Leeds Teaching Hospitals NHS Trust

St James's University 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused inspection on 20 December 2017, to follow up on concerns we identified during routine engagement, regarding the safe use of additional beds in non-designated areas during times of increased demand.

Intelligence data showed that at times of increased demand, staff placed additional beds/trolleys in non-designated areas. The use of non-designated areas included placing patients in ward corridors, using additional areas to nurse patients (such as treatment rooms, day rooms, and sensory rooms) and increasing the capacity of ward bays by placing patients in beds in the middle of the bay.

We raised the use of non-designated areas with the trust in May 2016, during a follow-up to a comprehensive inspection. At that time risk assessments of the use of non-designated areas were not consistently undertaken or applied, and there was a lack of robust assurance of the oversight of patients waiting on trolleys. A requirement notice was served to the trust, to ensure there were appropriate arrangements in place for assessing the suitability of patients to wait on trolleys on the assessment ward. Since the 2016 inspection, the trust had reviewed documentation, including risk assessment and standard operating procedures, for placing patients in non-designated areas; and they had commenced weekly and quarterly audits of the results.

In September 2017, through routine reviews of the National Reporting and Learning System (NRLS) data, we observed a number of reports that showed patients were still being placed in non-designated areas. Staff raised concerns that on some occasions, risk assessments of these patients had not been carried out appropriately; and some patients were being nursed in non-designated areas (including corridors) for a number of days. We discussed this with the trust. The trust explained that at times of increased demand for beds, capacity was increased by placing additional beds/trolleys in (what the trust termed) “non-designated areas”; such as ward corridors and in the middle of bays, and using treatment rooms, day rooms, and sensory rooms as escalation areas. The trust had identified two different occasions when non-designated areas could be used; and classified in there full capacity plans.

Information provided by the trust showed that between October 2017 and December 2017, non-designated areas within the trust were in use on the majority of days. The number of patients per day in non-designated areas ranged between six to 40 patients. During this inspection, we saw five patients nursed in non-designated beds in the areas we visited; three on the corridor, one located in the middle of a bay, and one located in a treatment room. At the time of the inspection, the trust was not able to provide length of stay data for patients in non-designated areas. However, during the inspection, we saw two patients that had been nursed in non-designated beds for a period of four days.

Information we reviewed showed that between March to December 2017, the trust had received seven formal complaints and eighteen patient advice and liaison service (PALS) concerns relating to the use of non-designated areas.

We asked the trust how they received assurance that patients in non-designated areas were receiving safe care and treatment. We reviewed the information provided by the trust, and discussed this at management review meetings. We concluded that a focused inspection was required to identify if a breach of the regulations had occurred.

To get to the heart of patients’ experiences of care and treatment we always ask the same five questions of all services: are they safe, effective, caring, responsive to people’s needs, and well-led? Where we have a legal duty to do so, we rate services’ performance against each key question as outstanding, good, requires improvement or inadequate.

At this inspection we inspected the core service of medicine only and the safe, responsive and well-led domains; we did not rate the services.

During the inspection we identified the following concerns:

- There was a lack of robust assessment and documentation of decision making for patients being nursed in non-designated areas.

Summary of findings

- There was a lack of suitably qualified staff; when taking into account best practice, national guidelines and patients' dependency levels. In addition, staffing levels were not altered to reflect the use of non-designated areas.
- There was a lack of robust documentation in relation to the requirements of the Mental Capacity Act (2015) and consent to being nursed in non-designated areas.
- The non-designated areas being used to nurse patients were not always suitable and did not meet all patients' needs.
- At the time of the inspection, the trust was not able to always meet patient's privacy and dignity in relation to the environment they were nursed in. The single sex accommodation annual declaration 2017, outlined that when patients were allocated to corridors, the trust required they were always allocated on same gender wards. However during the inspection, we did not see that the trust always achieved this. On ward J14 a mixed male and female ward we saw a male and a female patient located on the same ward corridor
- The use of non-designated areas reduced the privacy of patients and compromised their dignity.
- A number of incident forms we reviewed indicated a theme of nursing staff being overruled in decision making processes about placing patients on corridors. A number of reports also highlighted patients (or their relatives and representatives) who were unhappy or upset about being nursed in non-designated areas.

However, we also saw several areas of good practice including:

- We observed that during the inspection, staff treated patients with compassion and respect.
- Patients we spoke with said they felt listened to, they felt safe, and that they were treated with kindness.
- The service had systems in place for reporting, monitoring, and learning from incidents. Staff we spoke with knew the procedure for reporting incidents, and described completing an incident form each time a non-designated bed space was used.
- We also found effective communication between teams to ensure patients in non-designated areas were medically reviewed, as appropriate.
- The trust had developed a number of initiatives to improve patient flow, and relieve capacity and demand pressures.
- We found that all members of staff approached were happy to speak with us and share concerns, discuss challenges faced, and highlight good practice to us.

Importantly, the trust must:

- Ensure there are suitably skilled staff available to care for patients being nursed in non-designated areas; taking into account best practice, national guidelines, and patients' dependency levels.
- Ensure that when non-designated areas are in use, the privacy and dignity of patients being nursed in bays or corridors are respected and not compromised, and that the areas are suitable to meet patients' needs.
- Ensure there is robust assessment and documentation of decision making for patients being nursed in non-designated areas,; including assessment of patients' mental capacity, reasons for deviation from the operating procedure, patient preferences, and patients' right to consent.
- Ensure data is collated on the numbers, location, and length of stay of patients in non-designated beds.
- Ensure that staff reporting concerns about the use of non-designated areas are supported and receive feedback.

Ellen Armistead

Deputy Chief Inspector of Hospitals

St James's University Hospital

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Background to St James's University Hospital

Leeds Teaching Hospitals NHS Trust is one of the largest trusts in the United Kingdom. They provide healthcare and specialist services to the city of Leeds, the Yorkshire and Humber region, and nationally - as a specialist treatment centre.

The trust currently has six registered locations: Leeds General Infirmary (LGI), St James's University Hospital (SJUH), Chapel Allerton Hospital (CAH), Wharfedale Hospital (WH), Seacroft hospital (SH)and the Leeds Dental Institute (LDI).

The trust provides medical care, including older peoples care, across three sites; including at SJUH, where provision of medical care spans over 30 wards. At the time of inspection, medical specialities included acute medicine, elderly medicine, general medicine, gastroenterology, infectious diseases, oncology, and respiratory medicine; which housed an adult cystic fibrosis unit.

We previously carried out a follow up inspection in May 2016. At that inspection, medical services provided on the SJUH site were rated as good. We issued a number of requirement notices against breaches in respect of trust services; these included a requirement notice for a breach in regulation due for assessing the suitability of patients who were appropriate to wait on trolleys on the assessment ward. However, these were not consistently applied, or risk assessments undertaken. There was a lack of robust assurance over the oversight of patients waiting on trolleys.

Our inspection team

The team that inspected the service included a CQC Inspection manager, lead inspector, another CQC inspector, and a CQC assistant inspector. The inspection was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

How we carried out this inspection

Prior to the unannounced inspection, we reviewed the trust action plans to address the concerns in the requirement notice 2016; we also asked for additional information on the use on non-designated areas, including data on the numbers in use, the length of stay of patients in these areas, and compliance with the risk assessment process.

