The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Urgent and emergency services	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The trust runs services at Russells Hall Hospital, Corbett Hospital and the Guest Hospital.

Russells Hall Hospital provides urgent care, medical care, surgery, children and young people services, maternity services, outpatients, diagnostics, end of life and critical care services.

Outpatient services are also provided at the Corbett and Guest hospitals. Corbett hospital provides day case treatment alongside a range of outpatient services which include radiology, pharmacy, gynaecology, physiotherapy, rehabilitation and a wheelchair supply and maintenance service. Guest hospital is a satellite hospital which offers additional outpatient facilities.

The Trust also provides community services for adults (including sexual health) and End of Life Care. There are no community services for inpatients or children and young people. The community services provide clinical care to patients who are acutely, chronically or terminally ill in their own homes or from GP practices or health centres. The services are multidisciplinary and include nursing staff and allied health professionals. The Dudley Group was the first trust in the area to be awarded Foundation Trust status in 2008.

In January and February 2018, we took enforcement action against this provider under Section 31 of the Health and Social Care Act 2008 by imposing urgent conditions upon their registration. We are continuing to monitor progress against these. We took this action as we believe a person will or may be exposed to the risk of harm if we do not do so.

Our inspection of the trust covered only this hospital and only Emergency Department, IMAA and Medical ward A2 based at Russells Hall hospital.

We carried out an out of hours, unannounced, focussed inspection. We specifically looked at the safety aspects of our key lines of enquiry domain on the evening of 15 March 2018 at Russells Hall Hospital. This was based on information of concern we received relating to the management of patient flow and notice of concern relating to a death at the hospital.

We attended the emergency department (ED), the Immediate Medical Assessment Area (IMAA) and the A2 ward (a short stay ward).

Our key findings were as follows:

- Clinical observations were not undertaken in a consistent manner. We saw two patients whose clinical deterioration had gone unnoticed by staff, this had to be alerted to staff by the inspection team who then acted on this immediately.
- The medical and nursing cover across all areas was not sufficient to meet the needs of the patients.
- Agency or bank staff predominantly staffed each area we inspected. These were staff who may not fully understand the hospital processes and systems to keep patients safe.The staff we spoke with could not always locate clinical presentation information or history of the patients that could result in poor quality and unsafe care and treatment.
- We spoke with staff on A2 ward and the IMAA who described the teams as stressed and not coping as a result of the high number of agency staff. Staff also told us that the environment was unsafe and that they were concerned about the safety of patients.
- Patients admitted to these wards could stay for extended periods and we saw that on some occasions their specific health and dignity need were not met because of this. Some patients told us that they were uncomfortable staying in these areas for longer periods due to the design of the areas and the number of temporary staff who worked in the areas.

Summary of findings

- Patients were not wearing allergy wristbands, allergies were not easily identified unless records were consulted or reviewed.
- Staff documented oxygen saturation (SpO2) scores in National Early Warning Scores (NEWS) and recording of patients' vital signs in majors had improved since the December 2017 and January 2018 inspection.
- Staff on the emergency department demonstrated a good understanding of the triage system and felt they had enough support and information on the triage process and system through-out our inspection.

Professor Ted Baker
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	Inadequate 	• Clinical observations were not undertaken in a consistent manner. We saw two patients whose clinical deterioration had gone unnoticed by staff, this had to be alerted to staff by the inspection team who then acted on this immediately. • All of the areas we visited were predominantly staffed by bank and agency workers. • We spoke with nursing and clinical support staff about their experience of working on the ward. We spoke with patients directly and people who were visiting them on the ward to get their views on the quality of care. Staff told us they were stressed and did not feel the environments were safe. • Patient records were not always fully completed. Areas which were not always completed included observation charts, screening tools, risk assessments, care plans and medical clerking documents. • We saw patients were not wearing allergy wristbands, allergies were not easily identified unless records were consulted or reviewed. This meant that staff may not be able to identify those with allergies which could negatively affect their health and wellbeing. However: • Documentation of oxygen saturation (SpO2) scores in National Early Warning Scores (NEWS) and vital signs in majors had improved since our previous inspections in December 2017 and January 2018. • We did see that here had been some improvements in relation to the implementation of observation taking and safeguarding. Although there remained to be some issues which the trust were working to improve further.

Summary of findings

- Staff in the emergency department demonstrated a good understanding of the triage system and felt they had enough support and information on the triage process and system through-out our inspection.

Russells Hall Hospital

Detailed findings

Services we looked at
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Detailed findings

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Background to Russells Hall Hospital

Russells Hall Hospital is located in the heart of the Black Country area it covers a population of around 450,000 people in mainly urban areas. Russells Hall is part of The Dudley Group NHS Foundation Trust.

