United Lincolnshire Hospitals NHS Trust

Pilgrim Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. The trust serves a population of approximately 700,000 people, situated in the county of Lincolnshire.

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital on 18 December 2018. This was to follow up actions the trust had taken following our focussed inspection on 30 November 2018.

We did not inspect any other core service or wards at this hospital or any other locations provided by United Lincolnshire Hospitals NHS Trust. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital the urgent and emergency services consists of the emergency department (ED),Integrated Assessment Centre (IAC) whichincluded Ambulatory Emergency Care (AEC) and Acute Medical Short Stay Unit (AMSS).

The ED has one triage room, 10 major cubicles, three minor cubicles, one 'fit to sit' room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relatives room (which was also used as a mental health assessment room). The department also has one children's cubicle.

Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy before transfer to the major trauma centre at a neighbouring NHS trust.

Our key findings were as follows:

- There was an unreliable and inconsistent system in place to identify critically ill patients who may present to the department. The triage process was not effective in the early detection of acutely unwell patients. We saw despite increased triage staffing levels, patients were not always assessed in a timely way. Once triaged patients were not always allocated a priority category and if they were, this did not correlate effectively with the patients condition.
- Patients did not always have an early warning score calculated at triage, despite their presenting condition, indicating they may be at risk of deterioration.
- Patients arriving by ambulance remained on ambulances for significant amounts of time, despite a presenting medical condition which had the potential to deteriorate. We saw a patient with a suspected gastro intestinal bleed (serious bleeding in the stomach) wait 25 minutes to be brought into the department, despite crews highlighting the nature of the presenting condition to the Pre- Hospital Practitioner (PHP).
- Patients at risk of deteriorating consciousness levels were not monitored effectively. We saw a number of patients who had presented to the department with head injuries. These patients did not have neurological observations performed initially or on an ongoing basis.
- Patients arriving by ambulance and brought into the department were not always clinically assessed by the PHP. The PHP was reliant on observations from the ambulance crew rather than performing their own and recorded this as an assessment time. This posed a risk to patients as the PHP did not have the most up to date information and the patients presenting condition may have worsened.

Summary of findings

- Patients in the ambulance corridor did not always have observations performed in line with trust protocol. Patients went for long periods without observations. We saw a patient with a potential fractured neck of femur had not been offered any analgesia and, had been waiting more than two hours at the point we reviewed their notes, to be seen by a clinician.
- The Rapid Assessment and Treatment (RAT) process was ineffective at reducing ambulance handover times. We saw many patients held on ambulances and a long wait for a RAT assessment.
- Children in the department were placed at risk of harm as they were not cared for by nursing staff with the necessary competencies to provide safe and effective care. Whilst there was an identified registered childrens nurse in the department caring for some children, there was no oversight of new arrivals to the department, furthermore we observed children being triaged by nurses without additional pediatric competencies.

However:

- Since our last inspection the trust had implemented a process for transfering patients to wards and other clinical areas, which did not impact on nurse staff to patient ratios.
- Two hourly safety huddles had been introduced into the department.
- Nurse and medical staffing levels and skill mix were sufficient to meet the needs of patients during the period of our inspection.
- We saw the trust had taken some action to ensure the 'fit to sit' room was not overcrowded and patients were not cared for along a throughfare corridor in the department. They also tried to ensure patients being cared for in the main area of the department were of the same sex.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focused inspection of the emergency department to follow up on actions the trust had told us they had taken following our inspection on 30 November 2018 and to see if improvements had been made. We did not inspect any other core service or wards at this hospital or any other locations provided by United Lincolnshire Hospitals NHS Trust. During this inspection we inspected using our focussed inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Pilgrim Hospital

Detailed findings

Services we looked at
Urgent and emergency services;

Detailed findings

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Background to Pilgrim Hospital

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We previously inspected the emergency department at Pilgrim Hospital using our comprehensive methodology in February 2018. We rated it as inadequate overall. Following our February 2018 inspection Under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to three regulated activities. We took this urgent action as we believed a person would or may haven be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the emergency department at Pilgrim Hospital, Boston.