Detailed findings

We carried out an unannounced focused inspection on the core service of medicine, which took place on 20 December 2017.

As part of our inspection, As part of our inspection, we visited nine medical wards; covering acute medicine, acute medical elderly, general medicine, elderly medicine, and oncology. We also visited one surgical ward J47 as they had medical patients on the ward. We observed five patients being nursed in non-designated areas; and reviewed the records of one patient who had been recently nursed in a non-designated area. Patients were located on wards J14, J16, J21, J93 and J47.We observed five patients being nursed in non-designated areas; and reviewed the records of one patient who had been recently nursed in a non-designated area. Patients were located on wards J14, J16, J21, J93 and J47.

During our inspection, we spoke with 22 members of staff; including nurses, doctors, health care support workers, therapists, and administration staff. We also spoke with members of the executive team and medical senior management team.

In addition, we observed care using a short observational framework for inspection (SOFI). A SOFI is a specific way of observing people's care or treatment, looking particularly at staff interactions. This helps us understand the experiences of people who may find it difficult to communicate.

We reviewed six sets of medical notes for patients who had been nursed in non-designated areas.

The hospital was previously inspected in June 2016, at which time, three domains were inspected and an overall rating of good given. The safe domain was rated as requires improvement, and responsive and well-led domains were both rated as good.

Facts and data about St James's University Hospital

At the time of the inspection, St. James's University Hospital (SJUH) had approximately 391 general and acute medical beds.

The emergency and specialty medicine clinical support unit employed 1,259 whole time equivalent (WTE) staff. These included 461 registered nurses, 324 non-registered nurses, 94 consultants, 176 junior doctors, 28 training grade doctors, and 176 other staff.

There were 61,060 medical admissions to Leeds Teaching Hospitals NHS Trust between December 2016 and December 2017. Of these, 39,662 were emergency admissions, 1704 were elective admissions, and 19,694 were day cases.

Results of the CQC Inpatient survey 2016 showed SJUH performed as expected for most questions posed, with no significant changes in scores from 2015 to 2016. The trust performed worse than expected on six questions, including time between arrival and getting a bed on the ward, privacy for discussing treatment/condition, being treated with respect and dignity, cleanliness, emotional support from staff, and being well looked after by staff.

Friends and Family Test performance (% recommended) for SJUH showed that in November 2017, 94% of the patients who responded recommended the service; this was slightly worse than the England average of 96%. The response rate was 37%, better than the England average of 25%; with 2,249 patients responding out of 6,067 patients eligible to do so.

Medical care (including older people's care)

Safe	
Responsive	
Well-led	
Overall	

Information about the service

St. James's University Hospital (SJUH) provides medical care over 30 medical wards. At the time of inspection, medical specialities included acute medicine, elderly medicine, general medicine, gastroenterology, infectious diseases, oncology, and respiratory medicine; which housed an adult cystic fibrosis unit.

Due to concerns about whether safe care and treatment was being provided to patients nursed in non-designated areas, we carried out a focused inspection.

Summary of findings

We inspected, but did not rate, medical services at this inspection.

We highlighted areas of poor practice where the trust needs to make improvements, these included:

- There was a lack of robust assessment and documentation of decision making for patients being nursed in non-designated areas. Concerns included staff deviation from standard operating procedures, and ensuring that processes for gaining consent from patients to be nursed in non-designated areas were in line with the requirements of the Mental Capacity Act, 2005.
- There was a lack of qualified staff; when taking into account best practice, national guidelines, and patients' dependency levels. Duty rotas we reviewed showed that all areas were staffed below established levels on a number of occasions, and staffing levels were not altered to take account of patients being nursed in non-designated areas.
- The non-designated areas used to nurse patients were not always suitable to meet all of their needs; for example, patients living with dementia, not all patient bed spaces had accessible call bells, clocks, windows, and hand hygiene facilities. On some wards, doors banged into patient beds or patient beds blocked access to toilet, bathroom and shower facilities.
- At the time of the inspection, the trust was not able to always meet patient's privacy and dignity in relation to the environment they were nursed in. The single sex accommodation annual declaration 2017, outlined that when patients were allocated to corridors, the trust required they were always allocated on same gender wards. However during

Medical care (including older people's care)

the inspection, we did not see that the trust always achieved this. On ward J14 a mixed male and female ward we saw a male and a female patient located on the same ward corridor

- The privacy and dignity of patients being nursed in non-designated areas, such as bays or corridors, was compromised. We saw that when staff used privacy screens, the screens were of limited height and width, and did not ensure that staff could respect patient privacy and dignity at all times.
- A number of incident forms we reviewed showed a theme of nursing staff being overruled in decision making processes around placing patients in non-designated areas, especially on corridors. A number of reports also highlighted patients (or their relatives and representatives) who were unhappy or upset about being nursed in non-designated areas.
- Information we reviewed showed that the trust had received seven formal complaints and 18 patient advice and liaison service (PALS) concerns between March and December 2017, which related to the use of non-designated areas.

However:

- During the inspection we observed that staff treated patients with compassion and respect. Patients we spoke with said that they had been listened to, they felt safe, and they were treated with kindness.
- The service had systems in place for reporting, monitoring, and learning from incidents. Staff we spoke with knew the procedure for reporting incidents, and said they completed an incident form each time a non-designated bed space was used.
- We also found effective communication between teams to ensure patients in non-designated areas were medically reviewed, as appropriate.
- The trust had developed a number of initiatives to improve patient flow, and relieve capacity and demand pressures. Initiatives included working with an independent health care provider to provide care for patients who were medically fit for discharge. The trust had also opened a frailty unit, and made improvements to the discharge liaison team.

We found that all members of staff approached were happy to speak with us and share concerns, discuss challenges, and highlight good practice to us.

Medical care (including older people's care)

Are medical care services safe?

We inspected, but did not rate, medical services at this inspection.

We highlighted areas of poor practice where the trust needs to make improvements, these included:

- There was a lack of robust assessment and documentation of decision making for patients being nursed in non-designated areas. The trust completed weekly quality audits of patients in non-designated areas, and reviewed associated documentation. Data was collated into a quarterly report. We reviewed quarter two and quarter three reports, and saw that in September 2017, 80% of patients had a risk assessment completed; this dropped to 65.7% in January 2018. The audits demonstrated that the trust could not provide full assurance that patients in non-designated beds had been appropriately assessed.
- The risk assessment documentation completed did not include space to document what discussions and decisions had been made about moving patients to non-designated areas and whether staff making decisions had reasons to deviate from the standard operating procedure; for example, decisions involving patients living with dementia. The standard operating procedure did not specify the level or authority of staff allowed to undertake the risk assessment.
- There was a lack of qualified staff; when taking into account best practice, national guidelines, and patients' dependency levels. In addition, staffing levels were not altered to take account of non-designated areas being used. We reviewed the duty rosters for five ward areas and, of these, we examined four weeks of rosters over a four month period. We examined 420 registered nurse shifts and found 283 shifts not staffed to the established level.
- As the trust was unable to meet established levels of nursing staff, senior nursing staff had developed a minimum staffing level. This level featured fewer qualified nurses than the established level; however, from discussions with senior staff it was not clear how this minimum staffing level had been developed or what staffing guidance it was based on. Rosters we reviewed showed the trust had not meet this minimum level on 50 occasions (ward 11 and ward 14) in the period September to November 2017.
- Non-designated area environments were not always suitable to meet all patients' needs. For example, doors banged into patient beds, and beds blocked access to toilet, bathroom and shower facilities. It is recommended that water outlets such as bathroom and shower facilities should be regularly run to ensure effective management and control of Pseudomonas aeruginosa and Legionella. We were concerned that the difficulty of access to these areas had the potential to increase the risks of waterborne illness to patients.
- Not all patient bed spaces had accessible call bells, clocks, windows, and hand hygiene facilities. Trust quarterly non-designated areas audit data showed that from March to December 2017, of 407 patients reviewed, only 118 patients (29%) had direct access to a call bell. Post the inspection, the trust confirmed they had purchased additional call bells. The trust supplied data to show all patients in non-designated areas reviewed in January 2017 had access to call bells; however, the data did not specify the location of these patients or the total number of patients audited.
- Incident reports for the period December 2016 and 30 January 2017 included concerns about staff not being able to carry out treatment, patients (or their relatives and representatives) being upset about being nursed in non-designated areas, and inappropriate patient selection for care in non-designated areas.

