Care Quality Commission

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Doncaster Royal Infirmary

Quality Report

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Date of inspection visit: 27 to 29 November 2018
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Urgent and emergency services	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focussed unannounced inspection of the urgent and emergency care services at Doncaster Royal Infirmary on 27-29 November 2018. This inspection was to follow up concerns identified at our previous inspection in December 2017. In December 2017, we had concerns around the initial assessment process, paediatric nurse staffing levels, paediatric advanced warning scores (PAWS) were not always completed, compliance with mandatory training, including adult and paediatric life support was low, and there was a significant backlog of incidents that needed reviewing.

We inspected all five domains - safe, effective, caring, responsive and well led. At our previous inspection, safe, effective, responsive and well led had been rated as requires improvement. Caring was rated as good. This inspection was to see whether the required improvements had been made.

Following the inspection, we told the trust it must provide assurance that risks to patients were being addressed. The trust provided an initial action plan detailing actions to be taken to address the risks to patients. Further assurance was provided to us through regular updates and the trust established a working group to address the concerns we raised.

Our rating of this service stayed the same. We rated it as **Requires improvement** overall. Safe was rated as inadequate. Effective, responsive and well led were rated as requires improvement. Caring was rated as good.

- Concerns identified at the previous inspection had not been fully addressed. We still had concerns about the risks posed to patients and the potential to cause harm.
- When patients attended the emergency department (ED), adults and children stood in a queue waiting for triage/ initial assessment. At the last inspection, we found there was no clinical oversight of this queue and we told the trust it must review this. Although the trust had now introduced 'floor walkers' to monitor the queue, they were unqualified staff (i.e. a band 2 receptionist, who had received little or no training). This presented an ongoing risk, as unwell or deteriorating patients would not always be identified.
- The initial assessment was taking place in an environment not conducive to privacy and confidentiality. This also meant that full assessments, including observations and a full visual assessment were not taking place.
- Paediatric advanced warning scores (PAWS) were not calculated consistently. We were concerned that this did not allow for early identification and prompt treatment for children who were deteriorating.
- At our last inspection in December 2017, paediatric nurse staffing had been identified as an issue. Although service leads told us they had improved paediatric nurse staffing, since our previous visit there had not been recognition that there were insufficient paediatric nurses to provide safe and high-quality care. In addition, the paediatric training for adult trained nurses did not appear to have been addressed.
- Paediatric nurse staffing and medical staffing did not meet national guidance. Not all staff had the correct skills and competencies to support paediatric patients, including paediatric life support.
- Safeguarding adults and children training compliance for medical staff was low. Additionally, the safeguarding level three training did not comply with national guidance, as it was completed online.
- The room used for patients with mental health needs was not in line with national standards. Although staff had completed a risk assessment and there were plans for changes to the room, this had not been identified on the risk register as a risk. It only appeared on the risk register as a risk due to its proximity to the paediatric waiting area.
- Other risks identified at the inspection had not been identified on the risk register, or where they had been identified they had not been flagged as a significant risk.

Summary of findings

- Not all medicines were stored securely and fridge temperatures were not monitored in line with trust guidance.
- The trust was failing to meet most of the standards in the Royal College of Emergency Medicine (RCEM) audits.
- The trust's unplanned re-attendance rate to ED within seven days was worse than the national standard.
- The service did not meet the trust target for completion of appraisals.
- Staff morale in the department was low and we received mixed feedback about the leadership of the department. Some staff told us they felt that there was lack of support from senior staff.

However:

- More staff had been recruited to investigate incidents to help reduce the backlog that had been identified at our last inspection.
- Staff's understanding of the mental capacity act had improved since our last inspection.
- There was evidence of effective multidisciplinary working.
- Staff were caring and compassionate. We received positive feedback from patients.
- Managers worked closely with the clinical commissioning group and other stakeholders to try to provide appropriate services for patients.
- There was a new minor injuries unit, which meant there was an alternative pathway for those patients attending the department with minor injuries. This had also created extra space in the main department and staff had ideas for how to utilise the space more effectively.
- From November 2017 to October 2018, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.
- From November 2017 to October 2018, the trust's monthly median total time in A&E for all patients was similar to the England average.
- There were governance structures and processes in place.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with five requirement notices. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated this service as requires improvement. Safe was rated as inadequate. Effective, responsive and well led were rated as requires improvement. Caring was rated as good.

Doncaster Royal Infirmary

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Doncaster Royal Infirmary

Doncaster Royal Infirmary (DRI) is one of the acute hospitals forming part of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. There are almost 600 beds. It provides a full range of acute clinical services to the local population including:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostic imaging
- Critical care
- End of life care
- Children and young people's services
- Breast care unit
- Renal unit

We inspected urgent and emergency care services to follow up concerns raised at our previous inspection. We carried out an unannounced inspection between 27-29 November 2018.

To get to the heart of patients' experiences of care and treatment, we 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.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, the CQC national professional advisor for urgent and emergency care, and a specialist advisor with expertise in urgent and emergency nursing. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about Doncaster Royal Infirmary

From August 2017 to July 2018 there were 167,240 attendances at the trust's urgent and emergency care services.

The percentage of A&E attendances at this trust that resulted in an admission was 14.6% compared to the national figure of 19.3%

From December 2017 to November 2018 there were 19,642 paediatric attendances.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

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We inspected all five domains - safe, effective, caring, responsive and well led. At our previous inspection, safe, effective, responsive and well led had been rated as requires improvement. Caring was rated as good. This inspection was to see whether the required improvements had been made.

Following the inspection, we told the trust it must provide assurance that risks to patients were being addressed. The trust provided an initial action plan detailing actions to be taken to address the risks to patients. Further assurance was provided to us through regular updates and the trust established a working group to address the concerns we raised.

Urgent and emergency services

Our rating of this service stayed the same. We rated it as **Requires improvement** overall. Safe was rated as inadequate. Effective, responsive and well led were rated as requires improvement. Caring was rated as good.

