge and skills to care for patients presenting with mental health condition.
- Staff within the emergency and medical areas must have sufficient knowledge of the Mental Health Act (MHA), 1983, so they understand their responsibilities under the Act.
- Ensure that all clinical staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Systems must be in place to ensure that the risks of detained patients, including the risk of absconding, are fully assessed and mitigated where possible.
- Safeguards must be put in place when children or young people are admitted into adult environments such as the Emergency Decision Unit (EDU) to ensure they are sufficiently safeguarded from avoidable harm.
- The trust's own protocol for the management of actual or suspected bruising must be followed in all situations where an actual or suspected bruise is noted in an infant that is not independently mobile.
- Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively across all services.
- Staff mandatory training should be above the hospital's own target of 85%.
- Patients should not be transferred from ambulance trolleys in the corridor outside pitstop.Staff should move the patient to a more discreet area before attempting transfer, unless urgent transfer is required due to the patient's clinical condition.
- Patients waiting in the corridor for a space to become available in the 'pitstop' area should be either observed by staff at all times or have means of summonsing immediate help if required.
- Staffing numbers and skill mix of staff working in all areas must reflect patient numbers and acuity which should be adjusted according to variations in need.
- Staff on the medical wards must follow the trust's medicines management policy to ensure that medicines and prescribed, stored and administered appropriately.
- Patients in the ED must be seen by a senior medical doctor in a timely way following referral to medicine specialty.
- The acute medical model must be immediately reviewed to ensure that patients are seen by a treating physician and treated at the earliest opportunity.
- Equipment must be checked as per individual ward protocols to ensure it is safe and ready for use.
- Risk assessments must be completed to assess the range of risks to patients being cared for in escalation areas. These must take account of environmental factors such restricted access to curtains, call bells and oxygen. These risks must be mitigated where possible.
- Improve quality of incident grading and classification to ensure that they are escalated and investigated appropriately.
- Improve the undertaking of duty of candour and being open following incidents.
- Improve flow through the hospital to prevent patients being cared for in the ED for longer than necessary.
- Patients must not wait on trolleys for more than 12 hour periods in line with national standards.
- The hospital must declare mixed sex breaches as they occur in line with Department of Health guidance.
- Ensure all staff know how to raise issues regarding bullying and harassment.

Outstanding practice and areas for improvement

- Protect patient's confidentiality through safe storage of records.

Action the hospital SHOULD take to improve

In addition the trust SHOULD ensure:

- Conversations between the navigator nurses should be held in a private area to preserve the patient's dignity and respect.

This section is primarily information for the provider

Enforcement actions

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 Surgical procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Imposition of conditions - The registered provider did not have an effective process in place to ensure the safety of patients during times of high capacity, crowding or demand in the Acute Medical Unit GP referral area is escalated when the need requires it. This meant that patients are placed at the risk of harm.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Imposition of conditions - Patients with mental conditions including those patients detained under the Mental Health Act, 1983, were not adequately safeguarded to protect them from avoidable harm. The provider had not ensured that care was being provided in accordance with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...