However:

- The service had systems in place for reporting, monitoring, and learning from incidents. Staff we spoke with knew the procedure for reporting incidents, and said they completed an incident form each time a non-designated bed space was used.
- We also found effective communication between teams, to ensure patients in non-designated areas were medically reviewed, as appropriate.

Incidents

- The service had systems in place for reporting, monitoring, and learning from incidents.

Medical care (including older people's care)

- Staff we spoke with knew the procedure for reporting incidents, and said that they completed an incident form each time a non-designated bed space was used.
- The trust advised us that between January 2017 and November 2017 no serious incidents were reported that involved patients being nursed in non-designated areas during the period.
- Prior to the inspection, we reviewed information contained on the national learning and reporting system (NRLS). Data showed that from January 2017 to November 2017, 1,338 incident reports related to patients being nursed in non-designated areas. Of these, 1,130 incidents (84%) were reported by medical specialities. All of the 1,338 incidents reported were graded as low or no harm. Post inspection, the trust confirmed that from 30 December 2016 to 30 January 2017, they had received 1049 incident reports involving the use of non-designated areas. In both sets of data, double-counting of incidents might have occurred. The trust policy was to complete an incident form daily for patients in non-designated areas however senior staff we spoke with and staff working in the ward area confirmed that some staff completed an incident form for each day they observed a patient being nursed in a non-designated area, whilst other staff completed a single incident form covering the entirety of the patient's stay in a non-designated area. Staff we spoke with also confirmed that it equally possible that more than one member of staff reported the same patient in a non-designated area on more than one occasion.
- NRLS incidents we reviewed showed that between January 2017 and November 2017, staff highlighted a number of concerns relating to patients being nursed in non-designated areas. Their concerns included two reports of staff being unable to perform ECGs on patients (as they were located in a corridor) and being unable to carryout assessments on patients (as patients were being nursed in therapy rooms). We saw one report of a patient being nursed on a corridor who had difficulty communicating with staff. We saw 18 reports of patients (and their relatives and representatives) being upset and distressed about being nursed in non-designated areas. We saw one report concerning critically ill patients being nursed in inappropriate (non-designated) areas without access to monitors or curtains and a further seven reports of patients being unsuitable to be nursed in non-designated areas. A further sixteen reports indicated the patients observations (national early warning scores) were not appropriate to be nursed in non-designated areas. The NRLS data we reviewed also showed evidence of delays in treatment due to the number of patients being nursed in non-designated areas, and medical patients being nursed in non-medical beds in other areas of the hospital. NRLS data does not contain detailed information about incidents; therefore we were unable to review any impact that these issues had on patients.

Cleanliness, infection control and hygiene

- When patients were nursed in non-designated areas direct access to sinks in the immediate patient environment was not always available. Two out of three patients we reviewed did not have direct access to a sink. The one patient who had direct access to a sink, could not use the sink because of the close proximity of the bed. In addition, not all of the non-designated bed areas we observed had access to a sanitiser gel dispensary point. The current standard operating procedure and associated risk assessment did not specify that patients in non-designated areas had access to hand hygiene facilities. Staff we spoke with said that they would use the nearest available sink, even if they had to enter a different area.
- It is recommended that water outlets such as bathroom and shower facilities should be regularly run to ensure effective management and control of Pseudomonas aeruginosa and Legionella. During the inspection, we saw that the placement of non-designated area beds in the corridor of wards blocked bathrooms, shower and toilet facilities. This meant that staff were not able to access these areas easily to flush the water outlets. We were concerned that the difficulty of access to these areas had the potential to increase the risks of waterborne illness to patients. This could increase the risk of waterborne infections from pseudomonas and legionella. Staff we spoke with said that they reported this to supervisors who arranged for these areas to be flushed at a different time. Following the inspection, the trust confirmed that they had a process in place for flushing water systems when bathrooms were re-commissioned.

Environment and equipment

- At times of increased demand, staff placed additional beds/trolleys in non-designated areas. The use of non-designated areas included placing patients in ward corridors, using additional areas to nurse patients (such as treatment rooms, day rooms, and sensory rooms) and increasing the capacity of ward bays by placing patients in beds in the middle of the bay. The trust had identified non-designated areas as part of full capacity plan, and the head of nursing had identified suitable areas.
- The areas used as non-designated areas did not meet the requirements of Health Building Note 04-01 adult in-patient facilities, for example on the majority of occasions, non-designated areas did not have access to piped oxygen, integral curtains, electronic call bells and no windows for natural light or ventilation. We did see that patients had access to dignity screens and piped oxygen if required.
- During the inspection, we observed the following in respect of the placement of beds in non-designated areas:
  - Ward J14 we saw a patient who was being nursed on a corridor; the head of their bed was placed directly adjacent to a sink. We saw that when the toilet near the bed was used, the door banged the patient's bed. The corridor had no windows for natural lighting or ventilation.
  - Ward J16, the non-designated bed was not in use, but staff showed us were this would be located; we noted that the placement of the bed could block or hamper access to toilet areas, storage areas, and staff offices. There were no windows in the area shown for natural light or ventilation.
  - Ward J21, we saw that one patient was being nursed on the corridor in a lobby area. The location of the bed prevented access to the bathroom and toilet. Access to the cleaner's cupboard was restricted and we saw the domestic trolley banging into the patient's bed when being moved in or out of the room. The patient in bed was not provided adequate privacy. There were no windows in the lobby area for natural light or ventilation.
  - On wards J26, J27 and J28, non-designated bed areas were not in use. Staff showed us were these would be located if in use. There were spaces allocated for beds directly adjacent to the nurse station, with another non-designated area located across the corridor; these spaces did not ensure the confidentiality of conversations held at the nurse station, as discussions could be heard by other patients. Another non-designated area was also available in the day room of ward J27.
  - On ward J47, a patient was located in the middle of a six-bedded bay. This patient was located directly under a light, and they did not have access to curtains or privacy screens, or a nurse call bell.
  - We saw that one patient had been transferred to a non-designated bed space in the treatment room on ward J93. As this was an internal room, there were no windows for natural light or ventilation. The area did have access to a hand wash basin, access to piped oxygen if needed, and had an integral call bell in the room. The patient in this area was fully mobile and could easily access nearby toilet and shower facilities.
  - On ward J96, the non-designated bed space was situated in a side room, which was intended to be part of the adjacent assessment ward. The room was fully equipped and functional and was adjacent to ward J96, so nursing staff could access the patient easily. The room was in use on the day of inspection. The non-designated area on ward J97 was a sensory room; the room was equipped with piped oxygen, and was light and airy. The call bell in this room was fixed to the wall, so it could only be utilised by a mobile patient.
- The trust had identified non-designated bed areas available for use as part of their full capacity plan; and seven medical wards had been identified as able to take additional patients. The heads of nursing had identified suitable areas. Although not detailed on the surge two plans, staff we spoke with on ward J21 said that a surge two bed area had been identified on the ward. Staff showed us were this would be located, and informed us that that the area had been in use approximately twice in the last six months; the location of the bed would obstruct access to the fire exit. At the time of the inspection, we discussed this with the senior management team. Post inspection, the trust confirmed that the area did not have a surge two bed allocated. Ward J96 did not have a surge level two bed due to the acuity of the patients routinely admitted to that area. If in use, surge two beds on wards J93 and J97 would be