- Concerns identified at the previous inspection had not been fully addressed. We still had concerns about the risks posed to patients and the potential to cause harm.
- When patients attended the emergency department (ED), adults and children stood in a queue waiting for triage/initial assessment. At the last inspection, we found there was no clinical oversight of this queue and we told the trust it must review this. Although the trust had now introduced 'floor walkers' to monitor the queue, they were unqualified staff (i.e. a band 2 receptionist, who had received little or no training). This presented an ongoing risk, as unwell or deteriorating patients would not always be identified.
- The initial assessment was taking place in an environment not conducive to privacy and confidentiality. This also meant that full assessments, including observations and a full visual assessment were not taking place.
- Paediatric advanced warning scores (PAWS) were not calculated consistently. We were concerned that this did not allow for early identification and prompt treatment for children who were deteriorating.
- At our last inspection in December 2017, paediatric nurse staffing had been identified as an issue. Although service leads told us they had improved paediatric nurse staffing, since our previous visit there had not been recognition that there were insufficient paediatric nurses to provide safe and high-quality care. In addition, the paediatric training for adult trained nurses did not appear to have been addressed.
- Paediatric nurse staffing and medical staffing did not meet national guidance. Not all staff had the correct skills and competencies to support paediatric patients, including paediatric life support.
- Safeguarding adults and children training compliance for medical staff was low. Additionally, the safeguarding level three training did not comply with national guidance, as it was completed online.
- The room used for patients with mental health needs was not in line with national standards. Although staff had completed a risk assessment and there were plans for changes to the room, this had not been identified on the risk register as a risk. It only appeared on the risk register as a risk due to its proximity to the paediatric waiting area.
- Other risks identified at the inspection had not been identified on the risk register, or where they had been identified they had not been flagged as a significant risk.
- Not all medicines were stored securely and fridge temperatures were not monitored in line with trust guidance.
- The trust was failing to meet most of the standards in the Royal College of Emergency Medicine (RCEM) audits.
- The trust's unplanned re-attendance rate to ED within seven days was worse than the national standard.
- The service did not meet the trust target for completion of appraisals.
- Staff morale in the department was low and we received mixed feedback about the leadership of the department. Some staff told us they felt that there was lack of support from senior staff.

However:

- More staff had been recruited to investigate incidents to help reduce the backlog that had been identified at our last inspection.
- Staff's understanding of the mental capacity act had improved since our last inspection.
- There was evidence of effective multidisciplinary working.
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Urgent and emergency services

- Managers worked closely with the clinical commissioning group and other stakeholders to try to provide appropriate services for patients.
- There was a new minor injuries unit, which meant there was an alternative pathway for those patients attending the department with minor injuries. This had also created extra space in the main department and staff had ideas for how to utilise the space more effectively.
- From November 2017 to October 2018, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.
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Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Are urgent and emergency services safe?

Inadequate

Our rating of safe went down. We rated it as **Inadequate** because:

- At our last inspection we had concerns about the initial assessment of patients. Although the trust had implemented changes, such as the introduction of a floor walker, we still had concerns about the initial assessment process and the risk that was posed to patients. The floor walkers were band two or three staff, who had received little or no training, and the initial assessments frequently did not include a set of observations or a proper visual assessment.
- We were concerned that those children at risk of deterioration would not be identified early and receive prompt treatment. Paediatric advanced warning scores (PAWS) were not calculated consistently. From our observations of paediatric patients, and from our review of patient records we noted staff did not complete or record a full set of observations at initial assessment. We found there were long waits from initial assessment until a set of observations were done.
- Paediatric nurse staffing was not in line with national guidance. Only one paediatric nurse covered each shift, which meant when the nurse was transferring a child to the ward or was with a child in resus, the paediatric area was left without appropriate cover. Adult trained staff did not have the required paediatric competencies.
- Safeguarding training compliance remained low for medical staff. Only 32% had completed safeguarding children level three training. This had also been identified at our last inspection.
- Staff told us they could complete their safeguarding training online. However, this does not comply with intercollegiate guidance for level three safeguarding training.
- Although staff understood their responsibilities with regards to safeguarding, we were concerned that, due to the initial assessment process, safeguarding cases may not be properly highlighted. Minutes from a paediatric ED liaison meeting held in July 2018 had also noted concerns with safeguarding practice and lack of documentation at triage. It was noted that regardless of the amount of input from safeguarding to help ensure

information gathering/ assessment was thorough by ED staff, there was still a concern that staff were not completing this. An action noted from that meeting was for teaching to take place.
- There was no consultant with a paediatric emergency medicine (PEM) qualification. This had been identified at our last inspection. At this inspection, although there was a paediatric lead they had not fully completed the PEM training.
- Infection control policies were not always complied with.
- The environment was not conducive to preserving privacy, dignity and confidentially. Patients in the ambulance handover bay and the overflow area of the main department were nursed next to each other with no screens between them. Initial assessments took place in view of other patients.
- In the resuscitation room, we found that one of the bays had suction equipment missing and another had a monitor missing. We could not find checklists for neonatal emergency equipment checking and the nurse in charge was unsure where they were located.
- The room used for patients with mental health needs was not in line with national standards for liaison psychiatry services.
- Fridge temperatures were not recorded in line with the trust guidance. Not all medicines were stored in locked cupboards.

However:

- At our last inspection, there had been a backlog of incidents that had not been reviewed. At this inspection, they had recruited more staff who were qualified to investigate incidents and they were in the process of catching up with the backlog.

Mandatory training

- There was a clinical educator in post who supported staff's training needs. New staff attended a corporate induction day and completed a preceptorship course, which included mandatory training.
- At our last inspection in December 2017, mandatory training compliance rates were low. Staff told us at this inspection that they had completed their mandatory training. The clinical educator told us that staff had some allocated time now to complete training.
- Data provided by the trust showed that mandatory training compliance rates at the end of March 2018 were 60.62%, against a target of 90%. Compliance rates for the current year showed that at December 2018, compliance was 69.8%. However, these were not broken down by subjects or between nursing and medical staff, we are therefore unable to compare them with the mandatory training compliance rates reported on at our last inspection.

Safeguarding

- We saw up to date safeguarding adults and safeguarding children policies.
- Staff were aware of their responsibilities with regards to safeguarding. There were processes in place for the identification and management of adults and children at risk. However, due to our concerns around the initial assessment process and the robustness of the assessment, we could not be certain that all safeguarding cases were appropriately highlighted. We reviewed minutes from a paediatric ED liaison meeting on July 2018, which noted that there were concerns with safeguarding practice in ED and the lack of information documented at triage. It was noted that regardless of the amount of input from safeguarding to help ensure information gathering/ assessment was thorough by ED staff, there was still a concern that staff were not completing this. An action noted from that meeting was for teaching to take place. It is unclear whether this training had taken place.
- Staff we spoke with told us that the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) had now been incorporated in to the safeguarding training.
- At our last inspection in December 2017, compliance with safeguarding training was low. At this inspection, we were told that there was improved compliance as there had been a focus on ensuring staff completed the training. However, we were told that staff could complete the training online, which does not meet the intercollegiate guidelines for level three training. The Royal College of Paediatrics and Child Health (RCPCH) intercollegiate guidelines (2014) state that E-learning

can be used at level three as preparation for reflective team based learning. Level three training should be multi-disciplinary and inter-agency, and delivered internally and externally.