We carried out an unannounced focused inspection of the emergency department at Pilgrim Hospital on 30 November 2018, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. There were conditions still in place on the trusts registration in relation to the emergency department at Pilgrim Hospital, Boston. The trust continued to report to us monthly.

On 18 December 2018 we carried out a further unannounced focused inspection of the emergency department at Pilgrim Hospital, this was to follow up actions the trust had taken following our focussed inspection on 30 November 2018.

Detailed findings

Our inspection team

The team that inspected the service comprised of Simon Brown, Inspection Manager and one other CQC Inspection Manager. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Urgent and emergency services

Safe	
Caring	
Overall	

Information about the service

Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

The ED has one triage room, 10 major cubicles, three minor cubicles, one 'fit to sit' room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relatives room (which was also used as a mental health assessment room). The department also has one children's cubicle.

During the inspection, we visited the emergency department only. We spoke with 18 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with a number of ambulance crews from the local NHS ambulance trust and some private/ voluntary ambulance service crews who were in the department. We spoke with 8 patients. During our inspection, we reviewed 29 sets of patient records and a variety of other information in and around the department.

Summary of findings

- There was an unreliable and inconsistent system in place to identify critically ill patients who may present to the department. The triage process was not effective in the early detection of acutely unwell patients. We saw despite increased triage staffing levels, patients were not always assessed in a timely way. Once triaged patients were not always allocated a priority category and if they were, this did not correlate effectively with the patients condition.
- Patients did not always have an early warning score calculated at triage, despite their presenting condition, indicating they may be at risk of deterioration.
- Patients arriving by ambulance remained on ambulances for significant amounts of time, despite a presenting medical condition which had the potential to deteriorate. We saw a patient with a suspected gastro intestinal bleed (serious bleeding in the stomach) wait 25 minutes to be brought into the department, despite crews highlighting the nature of the presenting condition to the Pre- Hospital Practitioner (PHP).
- Patients at risk of deteriorating consciousness levels were not monitored effectively. We saw a number of patients who had presented to the department with head injuries. These patients did not have neurological observations performed initially or on an ongoing basis.
- Patients arriving by ambulance and brought into the department were not always clinically assessed by the PHP. The PHP was reliant on observations from the ambulance crew rather than performing their own and recorded this as an assessment time. This posed a risk to patients as the PHP did not have the most up to date information and the patients presenting condition may have worsened.

Urgent and emergency services

- Patients in the ambulance corridor did not always have observations performed in line with trust protocol. Patients went for long periods without observations. We saw a patient with a potential fractured neck of femur had not been offered any analgesia and, had been waiting more than two hours at the point we reviewed their notes, to be seen by a clinician.
- The Rapid Assessment and Treatment (RAT) process was ineffective at reducing ambulance handover times. We saw many patients held on ambulances and a long wait for a RAT assessment.
- Children in the department were placed at risk of harm as they were not cared for by nursing staff with the necessary competencies to provide safe and effective care. Whilst there was an identified registered children's nurse in the department caring for some children, there was no oversight of new arrivals to the department, furthermore we observed children being triaged by nurses without additional paediatric competencies.

Are urgent and emergency services safe?