situated in a corridor area or in the middle of a four bedded bay; and we noted mobile screens were available. Staff we spoke with said that these areas were very rarely used.

Medicines

- Patients in non-designated areas were included routinely in medicine rounds and comfort rounds, when pain assessments were made. We saw that patients in non-designated bed areas were given pain relief as appropriate.
- We saw that non-piped oxygen was available for patients nursed in non-designated areas, if required.

Records

- On the day of the inspection, it was a requirement that nursing staff should undertake intentional checks (rounding) of patients in non-designated areas hourly during the day, and two-hourly overnight. During the inspection, we saw that on the majority of occasions staff completed intentional rounds these were recorded accurately; however, we did see a number of gaps in recording of rounds in the days prior to the inspection. We discussed the hourly recording of pressure area checks (which implied that the patient had had pressure areas checked on the corridor every hour) with the senior management team. They confirmed that if patients were allocated to non-designated areas correctly (mobile and independent patients), then staff needed to record this on the rounding tool, however records we reviewed did not record this.
- The standard operating procedure detailed that all patients being nursed in the corridor be informed of the reasons why they were being moved into a non-designated area, and provided with a leaflet that included a letter apology. During the inspection, only one patient was able to confirm they had received the apology letter and leaflet; one patient confirmed they had not, and four patients were unable to confirm and we did not see evidence in the medical records.
- We saw that patient records, including risk assessments, were legible, signed, and dated.

Assessing and responding to patient risk

- At the inspection completed in 2016, we identified a breach of regulation 17 Health and Social Care Act (Regulated activities) Regulations 2014 Good governance and told the trust they must ensure arrangements were in place for assessing the suitability of patients who were appropriate to wait on trolleys on the assessment ward. At that time, risk assessments were not consistently applied or undertaken, and there was a lack of robust assurance over the oversight of patients waiting on trolleys. Since the 2016 inspection, the trust had reviewed documentation, including risk assessment and standard operating procedures for placing patients in non-designated areas; and weekly and quarterly audits of the results had commenced.
- All staff we spoke with were aware of the need to complete documentation and risk assessments for patients allocated to non-designated areas. However, there was a lack of robust assessment and documentation detailing decision making processes for patients being nursed in non-designated areas. The trust completed weekly quality audits reviewing patients in non-designated areas and the documentation used, and collated the data in a quarterly report. We reviewed quarter two and three reports and saw that in September 2017, 80% of patients had a risk assessment completed; this dropped to 66% completion in January 2018.
- The standard operating procedure clearly stated that any deviation from the eligibility criteria must be recorded. However, the risk assessment documentation used at the time of the inspection did not include a section to record decision-making actions or mitigation where risks were identified. This meant that the decision-making process and mitigation of risks were not clearly documented; even if staff deviated from the process. For example, during the inspection, risk assessments we reviewed did not record times when current staffing levels were lower than established levels, despite wards having non-designated areas open.
- During the inspection, we reviewed risk assessments undertaken for six patients that were or had been nursed in non-designated areas. In each case, ward staff had assessed the patient as appropriate for being in a non-designated area, in line with the trust's SOP and risk assessment policy. However, we saw patients risk assessed with a history of falls and acute confusion had been nursed in beds on ward corridors, which went against criteria identified for using these areas in the trust policy.

- On reviewing incident reports, we found further examples of patients who did not meet the specific criteria for nursing in non-designated areas, but had still been nursed in non-designated areas. These included patients with national early warning scores (NEWS) above the SOP threshold, and patients with incontinence, alcohol withdrawal, and seizures had been nursed in non-designated areas. The decision making process for deviating from the SOP was not clear and the relevant documentation did not allow staff to clearly record mitigating actions or the reasons why staff had deviated from trust procedures. We also saw a number of incident forms that showed decisions about patients initially assessed as suitable for nursing in a non-designated area where receiving ward staff had raised concerns about the suitability of transfers.
- In addition, the standard operating procedure did not detail the level of staff allowed to undertake the risk assessment of patients allocated to non-designated areas. During the inspection, it was not clear what oversight senior staff had on this assessment process, we reviewed three assessments and saw one occasion when non-registered nurses had completed the assessment. It was also not clear what level of training staff received to be able to complete this assessment.
- We observed that patients in non-designated area areas did not always have access to a call bell. During the inspection, only two patients out of five patients in these areas had access to a call bell. Not all nursing staff we spoke with were aware of their wards having access to additional call bells; for example, on ward J16 and J21, some staff were not aware of how to access a call bell for patients in non-designated areas. Despite access to call bells being a specific question on the risk assessment, these patients not having access was not recorded. The September 2017 quarterly non-designated areas audit showed that of 225 non-designated area patients reviewed, 37 had direct access to call bell and 16 had access to a hand bell. This meant that 172 patients nursed in a non-designated area (over three-quarters) did not have access to a call bells. Data from the January 2018 audit shows that of 182 patients reviewed, only 65 patients (a little over one-third) had direct access to call bell. Following the inspection, the trust confirmed that they had ordered additional call bells so that any patients in non-designated areas had access. The trust supplied data to show all patients in non-designated areas reviewed in January 2017, had access to call bells; however, data did not specify the location of these patients or the total number of patients audited.
- Staff we spoke with on wards J93, J96 and J97 said that they (as a team, while senior staff were on duty) identified two patients each day who met non-designated area nursing criteria, to help ensure only appropriate patients were transferred to other wards or non-designated bed areas if this became necessary later in the day or evening. Staff commented that if nothing had changed for these patients, the prior identification system helped them feel supported to move these patients if bed pressures demanded and senior / experienced colleagues had gone off duty.
- We saw that patients being nursed in non-designated areas were flagged on the patient management system, and had observations and national early warning scores (NEWS) recorded.
- We observed patients nursed in non-designated areas had access to fresh water and were provided with food and drinks appropriately.