- Data provided by the trust showed that at 31 October 2018, nursing staff compliance for level two safeguarding adults was 93%, safeguarding children level two was 100% and safeguarding children level three was 83%. Compliance by medical staff remained low, at 17% for safeguarding adults level two and 32% for safeguarding children level three. This data showed that there had been an increase in compliance for the nursing staff, but medical staff still had low compliance rates.

Cleanliness, infection control and hygiene

- All areas looked visibly clean and we observed cleaning staff cleaning cubicles after patient use. We saw staff cleaning mattresses after use.
- At our last inspection in December 2017, we found most mattresses were damaged, this posed an infection risk. At this inspection, we saw some mattresses that had small tears in them. Weekly ward assurance rounds were completed with the matron and housekeeper reviewing the department. We checked assurance round documentation and found it included a question asking if mattresses were intact. However, we saw that this question had not been routinely answered.
- A mattress audit carried out by the trust between 27 and 29 November showed that 17 out of 28 trolleys needed a new mattress. There was no indication on the audit of when this would happen. Following the inspection, we were told they were due for replacement in April 2019.
- Hand hygiene practice was variable. Although we saw most staff washing their hands or using hand gel in line with the policy, we observed staff at the initial assessment desk not cleaning their hands between patients. We saw several staff who were wearing multiple rings with either stones or grooves in them. This did not comply with the trust hand hygiene policy and the bare below the elbows initiative, which says that only one plain ring can be worn.
- Infection prevention and control audits completed by the trust showed an overall score of 82.9% in October 2018 and 95.9% in December 2018.
- We saw that bins were used properly for the correct waste. Sharps bins were not over full and were correctly labelled.
- Personal protective equipment, such as gloves and aprons, were available and we saw staff using them appropriately.

Environment and equipment

- The early senior review area, where ambulance handovers took place, was cramped and did not preserve confidentiality, privacy or dignity for patients. This area could contain up to four trolleys, if there were more than four patients waiting then they had to wait in the ambulance outside. There was only one paper screen available in this area, there was no confidentiality as other patients could hear the handover from ambulance personnel to ED staff. There was no privacy to be able to carry out a full examination and the area was cold due to the opening of the doors to the ambulance bay.
- In the green zone, there was a central area where patients on trolleys, waiting for medical assessment, were placed when all the cubicles were full. The trolleys were next to each other, in very close proximity, with no privacy screens between them and no access to call bells. This therefore meant that there was no privacy, dignity or confidentiality.
- The initial assessment desks were in the main waiting area in reception. This meant that there was no privacy or confidentiality as initial assessments were taking place in full view of other patients.
- The resuscitation room had six bays, one of which was equipped for children. During our inspection, we noted that one of the bays had suction equipment missing. We saw that there was suction available on the trolley but there were no checklists for the checking of this suction and we were therefore not assured that this would be working correctly. We escalated this to staff at the time of our inspection.

When we returned to this area later, we observed a patient being nursed in the bay, but there was still no suction available. We escalated this to the matron, who ensured the suction was fixed.

- One of the bays in the resuscitation area had a monitor missing. Staff told us that it had been missing for several months. They had a portable monitor for use in this cubicle but no time frame for when they would receive a new fixed monitor.
- There was a separate children's waiting area, which contained appropriate toys and games. Three cubicles were allocated as the paediatric cubicles.
- At our last inspection in December 2017, we noted that the room used for patients with mental health needs was not in line with the quality standards for liaison psychiatry services. At this inspection, we saw that the room still did not comply with standards. Staff told us that a risk assessment had been undertaken and they were waiting for the estates department to undertake improvements. The risk assessment had identified several actions to be taken including removing a sink, cupboard and radiator, changing doors and removing furniture.
- Equipment that we looked at, had been electrical safety tested.
- We saw up to date checklists for checking of resuscitation equipment. However, we could not find a checklist for the neonatal emergency equipment and the nurse in charge was unsure where this was located. We could not be assured that the equipment had been checked regularly.
- The department had opened a separate minor injuries unit, staffed by emergency nurse practitioners, where patients with minor injuries were sent after initial assessment. This area had a reception desk and waiting area, three consulting rooms and a treatment room.
- The clinical decisions unit (CDU) had 12 beds and four chairs. This provided a spacious, pleasant environment for patients.

Assessing and responding to patient risk

- At our last inspection In December 2017, we had concerns about the initial assessment of patients. This included the wait for initial assessment and the initial assessment process. At this inspection, we still had concerns about this process and the risk to patients.
- At our last inspection in December 2017, we observed patients waiting in a long queue for initial assessment. Whilst we did not see any long queues at this inspection, staff we spoke with told us the queue could still build up. The service had introduced floor walkers to identify when the queue was increasing and to escalate any patients they felt were seriously unwell. The emergency nurse practitioners, based in the minor injuries unit, also took patients from the queue to do an initial assessment, when they were not busy in the minor injuries unit. However, the floor walker was a band two or three and had received little or no training. When we spoke with the staff, they told us that they would escalate those patients that they thought looked more unwell, however there was a risk that a deteriorating patient may not be recognised. When the queue became longer than five patients this was escalated to the nurse in charge. Staff we spoke with told us that staff would be pulled from other areas, such as the resuscitation area, to cover the initial assessments. They told us this meant that one nurse could be left alone in the resuscitation area with up to six patients.
- The Royal College of Emergency Medicine (RCEM) recommends that all patients attending the emergency department should be registered within five minutes of arrival. At the time of our inspection, the time of arrival in the department was not captured and it was therefore unclear how long patients had been in the department before initial assessment. This had been identified at our last inspection in December 2017. There were plans in place for the introduction of electronic check in, which would capture the time that the patient had entered the department. This was due to start on the last day of our inspection, but when we spoke to staff they told us they had not been made aware of that and had not received any training on the electronic check in system.
- The initial assessment did not routinely include a full set of observations and a proper visual assessment was limited due to the assessment taking place in an

open environment, which did not allow for the removal of clothes. Staff we spoke with told us that on occasions they may take patients in to the side room to assess, if the room was free, but in the majority of cases this did not happen. Whilst we were on inspection we only saw one patient been taken to the side room for assessment. We reviewed 10 adult patient records, one patient, who attended with a mixed overdose and chest pain had an initial assessment at 6.39pm but did not have any observations recorded until 8.03pm. Another patient with abdominal pain was seen for initial assessment at 4.24pm but did not have any observations completed until 5.43pm.