Assessing and responding to patient risk

- The Royal College of Emergency Medicine (RCEM) 'Initial assessment of emergency department patients' suggests a detailed triage assessment should be made within 15 minutes of the patient's arrival. At our last inspection the trust was not meeting this standard. Following our feedback the trust had reviewed the staff allocation to triage. They had increased the numbers of triage nurses to two between 10am and 10pm to improve the timeliness of triage, however this had proved ineffective. At this inspection we reviewed the ED records for 19 patients who had their triage times recorded. Time from arrival to triage varied between one and 120 minutes. The average time to triage was 27 minutes. Seven patients waited between one and 15 minutes, eight between 15 and 30 minutes, two patients waited 30-60 minutes and two patients waited over 60 minutes.
- The triage process was not effective in the early detection of acutely unwell patients. Whilst the trust had a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) in place, these were not routinely used as part of the triage process despite patients presenting condition, indicating they may be at risk of deterioration. An early warning score is a guide used by healthcare staff to quickly determine the degree of illness of a patient and prompts support from medical staff and/or senior nursing staff when required. We found 16 out of 27 patients who should have had an early warning score calculated did not have one calculated as part of their initial triage process. We also found this to be the case at our last inspection.
- Staff used a categorisation scale of one to five (one being immediate priority and five least priority) following triage. This should ensure that the most sickest patients are seen first. We found only five out of a possible 27 triage notes we looked at recorded a patient priority category. Of the five who had the categories recorded we could not be assured they were categorised correctly. We saw a diabetic patient presented to the department with extremely high blood glucose levels, whilst they were triaged in a timely way they were categorised as a category three priority and

were not seen by a doctor for over two hours. We also saw a child with possible sepsis, whilst triaged in a timely way, they were categorised as category three and not seen by a doctor for 50 minutes. Both patients should have been for immediate priority (category one).

- At the last inspection and this inspection we found there was no oversight of patients pre- and post-triage in the main waiting room, and routine observations were not performed on these patients following triage despite increasing lengths of times to be seen by a clinician. We observed one patient with potential renal colic had been in the waiting area for over two hours to be triaged. Reception staff had alerted nursing staff to this patient as they were worried about the time they had waited. The patient's notes had gone missing.
- At our last inspection and at this inspection we found patients arriving by ambulance and brought into the department were not always clinically assessed appropriately by the Pre Hospital Practitioner (PHP). The PHP was reliant on observations and assessment from the arriving ambulance crew rather than performing their own. They subsequently recorded this as an assessment time, when in fact there had been no trust clinical assessment of the patient. This posed a risk to patients as the PHP did not have the most up to date information and the patients presenting condition may have worsened.
- Patients in the ambulance corridor did not always have observations performed in line with trust protocol. Patients went for long periods without observations. We saw an elderly patient living with dementia who had been brought to the department by ambulance, with a possible fractured neck of femur (fractured hip). The patient had not been offered any pain relief and, had been waiting more than two hours at the point we reviewed their notes, to be seen by a clinician. No clinical observations had been recorded for this patient.
- Children in the department were placed at risk of harm as they were not always cared for by nursing staff with the necessary competencies to provide safe and effective care. Whilst there was an identified registered children's nurse in the department during the period of our inspection, who was caring for a child, there was no oversight of new arrivals to the department. We saw how one child with a head injury waited 25 minutes to be triaged by a nurse without additional paediatric competencies. The registered children's nurse had not been alerted to this patient.
- During our inspection we found the majority of patients arriving by ambulance had waited beyond the recommended 15 minutes to be clinically assessed. Time varied between 33 and 120 minutes, however this may have been longer as some patients whose care we had tracked, had not been seen at the 120 minute mark when we left the department. The national standard is that 95% of patients should have initial assessment within 15 minutes of arrival to the department.
- The Rapid Assessment and Treatment (RAT) process was ineffective at reducing ambulance handover times. We saw many patients held on ambulances and waits of over two hours for a RAT assessment. During our inspection we observed significant handover delays for patients arriving by ambulance.
- During our inspection we found the department was to maximum capacity. We saw a backlog of patients arriving by ambulance who remained on ambulances between 25 and 45 minutes, despite having presenting medical conditions which had the potential to deteriorate. We saw a patient with a suspected gastro intestinal bleed (life threatening bleeding in the stomach) wait 25 minutes to be brought into the department, despite crews highlighting the nature of the presenting condition to the Pre- Hospital Practitioner (PHP) on several occasions. The emergency consultant in charge was aware of this patients imminent arrival, however had not clinically assessed the patients condition in the ambulance on arrival.
- Once in the main ED nursing staff used NEWS and PEWS to record routine physiological observations such as blood pressure, temperature, respiratory rate and heart rate. Observations were recorded electronically and included a 'track and trigger' system whereby scores were displayed visually within the department. Staff did not always carry out observations in line with trust protocol and in a timely way.