Nursing staffing

- The service used the safer nursing care tool to review staffing establishments based on patient dependency as per the National Quality Board/AUKUH/1:8 ratio. Senior nursing staff had also developed a separate, minimum staffing level for when the trust was unable to meet established levels of nursing staff. This level featured fewer qualified nurses than the established level; however, from discussions with senior staff it was not clear how this minimum staffing level had been developed or what staffing guidance it was based on. Following the inspection, the trust confirmed it was determined by the heads of nursing.
- We found at times there was a lack of suitably qualified staff; when taking into account best practice, national guidelines, and patients' dependency levels. In addition, staffing levels were not altered to take account of non-designated areas being used.
- We reviewed the duty rosters for five ward areas and we examined four weeks of these rotas over a four month

period. We examined 420 registered nurse shifts, which equate to 84 shifts per ward. The rotas showed that all areas were staffed below established levels on a number of occasions. For example:

- On ward J11, established staffing levels were set at two qualified nurses, 38 shifts were staffed with only one registered nurse recorded as on duty.
- On ward J14, established staffing was set at two qualified nurses, 54 shifts with only one registered nurse recorded as on duty. On one shift there was no registered nurse recorded as being on duty, Following the inspection the trust confirmed that a registered nurse was available on this shift.
- On ward J26, established staffing levels were set at four qualified nurses, 76 shifts were staffed below established levels; with two registered nurses recorded as on duty for 21 of the shifts.
- On ward J28, established staffing levels were set at four qualified nurses, 73 shifts were staffed below established levels; with two registered nurses recorded as on duty for 13 of the shifts.
- On ward J93, established staffing levels were set at four qualified nurses, 42 shifts were staffed below established levels; with two registered nurses recorded as on duty for eight of the shifts.

- Following the inspection, the trust provided information detailing the minimum staffing level this showed that:
  - On ward J11, established staffing levels remained at two registered nurses per shift days but decreased to one registered nurse overnight.
  - On ward J14, established staffing levels remained at two registered nurses per shift days but decreased to one registered nurse overnight.
  - On ward J26, established staffing levels (days) decreased from four to three registered nurses per shift. Overnight they decreased from three to two registered nurses
  - On ward J28, established staffing levels (days) decreased from four to three registered nurses per shift. Overnight they decreased from three to two registered nurses
  - On ward J93, established staffing levels (days) decreased from four to three registered nurses per shift. Overnight they remained the same at two registered nurses.
- The trust said that some staffing shortfalls were mitigated by senior nursing staff, who used additional non-rostered staff (such as, clinical educators or matrons) and decreasing operational activity. The trust did not provide evidence of how long additional non-rostered staff had stayed in the clinical area for. Ward mangers we spoke with said that the e-rota was a live document and showed all staff working in the clinical area each day. However, even with mitigation, the trust agreed some gaps in safe staffing establishment levels had occurred from September to November 2017; these equated to:
- On ward J93, established staffing levels (days) decreased from four to three registered nurses per shift. Overnight they remained the same at two registered nurses.17 gaps on ward J11,
- 33 gaps on ward J14,
- No gaps on wards J26 and J28.
- Following the inspection, the trust provided information detailing nursing fill rates for the areas inspected; data showed that from September to November 2017, actual registered nurse staffing levels fell below planned registered nurse staffing levels on 11 out of 15 occasions (day shifts). On nine of these occasions, the planned registered nurse staffing levels fell below the actual registered nurse staffing levels (night shifts). The registered nursing fill rates for the areas ranged from 67.7% to 123.6% for day shifts (with an average fill rate of 91%) and from 75% to 103% for night shifts (with an average fill rate of 98%).
- Staff we spoke with during the inspection said that staffing numbers were lower than the agreed established levels on most days, and that if established levels were met, staff would be moved to work in another area of the hospital.
- The standard operating procedure detailed that staff should liaise with matrons and clinical managers to identify additional staffing support when opening non-designated areas. The risk assessment required that the nurse in charge assessed staffing levels to take additional patients; and this should be escalated to the matron. During the inspection, we saw that staffing levels were or had been (in the immediate period) lower than agreed established levels, despite additional patients being on the ward. All nursing staff we spoke with told us that staffing levels would not be adjusted to accommodate additional non-designated patients. On the day of inspection, we noted that a registered nurse

on ward J21, had been moved to a different to work on a different ward, leaving the ward registered nurse staffing levels at below established levels. despite ward J21 having an additional bed open
- Post inspection, we saw information that indicated the current registered nurse vacancy rate was 30%.
- Staff on wards J93, J96 and J97 told us that the majority of their registered staff vacancies had recently been filled; and they felt their areas were adequately staffed and they were usually able to manage an extra patient in a non-designated area. Staff commented that new staff had settled well into their roles and teams.
- The executive and senior management team for the clinical support unit accepted that registered nurse staffing levels were lower than required at times, and they described initiatives to improve staffing levels. For example, the integration of professions allied to medicine (e.g. physiotherapists) attached to wards and included in nursing numbers, and the use of doctor assistant roles.

Medical staffing

- The standard operating procedure (SOP) did not detail that nursing staff needed to liaise with medical staff to agree the suitability of patients nursed in non-designated areas. We saw a number of incident reports where medical staff had highlighted the unsuitability of patients moved to non-designated areas.
- During the inspection, the medical staff we spoke with said that the increase in non-designated patients increased their workload, as their staffing levels had not been reviewed to take account of additional patients. We saw an incident form highlighting a number of routine medical activities had not been completed in a timely manner due to the increased workload in medicine. For example, 160 medical/elderly outliers including patients in corridors looked after by three medical staff over a weekend. The staff member completing the report detailed patients being moved without Oxygen, delays in receiving intravenous antibiotics or intravenous fluid. The trust was aware that the use of non-designated areas placed additional pressure on staff, they had held discussions with staff to clarify management, responsibilities , accountability and provide support for the clinical teams.
- We saw evidence of consultant geriatricians raising concerns relating to patient care and safety within the older adult service; they expressed fears over registered nurse staffing levels and patients being nursed in non-designated spaces.
- Medical staff we spoke with said that the frequency of ward rounds had increased to four times a day, which included review of outlying patients. Staff felt that this had improved patient experience and patient flow; as it facilitated the discharge and assessment of patients who did not subsequently need admission. The medical team had also tried to improve patient flow and decrease the workload of junior doctors by completing patient tasks at the time of ward rounds.

Major incident awareness and training

- Staff we spoke with on ward J21 showed us where a non-designated bed would be placed in the event of level two surge capacity. They showed us that placement of the bed blocked the fire exit to the ward, and they informed us that the non-designated area had been used approximately twice in the last six months. They were unable to provide us with evidence of its use, as the ward did not collect occupancy data. We discussed this with the executive team, who agreed to review the use of this area. The executive team provided information which showed that the non-designated area was not identified for use on the full (level two surge) capacity plan.

Are medical care services responsive?

We inspected but did not rate medical services at this inspection.

We highlighted areas of poor practice where the trust needs to make improvements, these included:

- There was a lack of robust assessment of patients' mental capacity in relation to consent to being nursed in non-designated areas. The current standard operating procedure (SOP) and risk assessment did not take into account individual or patient centred care needs. For example; the mental capacity of patients to consent to being nursed in the corridor into account. The SOP made reference to "moves being carried out in explicit

approval of families and carers"; it did not make reference to whether families or carers were in the appropriate legal positions to undertake this decision on the patient's behalf.