- The Royal College of Paediatrics and Child Health (RCPCH) (2018) recommends that all children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented with a pain score and a full record of vital signs. Any child with abnormal vital signs identified at triage should have observations repeated within 60 minutes or earlier for serious conditions. A full assessment should be completed by a decision maker with paediatric competence within 60 minutes or earlier according to clinical urgency as identified at triage. During our inspection we observed a child with a head injury who had been brought in by ambulance. They had been sent to the children's waiting area, with no observations carried out on arrival at the department, and had been waiting for an hour and a half when we spoke to them. We escalated this to the matron, who acted to ensure the child was seen.

- We reviewed 10 paediatric patient records and found delays between the initial assessment and any observations been carried out. For example, a 14-month old seen with a temperature of 39.1 and vomiting had an initial triage at 12.29am, they did not see a doctor until 2.39am and had repeat observations undertaken at 2.49am. There was no septic screen undertaken. We saw in records that a 37-week-old baby arrived at 1.02am with a temperature of 39.5. They had no further observations done and did not see a doctor until 2.50am. A 36 week old arrived at 8.22pm with breathing problems, they did not have observations recorded until 12.01am and did not see a doctor until 12.31am. An eight year old arrived at 8.02pm with gastrointestinal symptoms, observations were not completed until 11.17pm and the doctor saw them at 11.50pm.

- We saw that paediatric advanced warning scores (PAWS) were not always calculated and therefore staff may not be alerted to early identification of deterioration. We asked the trust to provide us with the results of PAWS audits for the last three months, however, these had not been done and we were sent a snap shot audit of 10 records from November. This showed that in six out of the 10 records, no blood pressure and therefore no PAWS score had been recorded. This had been identified at our last inspection as an area for improvement.

- Following our inspection, we formally wrote to the trust under section 31 of the Health and Social Care Act (HSCA) and asked them to provide us with an action plan and regular updates to evidence how they would address the immediate risks to adult and paediatric patients, to confirm that there was appropriate clinical oversight in place for the assessment and monitoring of patient risk and to ensure effective triage assessment and early warning score for children was in place. The trust took immediate action following our feedback, to change the way the initial assessment was carried out. We were satisfied that no immediate enforcement action needed to be taken.

- The median time from arrival to initial assessment, for emergency ambulance cases only, was better than the overall England median from October 2017 to September 2018. In the most recent month, September 2018, the median time to initial assessment was 5 minutes compared to the England average of 8 minutes. At our last inspection, we saw that patients arriving by ambulance were not booked in until the ambulance crew had handed over the patient. Patients waited outside in the ambulance if the ambulance assessment bays were full. At this inspection, we found that patients still waited outside in the ambulance if the assessment bays were full. However, we were told at this inspection the ambulance crew would push an arrival button to record the time of arrival.

- The early senior review area was where patients arriving by ambulance were assessed. A tier four or above doctor covered this area along with a nurse and a healthcare assistant. Patients were assessed in this area and investigations started before being taken through to the green area.
- From October 2017 to October 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Doncaster Royal Infirmary. The overall performance was between 30-40%.
- Staff had access to referral pathways for the mental health liaison team and child and adolescent mental health (CAMHS) team. There was a standard operating procedure for mental health streaming by the triage nurse. However, we saw that this had a review date of 2016, there was therefore a risk that staff may be working to out of date guidance.

Nurse staffing

- Nurse staffing had been assessed using the Baseline Emergency Staffing Tool (BEST). The BEST tool is a nationally recognised workforce planning tool. A business case had been put forward for adjustments to the skill mix in response to the outcome of the BEST tool, as more senior nurses were required.
- Planned staffing levels were 12 trained staff for an early shift, 15 trained staff for a late shift and 12 trained staff for a night shift.
- Nursing staff were allocated areas to cover for each shift. Only one qualified nurse was allocated to resus, to cover six beds. Staff we spoke with told us that nursing staff from the green area (patients waiting for assessment) in the department would be pulled in to cover resus if it became busy. This would leave the green area with one member of qualified nursing staff.We were also told that when there was more than one nurse in resus, a nurse could be pulled to cover streaming if a queue was beginning to develop, which would leave one qualified nurse in resus.
- Band four associate nurse practitioners had been employed to provide extra cover.
- One paediatric nurse was allocated to each shift. However, this nurse was required to transfer patients to the ward and help in resus if a child attended. This meant that the paediatric department could be left without a paediatric-trained nurse. Guidance from the Royal College of Paediatrics and Child Health (RCPCH) (2018) says that there should be two paediatric nurses present on each shift. Adult nurses covering the department should have training to ensure they have the relevant skills and competencies to care for infants, children and young people. Following our inspection, we asked the trust to provide us with evidence of how they would achieve this going forward. The trust told us that following our inspection they were actively recruiting more paediatric nurses. Immediate actions taken were to increase their temporary staffing arrangements to provide 24-hour cover with two paediatric nurses.
- During our inspection, the paediatric nurse on night duty had been moved to work on the paediatric ward, due to staffing issues and patient dependency. We were told by the service leads that this was an isolated incident and had not happened previously. However, on reviewing minutes from the paediatric ED liaison meeting, evidence showed that paediatric ED staff had previously been moved to support the paediatric ward. The trust advised that moving staff between departments was undertaken based on a risk assessment of the demand, acuity and dependency of patients.
- A band seven paediatric nurse worked across both hospital sites to provide paediatric leadership. Service leads told us that they had trialled having a paediatric healthcare assistant supporting the paediatric area and were now working on a business case to provide this.

Medical staffing

- There were 13 whole time equivalent (WTE) consultants, four of which were locums. Consultant cover in the department was from 7.30am until 10pm or midnight. Around 50% of shifts were covered until midnight. The Royal College of Emergency Medicine (RCEM) guidance recommends 16 hours a day of consultant presence. The consultant presence had increased since our last inspection.
- RCPCH guidance says that every emergency department treating children should be staffed with a paediatric emergency medicine (PEM) consultant with

dedicated session time allocated to paediatrics. The department did not have a PEM consultant. There was a paediatric lead consultant, who had completed one year of PEM training but had not completed the competencies.

- There were 15 middle grades on the rota, around 30% of the rota was covered by locum middle grades. Two to three middle grades covered the department at night. The service lead told us that they tried not to cover nights with locum middle grades. If there was no tier four middle grade available overnight then a consultant had to stay.
- A programme was in place for developing doctors from overseas so that they could apply for a certificate of eligibility for specialist registration (CESR).

Records

- Paper records and electronic records were used. Any paper records were scanned on to the electronic system following discharge or transfer from the department.
- Discharge summaries were generated and posted to GP's.
- Records we reviewed contained appropriately completed documentation. However, it had been highlighted in the September/October 2018 emergency department newsletter, that there were ongoing problems with lack of documentation. Staff had timely access to records.