Urgent and emergency services

- Patients who were at risk of deteriorating consciousness levels were not monitored effectively. We observed the care of three patients with head injuries. There had been no neurological observations carried out during the initial assessment or on an ongoing basis prior to and following review by a clinician. Neurological observations are essential to establish the patient's neurological status and to illustrate any changes.
- Safety and care rounding checklists were in use in the department, these had many actions that staff must complete in each of the hours the patient was in the department to ensure safety and comfort of patients. Checklists we reviewed for 10 patients indicated that these were inconsistently completed.
- At our last inspection we observed nursing staff regularly leaving the department to take patients to ward areas. There was no cover for them or the patients they were caring for whilst out of the department, nor did they hand over to the nurse in charge. At this inspection we observed a process in place for transferring patients to wards and other clinical areas, which did not impact on nurse staff to patient ratios. There was a dedicate team to patient transfers.
- Patients were not seen by senior clinician in a timely way. During our inspection we reviewed the care and treatment of 27 patients. Patients were waiting between 15 minutes and up to two and half hours to be seen by a doctor. The average time for patients to be seen by a senior clinician during our inspection was one hour and 31 minutes. Patients were not always seen in priority order and we saw patients who we would have expected to have a clinical review immediately were not seen in a timely manner. For example we saw a diabetic patient presented to the department with extremely high blood glucose levels, was not seen by a doctor for over two hours. Patients with extremely high blood glucose levels have the potential to develop serious life threatening complications.
- Since our last inspection the department had introduced two hourly safety huddles. We saw one safety huddle being performed in the department during our inspection, however this was not attended by some key members of the team, such as the nurse or consultant in charge. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.

Nurse staffing

- The nurse staffing levels and skill mix were sufficient to meet the needs of patients during the period of our inspection, however we saw and were told there were no plan or actions in place to assess nursing staffing levels were sufficient to meet any increasing capacity, demand or patient acuity issues.
- For the period during our inspection visit there was one registered children's nurse present in the department, however they were not always aware of all children presenting to the department and or involved in their care and treatment. This meant children in the department were placed at risk of harm as they were not always cared for by staff with the necessary competencies to provide safe and effective care.

Medical Staffing

- The staffing levels and skill mix were sufficient to meet the needs of patients during the period of our inspection, however we saw and were told there were no plan or actions in place to assess medical staffing levels were sufficient to meet any increasing capacity, demand or patient acuity issues.
- A consultant was present in the department for the entirety of our inspection visit. One doctor in the department had the necessary qualification to care for children.

Are urgent and emergency services caring?

Compassionate care

- During this inspection, we found patients cared for in the central area of the main department and on the

ambulance corridor. This meant patients privacy and dignity needs were not always respected. We saw many patients being treated in the middle area of the department.

- Ambulance staff transferred patients from the stretcher to trolley in an open area adjacent to an opening door. Ambulance staff told us that they were not meant to do this, however there were no cubicles available to facilitate this.
- We saw patients, whilst cared for by ambulance crews were left on the back of ambulances for long periods. This was due to lack of capacity in the department. This did not afford patients the dignity they deserved.
- Care rounding documentation was inconsistently completed and patients went for long periods without any staff checking on them, our own observations supported this.
- At our last inspection (30 November 2018) we found there was significant overcrowding in the department which impacted on patients privacy and dignity. At this inspection we saw the trust had taken some action to ensure the 'fit to sit' room was not overcrowded and that patients were not cared for along a thoroughfare corridor in the department. However, we still observed patients waiting to be seen by clinicians were cared for on ambulance trolleys in the ambulance corridor.
- Throughout our inspection we saw patients being cared for on trolleys in the central area of the department as there were no free cubicles to use, however at this inspection those patients in the central area were of the same sex. We observed some patients still received interventions and examinations in this area. This was the same as our previous inspection.