- At the time of the inspection, the trust was not able to always meet patient's privacy and dignity in relation to the environment they were nursed in. The single sex accommodation annual declaration 2017, outlined that when patients were allocated to corridors, the trust required they were always allocated on same gender wards. However during the inspection, we did not see that the trust always achieved this. On ward J14 a mixed male and female ward we saw a male and a female patient located on the same ward corridor
- At the time of the inspection, the trust was not able to provide length of stay data for patients in non-designated areas. However, during the inspection, we saw two patients that had been nursed in non-designated areas for four days.
- Information from the trust showed that between March 2017 and December 2017, 407 patients had been nursed in non-designated areas; of these, 243 patients (60%) had been nursed on corridors.
- Information provided by the trust showed that on most days from October 2017 and December 2017, non-designated areas were in use within the trust. The number of patients being nursed in non-designated areas ranged between six to 40 patients per day.
- During the inspection, we saw five patients nursed in non-designated areas in the wards we visited; three patients were being nursed on corridors, one patient in the middle of a bay, and one patient in a treatment room.
- The SOP had defined criteria to identify suitable patients that could be nursed in non-designated areas. Patients we reviewed at the time of the inspection met the trust's suitability criteria for nursing in non-designated areas. However, the SOP did not make reference to the need to assess or record whether the non-designated area was able to meet a patient's individual or patient-centred care needs.
- Some non-designated areas being used by the trust were not suitable to meet all patients' needs; patients were not always able to be orientated to time and place, as they had no access to windows or clocks.
- Information we reviewed showed that from March 2017 to December 2017, the trust had received seven formal complaints and eighteen patient advice and liaison service (PALS concerns) that related to the use of non-designated areas; information received from the trust showed that most complaints were about communication problems.

However:

- The trust had developed a number of initiatives to improve patient flow and relieve capacity and demand pressures; these included working with an independent health care provider to provide care for patients who were medically fit for discharge. The trust had also opened a frailty unit, and made improvements to the discharge liaison team.
- Senior staff on oncology wards continuously worked to identify and earmark patients that could be nursed in non-designated areas, prior to this being required.

Access and flow

- The Standard operating procedure (SOP) 2016 for choosing patients suitable for nursing in non-designated areas was linked to the winter plan, to be used during periods of extremis, and enacted when the full capacity plan was executed.
- The trust surge plan indicated that the trust could initiate surge level one and surge level two capacity plans when all beds within the clinical support units had been utilised. On review, the plan showed that the trust could increase capacity on the St James's Hospital site by 61 patients (surge level one) and a further 24 patients (surge level two); a maximum capacity of 85 additional patients. On the Leeds General Infirmary site, the trust could further increase capacity by 16 patients (surge level one) and seven patients (surge level two); a maximum capacity of 23 additional patients.
- The SOP identified that no ward could have more than two patients in non-designated areas at once; however, the surge plan (October 2017) indicated that wards J26, J27, J28 and J29 could all have three additional patients located on trollies (surge level one).

- In the August 2017 quarterly non-designated areas audit, data showed that of 225 patients allocated to non-designated areas, 136 patients (60%) had been nursed in the corridor, 39 (17%) in treatment rooms, 24 (11%) in additional beds in bays, and 26 (12%) in other areas; such as day rooms and nurses stations. In January 2018, of 182 patients audited, 107 patients (59%) had been nursed in the corridor, 41 (23%) in additional beds in bays, 16 (9%) in day rooms, and 18 (10%) in other non-designated areas.
- Information provided by the trust showed that from the 1 October 2017 to 22 October 2017, non-designated areas had been in use every day; for 14 of these days, they were in daily use on the St. James's hospital site. The number of patients nursed in non-designated areas ranged from six to 24 per day; the trust provided information to show that this amounted to 1% of the general and acute bed base. From the 30 October 2017 to 12 November 2017, between eight to 27 patients were nursed in non-designated areas every day across the trust. From the 13 November 2017 to 3 December 2017, 15 to 40 patients per day were nursed in non-designated areas across the trust. Usage continued through January.
- At the time of the inspection, the trust was not able to always meet patient's privacy and dignity in relation to the environment they were nursed in. During the inspection, we saw a male and a female patient located in non-designated areas on the same ward corridor on ward J14. The trust did not have a mixed sex accommodation policy, but we reviewed their annual declaration (2016-2017) and noted it was a trust expectation for adult in-patient admissions to be admitted to single sex bays, side rooms, or designated male or female wards. The trust acknowledged that during the winter periods patients of different sexes sometimes spent time on ward corridors whilst a suitable bed was allocated to them. Staff we spoke with said that the use of non-designated areas had not led to any mixed sex accommodation breaches to date. However, incident data we reviewed detailed a member of staff had raised concerns that patients assigned to corridors had breached single sex accommodation policies. Following the inspection, the trust conducted a review of incident reports and did not identify any mixed sex accommodation breaches.
- At the time of the inspection, the trust was not able to provide length of stay data for patients in non-designated areas, as the trust had only recently commenced collecting this data. This is contrary to the requirements of the standard operating procedure, which stipulated that the nurse in charge should monitor the date and time of non-designated areas moves. Post inspection, the trust confirmed they would not be able to provide data until February 2018. At the time of writing this report, this data has not yet been provided. During the inspection, we observed one patient who had been nursed on a corridor for four days, and another patient who had been nursed in a treatment room for four days. We also identified another patient who had been nursed in corridor for four days, but was allocated a bed space in a bay at the time of the inspection. Incident forms we reviewed showed that staff had reported incidences where patients had been nursed in the corridors for several days.
- Incident forms we reviewed showed that on occasions these decisions were made overnight; and at times, patients were woken to be moved into the corridor or other non-designated area. We also saw that patients were sometimes moved into non-designated areas early evening; however, their bedspaces was not reoccupied for some time.
- Staff we spoke with said that patients nursed in non-designated areas could be from their own ward, or they could be medical outliers from another ward.
- Nurses on ward J93 told us that they were raising money for a television and radio that could be used by patients housed in the non-designated area.
- The trust informed us about a number of patients with delayed transfer of care; these are patients who were ready to leave the acute hospital, but required further rehabilitation, treatment, or care in other organisations (for example, nursing, residential, or community care services). Information we reviewed from the trust showed that approximately 2000 bed days per month were lost due to delayed transfers of care. Information for December 2017 showed that on the 11 December there were 113 patients classed as medically fit and awaiting discharge to other organisations.
- The trust was working with independent providers to increase capacity within the organisation, and the trust was due to open additional beds within the organisation through this partnership. The trust had

also run a number of initiatives aimed at improving partnership working including, the "perfect week". Where the trust worked with partners to address and improve patient flow across the system.
- The trust had also extended opening hours in the day unit to increase capacity, and had identified additional spaces that could be re-commissioned into patient bed spaces, Post the inspection this had initially resulted in a reduction in non-designated areas used; however usage continued throughout January.

Meeting people's individual needs

- During the inspection, we observed five patients being nursed in non-designated bed-spaces; three patients were being nursed on the corridor on wards J21 and J14, one patient was located in the middle of bay on ward J47, and one patient was being nursed in a treatment room on J93.
- The SOP had defined criteria to identify patients suitable to be nursed in non-designated areas. At the time of inspection, patients we reviewed met the trust's suitability criteria for nursing in non-designated areas. However, the SOP did not make reference to the assessment or recording of a patient's individual or patient-centred care needs; for example, their location preferences or their capacity to consent to being nursed in a non-designated area. We also noted that patients with communication difficulties, learning disabilities, those living with dementia, immunocompromised patients, and patients with wound infections or vulnerable skin were not excluded from suitability criteria.
- There was a lack of robust assessment of patients' mental capacity in relation to consent to being nursed in non-designated areas. One patient we reviewed who was in a non-designated bed space was living with dementia; and had been nursed on the corridor for four days. The patient was not aware of the reasons they were being nursed on the corridor, and were unable to tell us how long they had been on the corridor for. The current SOP and risk assessment did not take into account patients' mental capacity to be able to consent to be nursed in a non-designated area. The SOP made reference to "moves being carried out in explicit approval of families and carers"; it did not make reference to whether families or carers were in the appropriate legal positions to undertake this decision on the patient's behalf. We reported this to the senior management team at the time of the inspection, and post inspection, the trust provided us with an updated risk assessment covering these issues.
- We observed that non-designated areas environments did not promote the well-being of patients living with dementia; as included in NHS Improvement's dementia assessment and improvement framework October 2017. Patients being nursed on the corridors in ward J14 and J21 did not have access to clocks, to help orientate them to time or place. However ward J14 had been decoratedin a dementia friendly style.
- The use of non-designated areas compromised the privacy and dignity of patients. We found the positioning of non-designated area beds in the middle of bays limited the space available to those nursed in them, and that of neighbouring patients. Patients we spoke with said that staff tried to maintain their privacy and dignity whilst that were being nursed on the corridor, but that this was difficult.
- Due to the limited height and width of the standard privacy screens, their use did not ensure that staff could cover all of the bed space fully and respect patient privacy and dignity at all times.
- Prior to our inspection, the trust said that when patients were nursed on corridors and needed to be examined, staff moved them into other enclosed areas, such as treatment rooms. Nursing and medical staff we spoke with told us that they sometimes had to examine patients in non-designated areas, including on corridors; they acknowledged that the practice was not ideal, but deemed it necessary to allow full assessment of the patient when other areas were not available. No patients we spoke with said that they had been examined, whilst being nursed on a corridor.
- Patients we spoke with said they found being nursed on a corridor "loud" and that they had "slept very little", they also said that the situation "wasn't ideal" and they had "no privacy or confidentiality". One patient highlighted that as they had no access to a call bell, they had to walk to the nurse's station to request pain relief. The same patient said that the light above their bed was always on and they found sleeping difficult; staff had provided an eye mask to help the patient to sleep.
- During the inspection, all patients we reviewed were being nursed on hospital beds and not on trolleys.
- Staff we spoke with said they chose patients to be nursed in non-designated areas who were independent

or fit for discharge; however, at the time of inspection, three patients we reviewed did not have a projected discharge date recorded when they were allocated to a non-designated area on a corridor.
- During the inspection, we observed that staff treated patients with compassion and respect. Patients we spoke with said that they had been listened to, they felt safe, and they were treated with kindness.
- During the unannounced inspection, we carried out a short observational framework for inspection (SOFI) on one area. Through our observations, we saw that patients' mood states were mainly positive or neutral, and interactions with other patients were positive. During the observation, we saw no interactions with staff for the 20 minutes of the observation.
- Staff we spoke with said that on one occasion a patient had asked to be placed in a non-designated bed space in a four-bed bay. The staff had discussed this with the other patients in the room, assessed the space available, and had been able to accommodate the patient's request. As this had been managed successfully, staff felt they would be happy to offer this again should the need arise.
- Staff we spoke with talked about initiatives, such as increasing the use of the discharge lounge, to alleviate pressure on beds and facilitate timely discharge.
- Senior nurses and managers we spoke with described other initiatives to improve patient flow, and relieve capacity and demand pressures. Initiatives included working with an independent health care provider, who provided three on-site wards where patients who were medically fit for discharge could be cared for while waiting for community placements or care packages. A fourth area was due to be opened in January 2018.
- The trust had introduced a frailty unit to help prevent unnecessary admissions of elderly patients, and had implemented a SAFER bundle that aimed to help staff consider reducing patient stays by one day; an initiative that could potentially free up significant bed capacity.
- A discharge liaison team had been introduced to help facilitate complex discharge arrangements and staff were being asked to identify 'Golden patients' who could be discharged before lunchtime.

Learning from complaints and concerns

- Information we reviewed relating to non-designated areas showed that the trust had received four formal complaints and nine patient advice and liaison service (PALS) concerns between March 2017 and August 2017. Between October 2017 and December 2017, the trust received a further three formal complaints and nine PALS concerns; information from the trust showed that most of the complaints revolved around poor communication.
- Staff we spoke with said that they had received many informal complaints from relatives or visitors, about their loved one being nursed in a non-designated area.
- Staff in all areas we spoke with said that the majority of these complaints were dealt with informally by nursing staff or the ward sister. They said that they had often called the matron to speak to patients and their representatives, when they were unable to appease them themselves.
- All staff we spoke with said they apologised to patients who had to be moved to non-designated areas; and that all of these patients had received a letter of apology from the chief executive. During the inspection, only one patient was able to confirm they had received the apology letter and leaflet; one patient confirmed they had not, and two patients were unable to confirm.

Are medical care services well-led?

We inspected but did not rate medical services at this inspection.

We highlighted areas of poor practice where the trust needs to make improvements, these included:

- All staff we spoke with were aware that the use of non-designated areas compromised the privacy and dignity of patients being nursed there and that of neighbouring patients, where applicable; and did not promote a positive patient experience. However, staff we spoke with said that when they raised concerns about the use of non-designated areas, they did not see any apparent action.
- The senior management and executive teams were aware of the lack of suitably qualified staff within medicine at the trust, and they were aware that they did not meet best practice or national guidelines National Quality Board/ AUKUH/1:8 ratio in this respect. As the trust was unable to meet the established levels of nursing staff, senior nursing staff had developed a minimum staffing level; however, it was not clear what guidance this minimum staffing level was based on.

Following the inspection, the trust confirmed it was determined by the head of nursing, however, It was also notable that, at times, the trust was unable to meet this minimum level. The trust had put some mitigation in place including escalation processes and daily staffing reviews.

- There was a lack of robust assessment and documentation of decision making around patients being nursed in non-designated areas. Audits of this information did not provide full assurance that all documented risk assessments were complete, and despite these being discussed at various trust committees, it was not apparent what action had been taken to improve safety.
- A number of incident forms we reviewed showed a theme of nursing staff being overruled in decision making processes around placing patients in non-designated bed areas on corridors; and many made reference to senior managers imposing these decisions. Nursing staff we spoke with said they had raised concerns about the suitability of patients nursed on corridors, and the level of nursing staff available on the ward to nurse additional patients, but did not always feel that they were listened to or supported to share their concerns.
- Information we reviewed showed that the trust had identified patients being nursed in non-designated areas on the corporate risk register; this risk was refreshed in November 2017 and December 2017. Within the clinical support units, non-designated areas had been identified as a risk, and added to the acute medicine and surgery risk registers in December 2017. However, despite identification of mitigating actions, including completing risk assessments on patients nursed in non-designated areas, compliance with risk assessments had not improved.
- The trust was not able to provide us with adequate information about the number and location of patients nursed in non-designated areas, and the length of stay of patients in these areas.

However:

- The senior management and executive teams informed us that decisions to nurse patients in non-designated areas had been made and was supported by the executive, nursing, and medical teams. Evidence we reviewed confirmed that these decisions had been made in August 2017, by the board and at head of nursing meetings. Following the inspection the trust confirmed that this support was given based on the risks presented to patients and to support the management of the risks. The trust had discussed this with local partners prior to the inspection.
- We found that all members of staff were happy to speak with us and share their concerns, the challenges faced, and highlight good practice to us.

Leadership of service

- The medicine core service had recently merged with emergency medicine to form the emergency and speciality medicine clinical service unit (CSU). The CSU had their own business strategies; objectives and goals and was led by a clinical director, a head of nursing and a general manager.
- All staff we spoke with highlighted concerns over staffing levels within medicine; and staff had completed incident forms to raise this issue. The senior management and executive teams were aware of the lack of suitably skilled staff within medicine at the trust, and were aware that they did not meet best practice or national guidelines in this respect. As the trust was unable to meet the established levels of nursing staff, senior nursing staff had developed a separate minimum safe staffing level. Following the inspection, the trust supplied documentation that stated that the established rate of registered nurses could be dropped from four to three when the trust had difficulty recruiting to established levels. However, it was not clear what guidance this minimum staffing level was based. Following the inspection, the trust confirmed it was determined by the head of nursing, however It was also notable, that the trust was sometimes unable to meet this minimum level. The trust did on occasions increase the levels on non-registered staff in these areas when registered nurse levels fell below establishment.Following the inspection the trust confirmed that this was developed by the heads of nursing. The trust also confirmed that they had escalation processes and daily reviews.
- Staff we spoke with and incident reports we reviewed confirmed that staff working on wards had highlighted concerns about the appropriateness of patients being nursed in non-designated spaces; however, they had been overruled by members of the senior management team – as the senior management team had deemed the patients suitable.

Medical care (including older people's care)

Governance, risk management and quality measurement

- The senior management and executive teams informed us that decisions to nurse patients in non-designated areas had been made and was supported by the executive, nursing and medical teams. Evidence we reviewed confirmed that these decisions had been made in August 2017, by the board and at the head of nursing meetings. Three options had been considered, which included holding patients in the accident and emergency department and opening additional wards. The rationale for the decision was to share the risk of additional patients across all clinical support units, to improve staffing levels and staff morale.
- Staff we spoke with and information we reviewed confirmed that the trust had only recently started recording the number and location of patients in non-designated areas, two months prior to the inspection. At the time of the inspection, the trust did not have a system to record the length of stay of patients nursed in non-designated areas, and information provided post inspection showed that this data would not be available until February 2018. At the time of writing this report, the trust remain unable to provide this data.
- The trust undertook peer audits of risk assessments completed on patients in non-designated areas; however, these did not provide full assurance that that all required risk assessments were completed, that patients had access to call bells or were being nursed in appropriate areas. Audit data had been discussed at risk and quality meetings within the trust. However, from minutes we reviewed, we did not see assurance of challenge from the committees; for example, the quality audit report was discussed at the September 2017 quality management group, yet minutes from the November and December 2017 meetings do not refer to further discussion of non-designated areas. We saw that concerns had been raised about medical involvement in risk assessments, and the chief medical officer had sent a letter to consultants setting out expectations of managing patients in non-designated areas.
- Information we reviewed showed that the trust had identified patients being nursed in non-designated areas on the corporate risk register, and this risk was refreshed in November and December 2017. Patient flow and capacity for emergency admissions risks were refreshed in November 2017. Within the clinical support units, non-designated areas had been identified as a risk and added to the acute medicine and surgery risk registers in December 2017. However, within elderly care and emergency medicine, the risk had been recorded since April 2017. However, despite identification of mitigating actions, including completing risk assessments on patients nursed in non-designated areas, compliance with risk assessments had not improved.
- The September 2017 governance meeting minutes and the logs for acute medicine and older people both identified concerns about patients being nursed on corridors; however, neither identified any specific actions that the clinical support unit could take in relation to this issue. This remained the case in the October 2017 and November 2017 minutes and action logs.

Culture within the service

- Staff we spoke with said that seeing patients nursed on hospital corridors was "normal"; they all said that the situation was "not ideal", and they did not like having to nurse patients on corridors. All staff we spoke with were aware of the reasons why the trust made the decision to locate patients in non-designated bed-spaces. The majority of the staff we spoke with said they felt they had no choice in the matter and felt unable to challenge the decision. All staff we spoke with raised concerns about nursing patients in non-designated areas; however, they said that when they raised concerns they did not see any apparent action and did not receive feedback.
- All of the staff we spoke with on Wards J93 and J96 said they were unhappy with the use of non-designated areas; however, felt that this was the safest option for patients under the current circumstances. Staff felt that this option ensured patients were treated as part of a ward cohort of patients and received the same level of care as other patients, and they felt that patient safety was maintained and patients received better continuity of care. There was a determination amongst managers and staff that the current situation was not good enough, and managers and staff would continue to strive to make improvements and ensure patient safety.
- From October 2017 to December 2017 we received information from staff working at the trust, which

highlighted concerns in medicine about staffing levels, patients being nursed in corridors and the use of additional beds in wards, and a lack of privacy and dignity for patients when screens were not available.

Public engagement

- Information we received post inspection acknowledged that the trust needed to do more engagement work with the public around capacity issues and winter plans. The trust had engaged with the local authority Scrutiny Board and Healthwatch regarding system wide pressures and discussed this in the public meeting of the Trust Board, prior to the inspection.

Staff engagement

- Staff we spoke with said that they were aware of different options to deal with winter pressures, such as opening a winter ward or sleeping patients in the emergency department. Staff we spoke with on wards J93 and J96 believed that having one or two additional patients on wards was the best option available for the patients and the trust. They felt that with current staff shortages, an additional ward could not be safely staffed and that this would mean removing staff from other wards; with the subsequent result that those they too would become short staffed. Staff in these areas also felt that they had been listened to when the trust had made this choice.
- Managers we spoke with said that in addition to maintaining patient safety, the use of non-designated areas also meant that staff had continuity in their own area, specialist staff would not be de-skilled by being moved to another area, and staff morale and retention would be better than if staff were moved to an area not of their choosing. There was wide acknowledgement that in a climate of qualified nursing shortages, the trust needed to maintain staff morale and job satisfaction as much as possible if they were to retain the staff they had.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that at all times there are sufficient numbers of suitably qualified staff; taking into account best practice, national guidelines, and patients' dependency levels.
- Ensure that when non-designated areas are used, the privacy and dignity of patients being nursed in bays or corridors are maintained and the location used is suitable to meet patients' needs.
- Ensure there is robust assessment and documentation of decision making for patients being nursed in non-designated areas; including assessment of mental capacity to consent to being nursed in a non-designated area, reasons for deviation from the relevant operating procedure, and individual patient needs and preferences.
- Ensure that there is robust oversight of patients being nursed in non-designated areas, including assurance that risk assessments are being conducted appropriately and that decisions to deviate from the operating procedure are clinically appropriate.
- Ensure data is collected on the number, location, and length of stay of patients in non-designated areas.
- Ensure that staff reporting concerns over non-designated areas are supported to do so and receive appropriate feedback.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care (1) The care and treatment of service users must- (b) meet their needs, and (c) reflect their preferences.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect (2) (a) ensuring the privacy of the service user

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (d) ensuring the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

Regulated activity	Regulation

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Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems and processes must be established and operated effectively to: (2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.