Medicines

- At our last inspection, we found that fridge temperatures were not checked regularly. At this inspection, we saw that regular checks had been completed, but these only recorded the current temperature and not the minimum and maximum temperature. This was not in line with the trust guidance which said that a record should be made of minimum and maximum temperatures and any action taken where temperatures fall out of the accepted range should be recorded.
- At our last inspection, we found that controlled drug (CD) balance checks were not always carried out. At this inspection, we found that all checks had been completed.
- We found that not all medicines were stored in locked cupboards. The fridge in the pharmacy room was found to be unlocked, but this room was accessed by a swipe card, therefore no unauthorised persons could access the room. However, we also found the fridge in a resus bay to be unlocked.
- Medicines were not always locked away within the triage area, for example we saw that medicines were dispensed from a trolley. This meant that there was access to the medicines by anyone using the area. We saw that reception staff would also use this area.
- We saw that intravenous fluids containing potassium were stored appropriately.
- Patient group directions (PGD's) were used for nursing staff at initial assessment to be able to administer medicine. We saw completed PGD's that were up to date.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From October 2017 to September 2018, the trust reported no incidents classified as never events for urgent and emergency care.
- In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018.
- Staff were aware of the duty of candour and patients were informed when something went wrong, given an apology and told of the actions taken as a result.
- Staff knew how to use the electronic system to report incidents and received feedback about incidents.
- At our last inspection, we saw that there was a backlog of incidents that had not been reviewed. At this inspection, we spoke with the clinical director who told us that they had recruited more people qualified to investigate incidents, to catch up with the backlog.

Urgent and emergency services

- The emergency department did not have separate morbidity and mortality meetings but attended a trust wide meeting. Any unexpected deaths or potentially avoidable deaths were reviewed in the department and discussed at clinical governance meetings. We saw from clinical governance meeting minutes that mortality and morbidity was a standing agenda item.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Our rating of effective stayed the same. We rated it as **Requires improvement** because:

- Not all staff had the correct skills and competencies to support paediatric patients. This included additional training for paediatric resuscitation.
- The RCEM audit results remained the same as at our last inspection in December 2017. The trust was failing to meet most of the standards, implementation of evidence based practice was variable.
- Appraisal rates did not meet the trust's set standard of 90%.
- The trust's unplanned re-attendance rate to A&E within seven days remained worse than the national standard of 5%. In the most recent month (September 2018) trust performance was 8% compared to an England average of 8.5%, this had increased from the previous year where it was 7.6%.
- There were paper copies of guidelines in the department that were out of date. There was therefore a risk that staff could be following out of date guidance. This had been highlighted at the previous inspection.

However,

- There had been improvements since our last inspection in relation to staff's knowledge and understanding of the Mental Capacity Act.
- There was evidence of good multidisciplinary working. A rapid assessment programme team was in place to review patients to enable them to return home with additional help. This helped prevent admission to a hospital ward.
- Patients were regularly offered food and drink and this was documented within patient records.

Evidence-based care and treatment

- Department policies were based on National Institute for Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines. Up to date NICE guidance was displayed in the department for staff to review.
- Guidelines and policies were available on the intranet. We saw that these were up to date. However, we also saw paper copies of guidelines in the department which were out of date. There was therefore a risk that staff could be following out of date guidance. This had been highlighted at our previous inspection.
- The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments. Action plans were in place to improve areas in the audit that were not at the required level.
- The department had created a computer programme named 'MY ED', this contained relevant pathways and protocols for staff to use which were up to date and relevant. We saw that staff used the programme as a point of reference and to ensure they were following current guidelines.
- We saw that management guidelines were in place for sepsis and fractured neck of femur.

Nutrition and hydration

- Water fountain and vending machines were accessible in the waiting area of the department.
- Patients were offered food and drinks. Tea and coffee facilities were available for patients and relatives in the main area of the department. For patients who were in the department for a period of time or within the clinical decision unit (CDU) meals could be provided. We saw on patients records that they had documented when the patients had been provided with food and drink.
- In the CQC Emergency Department Survey, the trust scored 6.4 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts.

Urgent and emergency services

Pain relief

- We saw that patients were given analgesia at the point of triage to provide pain relief. Patients told us that staff responded promptly to administer pain relief medication.
- In the CQC Emergency Department Survey, the trust scored 4.3 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was worse than other trusts.
- The trust scored 7.2 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Patient outcomes

- The RCEM audit: moderate and acute severe asthma 2016/17 remains the same as reported in our previous report. The trust failed to meet any of the national standards. The department was in the lower UK quartile for standard four and nine. The department's results for the remaining five standards were all between the upper and lower quartiles.
- The RCEM audit: consultant sign-off 2016/17 remains the same as reported in our previous report. The trust failed to meet any of the national standards. The department was in the upper quartile for two standards and lower quartile for one standard. The department's results for the remaining standard was not reported.
- The RCEM audit: sremains the same as reported in our previous report. The trust failed to meet any of the national standards. The department was in the upper quartile for one standard and lower quartile for four standards. The department's results for the remaining two standards were all between the upper and lower quartiles.
- We observed action plans were in place from findings of the audits and actions to be taken to meet the recommendations.
- From October 2017 to September 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% but about the same as the England average. In the most recent month, September 2018, trust performance was 8% compared to an England average of 8.5%. This had been an increase from the previous year where it was 7.6%.

Competent staff

- Staff completed triage training to support and understand the needs of the patient when attending the department.
- Paediatric advanced warning scores (PAWS) training was available for staff to complete. Data provided by the trust showed that 96% of staff had completed PAWS training.
- Vital signs training was competency and assessment based. To ensure that staff were competent, there were three levels to complete. Level two was completing the training and level three was being able to perform the observations independently. Staff were required to perform the procedure with an appropriate clinician who would provide an assessment of the procedure. Some staff we spoke with told us that they found it difficult to complete this due to time and staffing constraints. We saw on some staff records that they had completed the training but were not at level three where they could perform the paediatric observation independently. We were told that 14 members of staff had completed vital signs training and there were 48 ongoing packages.
- In data supplied by the trust we saw that 27 out of 63 (43%) adult trained nurses had up to date paediatric immediate life support (PILS) training and 12 out of 25 (48%) had up to date advanced paediatric life support (APLS) training. This meant that we were not assured that staff had the correct skills to manage life threatening situations for children.
- Out of nine paediatric trained nurses, three had completed the PILS course and three had completed the APLS course. Three of the paediatric trained staff had not completed PILS or APLS.
- For medical staff, 10 out of 27 (37%) had completed the APLS course. This meant that we were not assured that staff had the correct skills to manage life threatening situations for children. We saw evidence that more staff had been booked on to courses in 2019.