The core services provided at Russells Hall include urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care. The trust has approximately 629 inpatient beds, 21 escalation beds and 152 day case beds. The trust employs around 4,147 whole time equivalent staff (WTE). These included 482 medical staff, 1,225 nursing staff and 2,440 other staff.

We inspected ward A2, which was an area designed for patients that required short stay as well as the emergency department and the Immediate Medical Assessment Area (IMAA).

The emergency department (ED) including paediatric ED provides care for the population at Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

The main ED consisted of a dedicated ambulance triage bay, a separate triage room for patients, a resuscitation area, with a dedicated space for paediatric patients, a IMAA, treatment cubicles in the majors area including cubicles for High Dependency patients who are not yet ready to be transferred to a ward, and a minors' area with a dedicated ophthalmology assessment room.

Our inspection team

An inspection manager led our inspection team and the team included two CQC inspectors, one CQC assistant inspector and one specialist adviser.

How we carried out this inspection

We carried out a responsive focussed inspection to establish whether the trust was meeting their duties under the Regulations. This was because we received information of concern about the hospital. We inspected the Safety domain within the Emergency and Urgent Care Core service and specifically looked at the assessment and management of risk, safeguarding as well as nursing and medical staffing. We had previously inspected all of this core service in December 2017 where it was rated as "inadequate" overall.

Detailed findings

We carried out this inspection on the 15 March 2018 and visited the ED including the Immediate Medical Assessment Area (IMAA) as well as ward A2.

We reviewed staffing numbers, the skill mix of nursing and medical staff as well as the use of bank and agency staff. We spoke with nursing and clinical support staff about their experience of working on the ward and in the department. We also spoke with patients and those who were visiting them so we could obtain their views on the quality of care they were receiving. During the inspection we reviewed patient records which included observation charts, screening tools and risk assessments, care plans and medical clerking documentation. We also observed a staff handover where the nurses discussed the patients on the wards, their needs and levels of required observation.

Facts and data about Russells Hall Hospital

The Dudley Group NHS Foundation Trust operates acute hospital services from three hospital sites:

- Russells Hall hospital
- Corbett Outpatient Centre.
- Guest Outpatient Centre.

In addition, the trust provides community services in a range of community facilities to the populations of Dudley, parts of Sandwell Borough and some communities in South Staffordshire and Wyre Forest.

The trust serves a population of around 450,000 covering these boroughs with services commissioned by Dudley Clinical Commissioning Group.

The trust has 629 core inpatient beds, 21 escalation beds and 152 day case beds.

Urgent and emergency services

Safe	Inadequate
Overall	Inadequate

Information about the service

The trust had one Emergency Department (ED), located at Russells Hall hospital. Russells Hall Hospital is located in the heart of the Black Country area it covers a population of around 450,000 people in mainly urban areas. The emergency department (ED) provides care for the population at Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week. The trust also provides a paediatric emergency department.

There was an urgent care centre co-located with the emergency department. An external provider ran this centre. At main ED reception desk, a 'streaming nurse' who worked for the urgent care centre (UCC), saw all self-presenting patients' who attended ED at the hospital. Patients with minor illnesses or injuries were either diverted to UCC or the minor's area within the emergency department.

There were 180,001 attendances to the Emergency Department between April 2016 to March 2017.

Summary of findings

For what we found on our previous inspection, look here:

http://www.cqc.org.uk/provider/RNA

Following the inspection, and in response to concerns raised, the trust closed the IMAA.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

We did not rate the safety of the service on this inspection, but we found:

- Clinical observations were not undertaken in a consistent manner. We saw two patients whose condition had deteriorated and this had gone unnoticed by staff, this had to be alerted to staff by the inspection team who then acted on this immediately.
- The emergency department, the IMAA and ward A2 were predominantly staffed by bank and agency workers.
- Staff did not feel ward A2 environment was safe as a result of the staffing numbers and skills mix.
- Patient records, which included observation charts, screening tools, risk assessments, care plans and medical clerking documents were often contained incomplete sections which could pose a risk to patient safety.
- Some patients were admitted to short stay wards for periods outside the trust's expected timeframes. Some of those patients should have been admitted to medical wards so their needs could be appropriately met by specialist teams.
- Patients were not always provided with allergy wristbands. Allergies were not easily identified unless records were consulted or reviewed.

However,

- Staff documented oxygen saturation (SpO2) scores in the National Early Warning Scores chart (NEWS) and the recording of vital signs such as blood pressure and heart rate in the majors department had improved since the December 2017 and January 2018 inspection.
- Staff in ED knew how to report some incidents and managers investigated these incidents.
- Cleanliness and infection, prevention and control procedures were good throughout the emergency department.
- Patients were allocated a timely bed space, we saw no over-crowding and saw no patients receiving care in corridors.
- Staff we spoke with told us they received support from the department safeguarding lead, if ever they were unsure they would seek advice from the safeguarding lead.
- Staff we spoke with said the trust had recently recruited six trained nurses and were told another 10 staff members were in recruiting process.
- Twenty four whole time equivalent qualified nursing staff, specifically to ED had been recruited since October 2017. There were a further two experienced ED Consultants appointed, one commencing on the 1st June and the other 1st September 2018.

Incidents

- Staff reported a new process to improve recording and reviewing incidents. The new process introduced incident reviews at a monthly operational meeting rather than a quarterly governance meeting. This meant staff could review incidents more regularly. There were incident forms instead of informal emails to formalise the process. Staff could not provide us with any clear themes regarding incidents except about escalation and capacity and flow.
- Staff we spoke with told us they knew how to report incidents.

Safety thermometer

- We did not inspect this area during this inspection.

Cleanliness, infection control and hygiene

- We found that trolleys and bed spaces were cleaned between patient uses and appeared visibly clean.
- We saw that not all staff were 'bare below the elbows' and some medical staff did not wash their hands or use antibacterial gel between patient contacts

Environment and equipment

- Since our last inspection in January 2018, we saw the new ED reception area was open along with a 24-hour paediatric emergency service. There were now separate waiting areas for children and adult within the main emergency department.

- We saw no over-crowding and saw no patients receiving care in corridors; staff we spoke with told us this had changed since the expansion of the ambulance triage bay.

Medicines

- Staff on IMAA and A2 did not consistently follow processes in safely managing and storing medicines. We saw on two occasions that patient medication was not locked away. On one occasion we saw that a patient was taking medication without the knowledge of staff members. This was highlighted to staff and inspectors by a non clinical member of staff. This might mean there was scope for error or misuse that could result in harm.
- Medication was administered in a timely manner for the majority of the patients we reviewed in ED and IMAA. However, we did see one patient who was not given their pain relief, which was given via a special port under the skin, at the required interval. Staff told us this was because there were no staff members on duty with the right skills and competence to be able to administer the medication. However, we did see that after some discussion and prompting from CQC inspectors the patients received an injection of pain relief whilst a suitably skilled nurse could be located.

Records

- Records were not always written and managed in a way that kept patients safe. The records we looked at were not always accurate and complete. For example, on ward A2 and the IMAA, we asked two different nurses to talk us through patient diagnosis. This information was not easily documented in the patient's care records. The nurse could not clearly tell us the diagnosis or plan to support the patients' treatment while on the ward/unit.
- Staff told us a patient had deteriorated while on the ward. We reviewed the records for this patient and found it difficult to locate a recording of their condition and plan to manage their ongoing treatment. This was because the patient's care records were in no particular order. They were loose leaf, not contemporaneous and messy. When we asked, staff caring for this patient they were unable to locate information required to inform us of specific risks associated with the patient's deterioration.
- Staff told us there was a dual system in place for recording patient information including information used to assess and respond to a patient's risk. For example, some patient information was entered directly on to the electronic system on admission but may not have been included in a patient's paper record. This might mean that the written records were not contemporaneous or complete and staff may not have all the information required in one place.
- Care records that we looked at were often difficult to navigate. We requested patient information relating to a patient's admission. The nurses were unable to locate the information because it was not logged in the paper record, which was all they had access to.
- We reviewed nine sets of notes throughout ED and IMAA, we found them all to be inconsistent. For example, one patient record had another patient's information in the record, another patient had received intravenous antibiotics for query sepsis, but we were unable to find the sepsis-screening chart. We found some records were missing risk assessments chart, venous thromboembolism (VTE) assessment were incomplete, some records were missing manual handling assessments, one patient had bed rails in use but we were unable to find any falls risk assessment or bed rails use assessment.
- We also found in one electronic record in ED; an entry from a health care support worker using a registered nurses log in details.

Safeguarding

- We did not inspect this area

Mandatory training

- We did not inspect this area

Assessing and responding to patient risk

- Staff used a recognised tool to monitor patients, known as the National Early Warning Score (NEWS). This tool helps improve the detection and response to clinical deterioration in adult patients. Use of this system was key to assessing and responding to patient safety and improving patient outcomes.