- Information provided by the trust showed that 74% of all staffing working in the department had received an appraisal.

Multidisciplinary working

- There were effective working relationships between medical and nursing staff in the department. Both the nurse in charge and emergency physician in charge worked closely together to support the department with staffing, patient capacity and demand.
- Within the clinical decisions unit (CDU), the consultant in charge would complete a ward round daily plus a huddle to review patients within the unit and their ongoing care.
- Other speciality teams would attend the department and review patients, however there were sometimes delays in this occurring to the demands in their own working area. We spoke with some doctors attending ED to review patients who confirmed this.
- We saw that patients in CDU received care from the rapid assessment pathway team (RAPT). This involved multi-disciplinary professionals reviewing patients prior to discharge to review their ability to manage at home.
- The critical care outreach team would attend the department to review appropriate patients.

Seven-day services

- There was access to facilities such as blood tests, X-rays and CT scans available within the hospital.
- Advanced nurse practitioners provided treatment to patients in the departments seven days a week and supported staff to triage patients on arrival.
- There was 24-hour access to adult mental health teams, who were on site to provide support. Staff were aware of how to contact the teams. Staff could also access drug and alcohol teams.

Health promotion

- National priorities to improve the population's health were supported such as smoking cessation and alcohol dependency. Health and condition specific advice was provided in leaflets and posters throughout the hospital and on the trust's website.
- Staff provided health promotion advice to both patients and families. They could access and provide details on other services to support the patients with their lifestyle choices. Other agencies attended the department such as social workers and physiotherapists to support the patient to be more independent on their discharge.
- Information boards were in place to inform and support patients. These included providing information on infection control and influenza.
- The department provided patients with information leaflets about their condition and aftercare. Discharge advice was given to patients and carers to allow patients to safely manage their condition at home or where to seek advice if appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our inspection in December 2017, staff demonstrated little knowledge of the Mental Capacity Act. At this inspection, staff had knowledge of the Mental Capacity Act and were aware of implications and how to manage patients who did not have mental capacity.
- Patients told us that staff asked for consent prior to completing any care and procedures. We observed that staff would gain consent and discuss with the patient whilst completing the care. Medical staff would gain written consent for patients who required sedation.

Are urgent and emergency services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- We observed staff interacting with patients in a caring and compassionate way, and with a polite manner.
- Patients received emotional support as part of their care.
- Staff involved patients and those close to them in decisions about their care and treatment and kept them informed about progress.

Urgent and emergency services

- Friends and Family Test data was better than the England average for the department.

However,

- There had been some complaints raised regarding staff's compassion when the department was busy.

Compassionate care

- We spoke with seven patients and relatives and found that the majority told us that they found staff to be caring. We observed a number of interactions including the triaging of patients, we saw that staff responded in a caring manner.
- Staff responded compassionately to patient's pain, discomfort, and emotional distress in a timely and appropriate way.
- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England
- We saw from complaint data and department newsletter in November 2018 that there had been some complaints raised regarding lack of compassion and caring to patients.
- Staff tried their best to maintain privacy, dignity and confidentiality, but due to the layout of the environment this was difficult.

Emotional support

- Staff provided patients and relatives with emotional support. We saw that staff reassured patients and tried to put them at ease.
- Patient's families were supported in an appropriate place after a bereavement. There was a quiet room for relatives to use if needed. Chaplaincy services were available for multiple faiths.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand which was appropriate and respectful.
- We observed staff providing care to patients on arrival to the department. Patients were involved and asked information about their condition or illness.
- Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for. We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.
- We saw that staff discussed decision making with the patients and relatives. In times where emergency care was required to be given, staff explained the decisions needed. The information was given in a way that people could understand and without using complicated medical terminology.
- In the Emergency Department Survey, the trust scored about the same as other trusts for 21 out of 24 questions. The trust scored worse than other trusts for three questions, which were:

- Were you told how long you would have to wait to be examined?

- Did the doctors and nurses listen to what you had to say?

- Did a member of staff tell you about medication side effects to watch out for?

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

(for example, to feedback?)

Requires improvement

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Requires improvement** because:

- Since our last inspection, there had not been a full review of the initial assessment process to ensure it met the needs of the local population.
- Although data for meeting the Department of Health standards for patients admitted, transferred or discharged within four hours of arrival at the

department had improved since our last inspection, this did not take in to consideration the length of time that patients may have been waiting in the department before they were registered as arriving.
- Similarly, data for time of arrival to receiving treatment not exceeding one hour, as recommended by the Royal College of Emergency Medicine (RCEM), showed that for 10 months out of 12, from October 2017 to September 2018 this standard was met. However, this again did not take in to consideration the wait before the initial registration. The introduction of an electronic check in on arrival was going live at the time of this inspection.
- Staff we spoke with told us they felt pressured to meet targets and that there was an emphasis on targets rather than patient need.
- At our last inspection, we found that the department was not following its own policy for the use of the clinical decisions unit (CDU). At this inspection, we found that this was still the case and that at times there was inappropriate use of the CDU.

However:

- Managers worked closely with the clinical commissioning group and other stakeholders to try to provide appropriate services for patients.
- Operational meetings took place four times a day to look at capacity and flow.
- A patient flow co-ordinator ensured speciality medical patients were seen in a timely manner and there was an escalation process in place.
- From November 2017 to October 2018 the percentage of patients waiting more than four hours from the decision to admit to admission was better than the England average. No patient waited more than 12 hours from the decision to admit.
- There were strong links with and support from the mental health liaison team.

Service delivery to meet the needs of local people

- The department worked with commissioners, local authorities and external providers to plan and deliver services. However, we were not assured that there had been an effective response to the findings of our previous inspection, to effectively meet the needs of local people. Following this inspection, the trust worked with the commissioners to alter the initial assessment process, immediately following our feedback.
- There were facilities in place for patients that attended the department who were best suited to see a GP. Patients were streamed within ED and referred to primary care where necessary.
- The department had created a new minor injuries unit and staffing area. This provided support for staff and created an alternative pathway for patients to attend with minor injuries.
- The service continued to offer 24-hour support to patients suffering from mental health problems. This included access to the mental health liaison team who were on site and provided an assessment.
- A separate children's waiting area remained in place that provided good segregation for children away from the adults waiting area.
- Staff had visited other hospitals in advance of implementing the 'fit to sit' initiative. This was a NHS initiative which encouraged patients that were well enough to sit rather than lay on trolleys waiting to be seen.