Urgent and emergency services

- Whilst we saw improvements in how frequently patient's observations were being taken, we remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions.
- Nursing staff were not always using clinical judgement and were following the NEWS scoring system to completely dictate the frequency of observations. When the NEWS scoring system was discussed with nursing staff they displayed a lack of understanding of what the system was, why they were doing it and what their response should have been.
- As a result, patients with potentially life-threatening symptoms and conditions were not being monitored and escalated adequately. During a review of retrospective records for the month prior to the inspection, we saw an example where a patient had showed serious signs of illness and later passed away but due to their total NEWS score being within 'normal' parameters they were not escalated and treated promptly. In this case key symptoms were also not included in the calculation of the NEWS score including new confusion.
- Staff showed an inability to link clinical conditions with the types and frequency of observations required. For example, we observed patients who presented with asthma and did not have their peak flow readings recorded.
- Sepsis screening was still not undertaken for all patients. Senior doctors advised that they screened automatically 'in their head' without the use of the pathway or tool. We saw an example where a patient had been referred into the department by their GP with a possible serious infection. Despite having 'red flag' symptoms' on arrival sepsis screen and tool was not completed or in place.
- The arrangements for the monitoring and escalation of patients waiting to be admitted to acute medical wards were unclear, with no clear accountability of which team was responsible for the patient once they had been referred to medicine.
- The doctors and nurses in ED stated this was on their worry list and they felt it was a problem as patients could deteriorate and the ED team do not have the skills to provide longer term medical care.
- We retrospectively reviewed the records of a patient who had been referred for medical admission and had presented with 'red flags' for sepsis at presentation at 17.37 and throughout their stay. These included hypotension and tachycardia. Despite this a sepsis screen was not undertaken and no treatment for sepsis was commenced until over nine hours later. We found that the patient had been referred to the medical team and placed on a list for admission. During the time they waited for admission they deteriorated significantly and later passed away.
- Patients referred for medical admission were listed on a written sheet or computer system. Staff told us that they predominantly used the written sheet. We reviewed the sheet and found it did not contain sufficient detail to allow doctors to prioritise cases. An example of this was a patient identified with severe infection and deteriorating observations was listed with no highlight or prioritisation added. This meant that the doctors looking at the sheet did not have all the information about the seriousness of the patient's condition.
- Staff told us that they used the written sheet as the computer system was cumbersome and they would have to physically click into each ED record which they say is not feasible when there are multiple admissions.
- Staff told us and we found through review that some patients referred for medical admission were not put on the list and then 'found' later. We observed entries where patients were listed as 'missed'. These included patients who had presented with chest pain and sepsis. As a result, they were then not seen by the medical team for a number of hours.
- Junior doctors told us that they found it difficult to control the admission process and felt vulnerable. They also reported that they did not always know where admissions were but couldn't see a way to improve this.
- We spoke with a medical consultant who told us that they did not see or recognise an issue with the admission process.
- The medical team also told us that they no longer had access to patients current NEWS and observations if the patient was in the ED as the department were completing these on paper.

- We identified a number of patients who were unwell where the medical team were not aware of their condition. This included a patient with suspected meningitis who was placed on the list as 'med referral' with no detail and a patient with a NEWS score of 8.
- Staff in ED were unclear on how to escalate patients who had already been referred to the medical team and did not always do this in a timely way. We found a patient with a NEWS score of 8 who had not been escalated and was only done so when an inspector raised this. Another patient had a NEWS score of 7 and the medical team were unaware of this.
- On the IMAA we were not assured staff completed the scoring system accurately or understood the escalation process and we felt patients were at risk. For example, scoring was not always complete in patient records which meant there was a risk they were not having the right level of observations to keep them safe. It could also mean that patient deterioration may not be picked up and escalated in a timely manner.
- We saw four patients on IMAA and in the ED whose diagnosis was "query sepsis." However, these patients did not have a fully completed sepsis-screening tool.
- The trust were auditing their sepsis performance every week and were taking action when they found care and treatment was not in line with the trust policy.
- The trust had a sepsis team based within ED. The teams aim was to strengthen the response and time to those patients who presented with sepsis.
- There was a sepsis training programme in place and as of 19 March 2018, 102, staff out of 107 had been trained to identify and treat sepsis patients. The remaining five staff were either on long-term sick or maternity leave.
- When we asked the nurse in charge on ward A2 whether there were any patients on the ward with sepsis, we were told there were not. However, when we looked at patient records, spoke with patients and staff on the ward, we saw that there were patients on the ward with sepsis and that they were being clinically managed for it. This could mean that not all staff were aware of how patient risks relating to sepsis were being managed.
- We saw patients were not wearing allergy wristbands, allergies were not easily identified unless records were consulted or reviewed.
- We found one patient who had been on ward A2 for a period of around 2 weeks. The patient had lost a significant amount of weight during this time. The patient's family told us they were concerned about their relative's deterioration. We looked at the patients care records and there were no recorded observations of whether the patient had taken fluids or whether they had eaten any food over a period of two days. This meant that anyone assessing the patient would not know if they had fluids or food to aid their recovery or avoid decline in their physical wellbeing. In addition, this patient was not receiving timely care and pain relief. When told, staff immediately escalated concerns to medical staff and the patient was then managed appropriately.
- At the time of our visit to ward A2 there were five of the six scheduled clinical support workers available to cover the entire ward.
- Two patients on ward A2 required one to one support but the staffing numbers did not appear to be sufficient to provide this level of care. We noted one of these patients had fallen twice. During the inspection we escalated our concerns to the nurse in charge who took action to provide safe care for this patient.
- We found that in the IMAA some patients did not have any nursing assessment or risk assessments despite being on the unit for a number of days.
- When we inspected in December 2017 and January 2018, we had concerns about the triage system. During this inspection staff demonstrated a good understanding of the triage system and felt they had enough support and information on the triage process. We raised all of our concerns about the risks we found to patients during this inspection. Senior leaders took immediate action to respond to these concerns. This resulted in the closure of the IAMU.

Nursing staffing

- The ED was fully staffed at the time of our inspection however this fill rate was achieved by using temporary agency staff. Both substantive staff and patients told us that they felt the care delivered by agency staff was

significantly different to the care delivered by substantive staff. Substantive staff told us that they were concerned about the quality of care provided by agency staff and felt it added to their workload as they had to 'supervise' these staff.

- The acting senior nurse on A2 ward told us they were unable to access the computer system duty rota because they were not trained. There should have been a registered nurse and two clinical support workers at each of the three stations on a shift. At the time of our inspection there were five clinical support workers on duty to cover the three stations along with three agency nurses. This meant the entire area was staffed with no substantive nursing staff.
- Staff told us that they did not feel the staffing levels on ward A2 and IMAA were safe as they often had multiple patients who were unwell, including patients who required one to one care.
- Data provided by the trust for the IMAA area for the four weeks prior to the inspection showed that nurse staffing was consistently not met and some shifts were run completely by agency staff.
- We found that from 1st February to 8th March 2018 only three out of 36 days were fully staffed.
- On 40 out of 72 shifts there were no substantive registered nursing staff on duty.
- In some cases the unit only had one trained agency nurse as the registered nursing establishment.
- We reviewed a further six days of staffing for IMAA and found that none of these days were fully staffed with the correct mix of staff and noted a high use of agency staff.
- Staff in the ambulance triage area told us there had been improvements since our inspections in December 2017 and January 2018.A dedicated triage nurse was now allocated purely to undertake triage. Additional staff had been provided on each shift in order to carry out triage in a timely way. Without exception, all of the staff we spoke with were positive about these improvements.
- Staff we spoke with said the trust had recently recruited six trained nurses and were told another 10 staff members were in the recruitment process.

Medical staffing

- Since our inspections in December and January 2018, action had been taken to increase the medical staffing levels within the ED.
- There was no 'on unit' medical cover in the IMAA after 4pm.
- We spoke with medical staff who told us that two additional acute physicians were now working alongside ED to help staff care for medical patients. This also helped the flow of patients throughout ED and IMAA.
- Nursing staff we spoke with said there was always a doctor in the ambulance triage bay to offer additional support to them.
- Medical staff we spoke with told us an additional four medical staff were rostered to cover evening shifts in ED specifically.
- The senior leaders in the hospital told us there had been a successful recruitment campaign and they had appointed an additional two experienced ED Consultants, one commencing on the 1 June and the other 1 September 2018.
- Two consultants worked across three stations on ward A2. They attended the ward in the morning between 7.30 and 8. 00am.There were no medical staff on ward A2 in the evening; however, staff could access medical staff from another ward if required.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

In January and February 2018, we took enforcement action against this provider under Section 31 of the Health and Social Care Act 2008 by imposing urgent conditions upon their registration. We are continuing to monitor progress against these. We took this action as we believe a person will or may be exposed to the risk of harm if we do not do so

In addition to this action the hospital MUST take the following action to improve:

- The trust MUST ensure that there is an effective and easily identifiable system in place to identify patients with allergies.
- The trust MUST ensure that staff record an accurate, complete and contemporaneous record of the care provided to patients.
- The trust must ensure that there is a risk based and appropriate system to prioritise patients awaiting admission.