Meeting people's individual needs

- The clinical decision unit (CDU) provided an overnight facility for patients with complex discharge needs and allowed a team to assess their social, physical and medical needs prior to discharge. The unit could also prevent admission into hospital.
- There were no changes since our last inspection in December 2017 regarding processes in place for learning disabilities, interpreters and patients living with dementia. A specialist learning disabilities nurse would come to the department if needed to support those patients with complex needs.
- The reception and streaming desk was at a low level for wheelchair users. The waiting area could accommodate wheelchairs and mobility aids and there were accessible disabled toilets.
- A quiet relative's room was available to be used by staff as necessary.
- The trust scored about the same as other trusts for each of the three Emergency Department Survey questions relevant to the responsive domain. These included:

- Were you given enough privacy when discussing your condition with the receptionist?
- Overall, how long did your visit to the emergency department last?
- Were you given enough privacy when being examined or treated?

Access and flow

- At our last inspection in December 2017 we saw that although there was adequate seating, patients had to stand a considerable amount of time in the queue to see the streaming nurse before they could sit down. The length of time they had to stand depended on how busy the department was.
- At this inspection we saw the streaming process remained the same and saw that patients would wait in a queue to be seen by the nurse. A standard operating procedure had been adopted for when five patients were waiting then additional staff would review the queue. However, we did not always see this in operation, patients did not wait in the queue for long periods of time although we still saw vulnerable and frail patients waiting.
- Staff told us that when the standard operating procedure was implemented staff would be pulled from other areas such as majors department and urgent care centre. This meant that patients would then wait for periods of time in other areas.
- The trust was due to start a ticketing system where patients would take a ticket on arrival, sit down and then would be asked to see the streaming nurse. This new ticketing system went live on our last day of inspection although it was not operational whilst we were there.
- An operational meeting was held four times a day which looked at capacity and patient flow. The department had an electronic escalation and capacity tool that helped staff understand the flow through the department and bed capacity.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From November 2017 to
- We reviewed 20 notes and found that 16 were seen with the Department of Health's standard. The remaining five were admitted or discharged between four hours and six hours.
- We saw there were patient flow co-ordinators in place. Their role was to review patients in the department and to identify if they would be able to see a speciality medical referral within one and half hour hours. An escalation process was in place from 30 minutes where there was no response from the required team.
- Many staff told us that they felt there was a pressure to meet the four hour target with the emphasis on this rather than the care required. We heard conversations that supported this and heard staff say that patients were not near the target or questioning why they had gone over the target.
- Regular daily meetings were in place to review and understand the bed availability with the department and hospital. It provided details of the pressures within the department and the escalation processes in place.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for 10 months over the 12 month period from October 2017 to September 2018. In the most recent month, September 2018, the median time to treatment was 52 minutes compared to the England average of 61 minutes. This had improved from the previous year where the median time to treat was 58 minutes. However, due to the initial assessment process and the wait some patients experienced before booking in, it is possible that several patients would have waited over an hour from their time of arrival to the time they received treatment.
- From November 2017 to October 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.
- At our last inspection in December 2017, the clinical decision unit (CDU) had an operational policy in place to ensure that the unit was not used as an inappropriate place for patients to wait for an

admission to a hospital ward. We were told that the unit was used for this purpose and to potentially prevent the department breaching the four hour target.

- At this inspection, staff told us that the unit was still used as an inappropriate place and a new standard operating procedure was to be completed to review the criteria. The criteria would identify if the patient is on a specific pathway relevant to be in the unit. Staff told us they sometimes felt pressured to admit patients onto the unit. The expectation was that if a patient remained in the unit after 24 hours they should be admitted to a ward environment. We saw that patients were admitted within the four hour target to CDU, on reviewing one patient record we saw that the patient was awaiting surgical assessment.
- Some staff told us they felt that patients had been referred and admitted to CDU for the rapid assessment programme team (RAPT) to review inappropriately. For example, a patient living in a care home who was bedbound and required hoisting was admitted to CDU for a RAPT referral.
- Over the 12 months from November 2017 to October 2018, no patients waited more than 12 hours from the decision to admit until being admitted.
- From October 2017 to April 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was similar to the England average. Since April 2018 however there has seemingly been a data issue and no data had been submitted for this metric.
- From November 2017 to October 2018 the trust's monthly median total time in A&E for all patients was similar to the England average. In the most recent month, September 2018, the trust's monthly median total time in A&E for all patients was 147 minutes compared to the England average of 154 minutes.

Learning from complaints and concerns

- There was no change to the complaints process we documented in our last report. Staff told us that there had been complaints regarding the previous waiting and triage system about the amount of time patients had to wait to book in.
- Ward managers in the department were aware of ongoing complaints and were working with staff to investigate the complaint.
- Information provided by the trust showed that there were 52 complaints over the last 12 months, 11 were regarding staff attitude.
- We saw that complaints and themes of complaints were discussed within the department's newsletter.

Are urgent and emergency services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

- There had been lack of oversight and action in responding to concerns identified at our last inspection in December 2017. Senior and executive leaders had failed to identify the risk to patients.
- Governance arrangements were in place. However, they had failed to identify safety concerns relating to the initial assessment of patients and lack of robustness.
- We received mixed feedback from staff about the leaders in the department, some staff felt that there was a lack of support from senior staff.
- Staff morale was low. Morale meetings had been implemented to try to address the concerns affecting morale. Staff we spoke with told us they did not always feel action was taken regarding their concerns.
- There was a system for identifying, capturing and managing issues and risks, however, the risk register we saw did not fully capture the risks we saw throughout the inspection.

However:

- The new service leads had a vision for the direction they wanted the department to go in.
- In response to the inspection, the executive team had produced an action plan and had made immediate changes.

Urgent and emergency services

Leadership

- There had been a change in care group structures since our last inspection. The emergency department (ED) was part of the division of medicine. The division had a divisional director, an associate director of nursing, a deputy chief operating officer and a general manager for emergency medicine. A clinical director for emergency medicine and two heads of service had been appointed in October 2018.
- We received mixed feedback from staff about the leaders in the department. Some staff we spoke with told us that leadership was good. The matron was visible and provided clinical support when needed. When the department was busy, we were told that managers came to help with bed movements. However, some staff we spoke with told us they felt there was a lack of support from senior staff and they were unclear of the role of the band seven nursing staff. Staff we spoke with told us that although the band seven staff had completed the advanced resuscitation training, they did not work in resus.
- Some of the staff we spoke with told us that they felt they did not receive any feedback about concerns they had raised and therefore felt that service leads were not listening to them.
- Although clinical staff told us they felt that the initial assessment process wasn't safe and had raised their concerns with leaders, service leads had scored the risk at a medium level (12), which meant it was not escalated to the trust management board. We were concerned the risk to patients had not been fully recognised at a senior level. The focus, following our last inspection in December 2017, appeared to have been on any queues that may form and had not taken in to consideration the environment in which initial assessments were taking place and whether the assessments were being completed thoroughly.

Vision and strategy

- We spoke with one of the new service leads and the new clinical director. Both told us about their vision for the service and what they hoped to achieve.
- At our last inspection, there had been plans to create a separate minor injuries unit. At this inspection, this area was now opened. Staff told us that a capital bid had now been put in to allow them to change the layout of the main department.
- The ED was developing a strategy and outcomes from engagement with the public were going to feed in to this.

Culture

- There was a desire from staff to provide effective care and treatment to patients.
- We found mixed opinions from the staff we spoke with about their experience of working in the department. Some of the staff we spoke with told us they enjoyed working in the department and that there was an open culture and the relationship between staff was good. Others told us that there was a lack of support from senior staff and that morale was low. One reason they identified for this low morale was that senior staff in the department appeared to be more focussed on meeting performance targets.
- It had been recognised by service leads that staff morale was low and staff morale meetings had been set up to try to address the issues that were affecting morale. We reviewed minutes from the morale meeting and found that the main issues causing low morale were the off duty rota, team work/ communication, streaming, band seven's and staff band roles.
- Junior medical staff spoke positively about the support they received from senior medical staff. All staff we spoke with told us that communication between doctors and nurses was good.

Governance

- There were governance structures and processes in place. A governance lead for the department had two hours a week dedicated to the governance role, supported by administrative staff and the central patient safety team.
- Regular meetings took place, such as monthly divisional directors meetings, monthly management board meetings, patient safety meetings and urgent and emergency strategy meetings.

- Governance meetings were held monthly. Separate meetings were held for Doncaster Royal Infirmary (DRI) and Bassetlaw District General Hospital (BDGH). Staff told us they were planning to introduce combined cross-site governance meetings. Relevant information from unit governance meetings was included in the divisional clinical governance meeting.
- We reviewed minutes from the clinical governance meetings and saw that items on the agenda included learning from incidents and complaints, staffing, policy reviews and review of the risk register. However, governance arrangements had failed to identify safety concerns relating to the initial assessment of patients and lack of robustness.
- Monthly operation and communication meetings were held. Discussions took place about items such as quality and governance, performance and staffing. However, when we requested minutes from these meetings for the last three months, we were provided with minutes from July and October 2018. This suggested that meetings were not held as frequently as we were told they were.
- An urgent and emergency care workstream had been established to ensure closer working between the trust and commissioners.

Managing risks, issues and performance

- There had not been sufficient oversight or action taken in response to the concerns identified at the previous inspection in December 2017. At this inspection, we still found similar issues with the initial assessment process, paediatric nurse staffing and lack of audits around deteriorating children.
- Following our inspection, we formally wrote to the trust under section 31 of the Health and Social Care Act (HSCA), outlining the concerns we had identified at this inspection and the risks posed to patients, with the potential to cause harm. The trust provided an action plan and this continues to be monitored through regular engagement with the trust. We were satisfied that no immediate enforcement action needed to be taken.
- We reviewed the department risk register which had identified eight risks. Seven of the risks related to DRI. Most of the risks had been opened in 2015 and 2016 and included delay in the review of x-ray reports, reduced vision of paediatric patients and the process for prescribing in the clinical decisions unit (CDU). The risk of patients deteriorating whilst waiting to book in had been added to the risk register in April 2018. The mental health assessment room had been identified as a risk, but only in relation to its location next to the paediatric area, rather than its non-compliance to standards. Lack of paediatric nurses had been identified as low risk and was not due for review until September 2019.
- The department took part in national and local audits, including the Royal College of Emergency Medicine (RCEM) audits and had developed action plans to address areas of non-compliance. Staff told us that audit action plans were displayed on the quality and safety noticeboard in the department.
- Service leads told us they had a robust winter plan in place. The use of escalation beds on wards had been discussed to ensure flow through the department.

Managing information

- Staff had access to all relevant policies and procedures on the trust intranet. 'My ED' had been developed to store all the protocols in one place with easy access.
- The department collected, analysed and used information to support activities. Performance reports were produced monthly and, with other services reports, were presented at the board meeting.
- However, due to the booking in and initial assessment process, there was a risk that the time to initial assessment data and four hour access data may not be robust as it did not capture the time spent in the department before the initial assessment.
- A high intensity group was in place that reviewed specific patients that used the department regularly. The purpose of the meeting was to support and reduce the need of the patients using the department.

Engagement

- In October 2018, the trust held a 'System Perfect' week. As part of this week the team wanted to gain a better understanding of how and why patients used ED, as well as how care and treatment could be

improved for patients. Local events were held to engage with patients, the public and local businesses. There was also a proactive social media campaign to encourage full use of all health provision within the local area.

- Comment cards were available in the department for patients to provide feedback.
- Staff were kept up to date with information through emails and newsletters. Various meetings were held to engage with staff. For example, documentation meetings, morale meetings, departmental meetings and operations and communications meetings.
- The matron and operational manager had held listening events following staff and patient surveys. Staff had been involved in the recruitment of a new lead nurse.

Learning, continuous improvement and innovation

- One of the consultants had received a Royal College of Nursing (RCN) award for his work in developing doctors from overseas so that they could apply for a certificate of eligibility for specialist registration (CESR).

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must review their process for initial assessment to address the risks to adult and paediatric patients.

The provider must ensure that nurse staffing levels, including paediatric trained nurses, are increased to ensure the safety of patients.

The provider must ensure the room used to care for patients with mental health needs conforms to the Psychiatric Liaison Accreditation Network (PLAN) standards.

The provider must ensure that there is effective monitoring and escalation of deteriorating paediatric patients and that staff complete relevant training including paediatric life support.

The provider must ensure all staff have completed relevant safeguarding training. Safeguarding training must meet the recommendations of the intercollegiate guidance for level three.

The provider must ensure medications are stored appropriately and staff comply with trust guidance.

The provider must ensure that all staff have completed appraisals.

Action the hospital SHOULD take to improve

The provider should ensure there are robust actions taken to achieve optimal clinical outcomes for patients as indicated by the RCEM audits.

The provider should ensure the environment provides patient's privacy, dignity and confidentiality.

The provider should ensure the risks on the risk register match all the risks identified during the inspection.

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 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing