Hampshire Hospitals NHS Foundation Trust

Basingstoke and North Hampshire 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

This was a focussed unannounced inspection of the emergency department of Basingstoke and North Hampshire Hospital on 4 February 2019.

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

During this inspection we noted the department to be under immense operational pressure in part caused by extreme weather conditions resulting in patients not being discharged over the preceding weekend due to unsafe road conditions. Consequently, the trust had declared an internal major incident over the preceding weekend. These poor conditions meant it was unsafe for patients to leave the hospital grounds. The result was a congested emergency department with multiple attendances, again in part due to the poor weather. We observed patients being cared for along the main corridor of the emergency department and some patients being in the department for extended periods due to a lack of beds across the hospital. We noted the bed position improved during the inspection resulting in patients being discharged across the hospital allowing patients in the emergency department to be admitted to inpatient beds. The trust reported There were 236 patients seen on the day of the inspection, (including 10 that were still in the department from the Sunday) and 61 arrived by ambulance. An average day would be 170 patients seen with 60 arriving by ambulance. There were 54 admissions against an average of 40.

The average number of patients who walk into the department is 110 per day and the departments had 165 walk in patients on the day of the inspection. This was as a result of the extreme weather over the weekend.

Our key findings were:

- Provision for mental health patients remained challenging. Patients continued to experience delays in being reviewed by external partners and the environment in which patients were being managed was not fit for purpose. However, the trust had introduced risk mitigation initiatives to reduce the likely-hood of patients being able to harm themselves or others.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- Care and treatment was not always planned and carried out in a timely way.
- The process of streaming patients who self-presented to the department was not fit for purpose. Sporadic absences of the streaming nurse because of the requirement to undertake other duties including undertaking physical observations on patients meant bottle-necks occurred quickly at the front door.
- There were still occasions when the privacy and dignity of patients were now always promoted or protected.
- Compliance against constitutional standards remained a challenge. However, new models of care and the introduction of well-rehearsed escalation protocols were starting to show signs of some incremental improvement.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate however there was a sense of collective ownership of the challenges.

However:

- The environment in which patients received care and treatment continued to remain a challenge. However, staff acknowledged the constraints of the department, had made some changes including the opening of a paediatric assessment unit, majors 2 “Fit to sit” area and an emergency decision unit.

Summary of findings

- The expansion and standardisation of the rapid assessment process resulted in improved handover performance for patients who were conveyed to the department by ambulance.
- Efforts had been made to improve the experience of patients using the department. Staff sought to utilise clinical assessment rooms and cubicles to consult and treat patients as compared to using the corridor as had been previously noted.
- Staff spoke to patients with compassion. Patients told us they felt listened too and staff considered the views and opinions of patients.
- Whilst there was no formalised vision or strategy for the department, the historic "Done to" and "Learned helplessness" which was present at the previous inspection had dissipated. Health professionals worked collectively to address the challenges within the emergency care pathway.
- Improved governance arrangements had led to increased oversight of risks and quality. Staff acknowledged that more needed to be done to ensure care was provided in a consistent way.

Action the hospital MUST take to improve

Ensure patients receive a timely assessment of their care needs and that a plan of care is established and delivered in line with national best practice.

Ensure patients receive care and treatment in an environment which is fit for purpose and meets national standards.

Ensure staff consistently utilise safety measures as determined by trust policy.

Ensure the emergency department operates an effective and safe process for receiving and assessing patients who self-present to the department.

Dr. Nigel Acheson
Deputy Chief Inspector of Hospitals

Basingstoke and North Hampshire Hospital

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Detailed findings

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Our inspection team

The team included a CQC inspector and three specialist advisors: a clinical fellow who specialised in neurology and acute stroke management; an emergency care consultant who was also the designated clinical lead for emergency medicine for a large teaching hospital; and an experienced emergency care nurse.

The inspection was overseen by Amanda Williams, Head of Hospital Inspection (Interim) for South London and South-Central England.

Facts and data about Basingstoke and North Hampshire Hospital

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

The ED has one triage room, 12 major cubicles, four minor treatment rooms and an additional three trolley clinical assessment and treatment area, one 'fit to sit' room referred to as "Majors 2", four resuscitation bays, a rapid assessment and treatment (RAT) bay and an adult waiting room. The department had also opened a short stay assessment unit, which at the time of the inspection was staffed by a general practitioner who had experience of acute medicine. The department had a small emergency decisions unit which was mostly used for patients waiting for transport, assessment by the trust's frailty team or who were receiving a period of short treatment prior to being discharged home.

The main reception area accommodated patients referred to see primary care physicians who operated a general practice out of hours service directly adjacent to the emergency department. The department had also recently opened a paediatric assessment unit enabling children presenting to the department between the hours of 2pm and 10pm to be seen and treated in a purpose-built children's area which was audio-visually separated from the main adult emergency department.

Between 23 October 2018 and 29 January 2019, the hospital saw 17,015 attendances to the emergency department. Over a 6-week average to 30 January 2019, the hospital saw 1,099 type 1 attendances each week; 810 walk-in attenders each week and; 374 ambulances each week.

The 6-week average ambulance handover time was 31 minutes. The number of patients who attended the emergency department and then who were subsequently admitted (we refer to this as the conversion rate) was 26.3% on average over the six-week period to week ending 30 January 2019.

The percentage of patients (on average over a six-week period to week ending 30 January 2019) who were treated within 60 minutes was 46.62%. The hospital achieved a six-week average of 80.92% against the constitutional four-hour emergency target up to week ending 30 January 2019.

Urgent and emergency services

Safe	
Caring	
Responsive	
Well-led	
Overall	**Not sufficient evidence to rate**

Information about the service

We carried out an unannounced focussed inspection of the emergency department at Basingstoke and North Hampshire Hospital on 4 February 2019.

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

Basingstoke and North Hampshire Hospital (unscheduled care) provides an emergency medicine service through a Type 1 Emergency Department (ED) including trauma & cardiology. There is a minor injuries service provided by the emergency nurse practitioner service.

The department has:

- 12 majors' cubicles (including side rooms)
- Four bedded resuscitation room where both adults and children are seen.
- A newly created "Fit to Sit" assessment area
- Four bay rapid assessment and treatment area
- A new paediatric assessment unit which opened in January 2019

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

We previously inspected the emergency department at Basingstoke and North Hampshire Hospital in July 2018. We rated it as inadequate overall. At that inspection we rated as inadequate because:

- Patients were not always protected from avoidable harm. There were limited effective system(s) in place to assess and monitor the ongoing care and treatment to patients, including monitoring patients for signs of clinical deterioration.
- Staffing levels and skill mix were not sufficient to meet the needs of patients as a result; patients did not have their care and treatment carried out in a timely manner. There was not a minimum of one children's nurse present on each shift nor was there consultant presence in the department for 16 hours per day; both were not meeting national guidance.
- The layout of the emergency department was not suitable for the number, or age, of admissions the service received. There was significant overcrowding and, at times, patients were being cared for on trolleys in the major's area of the department as there were no free cubicles to use. Patients were also directed back to the main waiting room to await test results or review from speciality. There was limited clinical oversight of the waiting room therefore those patients waiting prolonged periods of time were not routinely receiving physical observations. This meant staff may not always detect a deteriorating patient.
- Patients care, treatment and support did not always achieve good outcomes, promote a good quality of life and was not always based on the best available evidence. Audit participation was low during 2017 and results were not used to improve patient outcomes. Sufficient priority was not given to patients' pain needs.
- Patients were not always treated with compassion, kindness, dignity and respect. Staff attitudes and poor environmental design resulted in a negative impact on the care patients were receiving and limited the time staff had to spend with patients. We observed numerous incidents where patients' privacy and dignity needs had not been met appropriately.

Urgent and emergency services

- Patients could not access care and treatment in a timely way. Waiting times for treatment and arrangements to admit, treat and discharge patients were worse than the England average and national standard.
- There had not been the leadership capacity and capability to deliver high quality, sustainable care. Leadership within the department had not been sufficiently effective. There did not appear to be one individual taking overall responsibility for the day-to-day running of the department. Front line staff had not felt supported, respected or valued by their immediate line manager(s) however the appointment of a new matron was reported as being extremely positive by staff.
- Staff had not been engaged and morale in the department was low; frustrations around leadership, low staffing, capacity and flow and the environment had led to a culture of acceptance with staff lacking the drive to challenge systems and processes within the department.

Following our July 2018 inspection, under section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to one regulated activity; treatment of disease, disorder or injury. We took this urgent action as we believed a person or persons would or may have been exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activities in a way which complies with the conditions we set. The conditions related to the emergency department at Basingstoke and North Hampshire Hospital and Royal Hampshire County Hospital in Winchester.

During the inspection, we visited the emergency department and assessed each clinical pathway including minors, majors, resuscitation and paediatrics. We spoke with 22 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with six patients and two relatives. During our inspection, we reviewed twelve sets of patient records.

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

Our key findings were:

- Provision for mental health patients remained challenging. Patients continued to experience delays in being reviewed by external partners and the environment in which patients were being managed was not fit for purpose.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- Care and treatment was not always planned and carried out in a timely way.
- The process of streaming patients who self-presented to the department was not fit for purpose. Sporadic absences of the streaming nurse because of the requirement to undertake other duties including undertaking physical observations of patients meant bottle-necks occurred quickly at the front door.
- Efforts had been made to improve the experience of patients using the department. Staff sought to utilise clinical assessment rooms and cubicles to consult and treat patients as compared to using the corridor as had been previously noted.
- Staff spoke to patients with compassion. Patients told us they felt listened too and staff considered the views and opinions of patients.
- Compliance against constitutional standards remained a challenge. However, new models of care and the introduction of well-rehearsed escalation protocols were starting to show signs of some incremental improvement.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate however there was a sense of collective ownership of the challenges.

However:

Urgent and emergency services

- The environment in which patients received care and treatment continued to remain a challenge. However, staff acknowledged the constraints of the department, had made some changes including the opening of a paediatric assessment unit, majors 2 “Fit to sit” area and an emergency decision unit.
- The expansion and standardisation of the rapid assessment process resulted in improved handover performance for patients who were conveyed to the department by ambulance.
- There were still occasions when the privacy and dignity of patients were now always promoted or protected.
- Whilst there was no formalised vision or strategy for the department, the historic “Done to” and “Learned helplessness” which was present at the previous inspection had dissipated. Health professionals worked collectively to address the challenges within the emergency care pathway.
- Improved governance arrangements had led to increased oversight of risks and quality. Staff acknowledged that more needed to be done to ensure care was provided in a consistent way.

Are urgent and emergency services safe?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

- Provision for mental health patients remained challenging. Patients continued to experience delays in being reviewed by external partners and the environment in which patients were being managed was not fit for purpose. Risk mitigation initiatives were in place to reduce the likely-hood of high risk patients being able to harm themselves or others.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- Care and treatment was not always planned and carried out in a timely way.
- The process of streaming patients who self-presented to the department was not fit for purpose. Sporadic absences of the streaming nurse because of the requirement to undertake other duties meant bottle-necks occurred quickly at the front door.

However:

- The environment in which patients received care and treatment continued to remain a challenge. However, staff acknowledged the constraints of the department, had made some changes including the opening of a paediatric assessment unit, majors 2 “Fit to sit” area and an emergency decision unit.
- The expansion and standardisation of the rapid assessment process resulted in improved handover performance for patients who were conveyed to the department by ambulance.

Environment and equipment

The emergency department had one assessment room which was located at the main reception area, 12 major’s cubicles, four minor treatment rooms and a newly established minor’s assessment and treatment bay; a four-bed resuscitation area for which one bay was designated as a children’s resuscitation bed space although could be used to manage adults also. In addition, the department had extended its foot-print to

increase the number of rapid assessment bed spaces from one to four; had introduced a "Majors 2 – fit to sit" clinical assessment area and a clinical decision unit which was managed by way of a standard operating procedure to ensure only specific patient groups and conditions could safely be managed in the area.

In response to the concerns raised by the Care Quality Commission in 2018, the trust had worked quickly to design and build a purpose-built children's assessment unit; this opened in January 2019. Due to the quick construction stage, the new children's assessment unit was to be opened during peak times between the hours of 2pm and 10pm. The intention was for the unit to be staffed by a specialist paediatric consultant and children's nurse four days a week and by the emergency department for the remaining three days. Staff reported some initial challenges in securing medical and nursing rotas however the assessment unit was open on the day of our inspection. The department's intention, once at full nursing and medical establishment, was to open the department 24 hours a day, seven days a week.

We had previously reported the design and layout of the emergency department was no longer suitable to meet the growing demands of the service. During this inspection we noted the department to be under immense operational pressure in part caused by poor weather conditions resulting in patients not being discharged over the preceding weekend due to unsafe road conditions. These poor conditions meant it was unsafe for patients to leave the hospital grounds. The result was a congested emergency department with multiple attendances, again in part due to the poor weather. We observed patients being cared for along the main corridor of the emergency department and some patients being in the department for extended periods due to a lack of beds across the hospital. We noted the bed position improved during the inspection resulting in patients being discharged across the hospital allowing patients in the emergency department to be admitted to inpatient beds.

Staff told us that following the introduction of the majors two area and the opening of the clinical decision unit, flow across the emergency pathway had improved but accepted it had not been entirely resolved. Staff told us it had not been necessary to nurse patients in the main emergency department corridor because there had been sufficient capacity within the confines of the existing department and that what we observed on the day of the inspection had become the exception rather than previously accepted practice.

Changes to the layout of the department meant there was more capacity for clinicians to assess and review patients. Changes to working practices and the introduction of new models of care including the "Fit to Sit" concept helped support patient flow and improved departmental performance against the standard set by the Royal College of Emergency Medicine (RCEM) which recommends all patients should commence their treatment within one hour of arrival. Data available to the Commission shows the average length of time for treatment to commence was 78 mins in November 2018; this was longer than the RCEM standard and worse than the England average. A review of data suggested there was no apparent pattern to department performance in respect of the number of attendances versus the time to initial treatment. However, during time of surge and increased activity, the time to treatment seemed to reduce suggesting escalation protocols and responses from speciality could be having a positive impact of the effectiveness of the department. Further data and analysis from the trust would look to identify any bottlenecks or areas of good practice leading to reduced delays in commencement of treatment.

Where we observed patients being cared for in the main corridor, a nurse had been allocated to meet the ongoing needs of patients. We spoke with five patients who were receiving care whilst being accommodated on the main corridor. Four patients reported nursing and medical staff had been responsive to their needs; patients were aware of the treatment plans and anticipated waiting times. One patient complained of having asked a nurse for help to use the toilet on three separate occasions but felt they had not been listened too; we escalated this patient to the nurse overseeing the corridor who promptly supported the patient.

We observed the resuscitation room to be operating at full capacity during the inspection. Majors cubicle five had been identified as an escalation area in the event a fifth bed space was required. We attended the 13:00 board round during which the lead consultant considered each patient in the department; this included those patients currently being treated in the resuscitation area.

Dynamic risk assessments were made to establish whether patients still required treatment within the resuscitation area or whether they were sufficiently stable to be transferred to the major's department.

Attempts had been made to improve the storage of equipment and consumable stock within the resuscitation area. Equipment had been standardised and stored to enable quick recognition. Staff from other clinical areas including intensive care reported the new arrangements made it easier for them to orientate themselves to the resuscitation area, thus reducing the time they spent looking for equipment and therefore taking them away from providing patient care. However, storage cupboards across the major's department were disorganised with assorted consumable items, dressings and other equipment placed randomly and in no specific order. This meant staff spent longer looking for consumable items.

We previously raised concerns over the suitability of the environment to which patients at risk of self-harm or suicide received care and treatment. There previously lacked insight and appropriate risk-mitigation processes to safeguard patients who presented with suicidal ideations or thoughts. The local leadership team had since undertaken a ligature risk assessment of the department. There were challenges in terms of the level of work which could be undertaken to remove all risks within the department. A room co-located in Majors-2 was designated for the assessment of patients presenting in mental health crisis. The matron acknowledged the location of the room was not appropriate however the limitations of the environment meant there were few alternatives. The trust reported they had completed a risk assessment of the room which determined the room as being adequate. We noted equipment including linen trolleys and water bottles near the mental health room; these presented a risk should patients suffering from severe psychotic episodes or periods of heightened disorientation or aggression. Further, staff raised concerns over the proximity of a kitchen area which contained hot water supplies. Staff told us the service provided by the speciality commissioned mental health trust was poor. Patients experienced delays in being assessed by specialist psychiatric liaison teams due to limited service provision. The local leadership team and executive continued to monitor response times as well as reviewing all four-hour breaches associated with patients being treated against the mental health pathway. To mitigate against high risk patients causing self-harm or attempting to take their own lives whilst in the emergency department, a new vulnerable adult triage process had been introduced. This was to be complemented by training directed at band five nursing staff to help them recognise and support high risk patients. In addition, the department had introduced "Code green" alerts which were issued across the tannoy system located throughout the emergency department. This alerted all staff to the presence of a highly vulnerable or "at-risk" person within the department. One to One nursing care was provided for those individuals assessed as being at high risk of harm.

Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys which were sealed with a tamper evident tag. Safety checks were carried out daily. This was an improvement on our findings of our previous inspection in 2018.

A number of medicine boxes were located across the department. These included fascia iliac block boxes and medicines for the management of anaphylaxis. We noted these boxes were either incomplete or empty. Staff told us they were in the process of reorganising the department and that some boxes were no longer required but had not yet been removed from the department. There was an inherent risk that individual staff not familiar with the department would seek to access these boxes and find them to be empty or incomplete therefore possibly impeding the quick delivery of patient care and treatment.

Assessing and responding to patient risk

National standards require 95% of patients to have had an initial assessment within 15 minutes of arrival to the department. For patients who arrived to the trust by ambulance, data reported a median time to initial clinical assessment of four minutes in November 2018 which was better than the England average. We reviewed the process by which patients were initially received in to the department when conveyed by ambulance. The department had previously established a one cubicle rapid assessment area. This area was previously too small to accommodate the number of ambulance conveyances and therefore became congested during times of surge. Since our previous inspection, significant work had been undertaken to improve the rapid assessment area. Three

additional bed spaces had been created which were now staffed by a senior clinical decision maker. To complement the medical support, an experienced nurse was also allocated to the rapid assessment area. Staff working in the rapid assessment area had access to a live screen which informed them of any incoming ambulances from the local NHS ambulance trust, alongside estimated times of arrival. This enabled the team to create capacity within the rapid assessment area therefore reducing the length of time ambulances were required before a patient was clinically assessed on arrival to the hospital. With the introduction of the rapid assessment area, data demonstrates significant improvement in the number of ambulances being delayed. The department was able to track performance and could describe scenarios when performance had slipped due to high attendances of ambulances in very short periods of time. Whilst this placed the rapid assessment process under pressure, staff reported good system support and resilience to enable the team to recover with minimal delays.

Patients who presented to the emergency department independently (walk-in) were first required to be seen by a streaming nurse before checking in with a receptionist. Once checked in, staff told us patients would have a set of physical observations completed by a nurse or health care assistant. There was an escalation protocol which allowed patients presenting with specific conditions to be prioritised and moved to either the resuscitation bay, majors or the rapid assessment area from streaming if the patient appeared seriously unwell or who presented with time-critical symptoms such as those with symptoms of stroke or heart attacks for example. We observed this process during the inspection and concluded it was not fit for purpose. Due to staffing arrangements, there were periods during which the streaming nurse was absent from the streaming desk. This led to queues which led out of the front door of the emergency department. We observed the streaming nurse leaving the desk to undertake triage duties when there was no nurse or healthcare assistant to stream. Additionally, the streaming nurse left the streaming station to escort patients to other parts of the department again resulting in congestion at the front door. We also observed patients who presented with lower limb injuries walking with difficulty in to the department. Limited signage within the waiting room led to confusion as to the process patients should follow. Additionally, those patients we observed with lower limb injuries walked extra distances to report to the reception staff to then be re-directed to wait at the streaming queue where only three seats were available. We observed on occasions when patients initially queued to see the streaming nurse who was not present; because no-one was present, the patient then reported to reception staff who redirected patients back to the streaming queue; three patients were observed joining the back of the queue, subsequently increasing their total time spent in the department. During busy periods, patients were observed waiting for periods of seven minutes or more to be streamed by the nurse who was engaged undertaking triage duties with another patient. Whilst this wait did not exceed the 15 minute standard set by the Royal College of Emergency Medicine, the lack of clinical staff presence at all times meant high risk patients may have experienced delays in being initially assessed and therefore having their care fast-tracked.

At 17:15 we noted five patients waiting to be streamed. At 17:21 the streaming nurse returned to the streaming station to commence streaming of patients. The nurse was subsequently supported by a second nurse to help reduce the number of patients waiting.

As part of the streaming process, patients were asked to describe their presenting complaint; the location of the streaming station afforded no privacy or confidentiality so it was easy for other patients to overhear the presenting conditions of all patients being streamed. Additionally, streaming nurses were observed leaving their computer terminal unlocked. A patient information system was left on display therefore allowing visitors and patients easy viewing of patient information.

We observed one patient who presented to the streaming nurse complaining of chest pain. The patient was streamed and then booked in with reception staff. The patient was observed holding their chest, clearly displaying signs of discomfort. We observed the patient for a period of twenty-nine minutes during which time there was no health professional present to undertake the triage process. The patient remained in the waiting area for longer than the recommended fifteen minutes without any formalised clinical assessment, physical observations or pain assessment being undertaken. We subsequently escalated this patient to a member of the medical team to ensure the patient was assessed and

managed in a timely way. The trust have since reported they completed a case review for this patient and reported the patient did not come to any harm as a result of their initial wait.

Staff told us that patients presenting with minor injuries would not always receive physical observations. Instead, triage nurses would assess the individuals pain level and where appropriate administer pain relief; the patient would then be referred to be seen by an emergency nurse practitioner within the minor injuries pathway.

As part of their induction all reception staff had received training on 'red flag' presenting complaints and the deteriorating patient. Red flags are signs and symptoms that indicate the possible or probable presence of serious medical conditions that can cause irreversible disability or untimely death unless managed promptly.

The department operated a range of clinical protocols for the management of specific conditions. For example, staff had access to a sepsis care bundle for those patients at risk of or who presented with sepsis indicators. Audits showed variability in the completion of safety checklists and early warning scoring systems.

We reviewed twelve patient records during the inspection. Whilst there was a "track and trigger" tool in place to monitor those patients who had been admitted to the department, staff did not always carry out observations in line with trust protocol and in a timely way; we saw critical observations go overdue. There was variation in the use of national early warning system escalation stickers within nursing and medical records. The use of sepsis-6 care bundles was noted to be sporadic and incomplete.

Staff did not always commence interventions or treatment in a timely way. We saw a patient waited nine hours before being commenced on antibiotics despite the need for antibiotics being recognised on presentation to the department. Whilst immediate dose antibiotics had been prescribed on the ED paper drug chart, no further prescriptions had been issued, therefore resulting in the patient not receiving their second dose of antibiotics within the recommended time-frame. The patient had also been prescribed intravenous fluids but these had not been commenced when we spoke with the patient. The patient was also noted to be taking a range of regular medication; these had been prescribed by the medical team on an electronic prescribing system but had not been written on the ED drug chart subsequently meaning the patient was at risk of not receiving their regular medicines because emergency staff did not utilise or have access to the e-prescribing system.

Another patient presented with shortness of breath. The patient was assessed approximately one hour and thirty minutes after their arrival to the department. The patient was reviewed by a doctor approximately five hours after arriving in to the department following which medicines were prescribed to the manage the patient's condition; this meant the patient was in the department for a period exceeding five hours before receiving active treatment.

A third patient waited approximately two hours and twenty minutes between having their medicines prescribed and subsequently receiving them.

A fourth patient presented with an initial NEWS2 score of 5; the patient had a high temperature and provisional blood tests suggesting an underlying infection. Antibiotics were not administered until some seven hours 45 minutes after presentation. The patient also experienced a delay in receiving secondary antibiotics which had been prescribed at 13:30.

A fifth patient experienced a delay of four hours and forty minutes before they received fluid resuscitation. This was despite the patient presenting with an initial hypotension (low blood pressure) which further worsened whilst in the department.

Nursing staffing

The department had introduced daily safer staffing meetings to assess the needs of patients and to plan staffing levels accordingly. There remained a high reliance on agency and temporary staff to support the department however staff reported seeing and working with regular agency staff which ensured consistency across the department.

Significant improvements in the management of the nursing workforce had been made, in part through strong nursing leadership. This ensured staff with the right skills were deployed appropriately across the department. Regular board meetings ensured nursing skill mix and patient needs were assessed and escalated to the wider trust bed meeting.

Urgent and emergency services

The local team had undertaken a review of the nursing and health care assistant staffing establishment to ensure appropriate numbers of staff were available to be deployed to meet the individual needs of patients.

A comprehensive staff skill matrix had been created which detailed each member of staff across the department and any professional skills they had. Examples included those individuals trained to provide paediatric intermediate life support, safeguarding vulnerable children, trauma life support and other advanced courses. Arrangements were in place to ensure at least one member of staff in possession of advanced paediatric life support was rostered to each shift. This was a significant improvement when compared to our findings of our previous inspection.

There were not sufficient registered sick children's nurse to cover every shift. To address this a number of staff had undertaken competencies to provide a safe environment when caring for children with advice sought for the paediatric wards when necessary. Review of the rotas showed there was always at least one nurse who had received paediatric immediate life support training on duty.

There was a regular programme of paediatric study days and practical simulations to increase the skills and knowledge of ED nursing staff.

Medical staffing

There was a consultant present in the department for 16 hours a day, seven days a week, with a registrar (ST4) available 24 hours a day.

We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed. Handovers between different teams of doctors was well-structured and detailed. Junior doctors were present at board rounds in order they could update the lead consultant. Some staff reported that board rounds could take up to one hour on days when the department was extremely busy which led to lost productivity in the emergency department due to junior doctors attending and updating the board round.

We observed early senior involvement in the treatment of patients throughout our inspection. However, it was observed that once patients had been referred to speciality and a decision to admit a patient had been made, there was then limited clinical oversight of patients who remained in the department. As has previously been reported, basic elements such as ensuring regular medicines had been prescribed for the patient had not occurred.

Medical records were found to be confusing in some instances. The grade and role of doctors were not routinely recorded. In one case, we found three separate pathway documents being used for the same patient.

The planning of on-going medical care was not always recorded. For example, two patients with known chronic obstructive pulmonary disease (COPD) had undergone an arterial blood gas on arrival to the department. Both patients were known to retain carbon dioxide (a known complication of COPD). Increased levels of carbon dioxide in the blood can cause symptoms including but not limited to confusion, dizziness, headaches and in extremely severe cases even death. There was no plan to repeat the arterial blood gas of either patient nor was a decision made to monitor the end tidal carbon dioxide levels of either patient, despite clear recognition of the patient retaining carbon dioxide (end tidal carbon dioxide monitoring is a non-invasive method of monitoring the level of carbon dioxide exhaled with each breath).

Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible and that there had been noticeable changes since our last inspection in July 2018.

Are urgent and emergency services caring?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

- Efforts had been made to improve the experience of patients using the department. Staff sought to utilise clinical assessment rooms and cubicles to consult and treat patients as compared to using the corridor as had been previously noted.
- Staff spoke to patients with compassion. Patients told us they felt listened too and staff considered the views and opinions of patients.

However

- There were still occasions when the privacy and dignity of patients were not always promoted or protected.

Compassionate care

We had previously reported that patients were not always treated with compassion, kindness, dignity and respect. Staff attitudes and poor environmental design resulted in a negative impact on the care patients were receiving and limited the time staff had to spend with patients. We observed numerous incidents where patients' privacy and dignity needs had not been met appropriately. At this most recent inspection we found there had been some improvements in how patients were treated. Staff were observed speaking to patients with compassion and respect. Staff took time to locate appropriate clinical areas to consult with and assess patients as compared to undertaking care in corridors as was previously observed. Efforts had been made to improve the arrangements to maintain patient's dignity and privacy. Staff used curtains and closed doors during examinations.

However, due to the congestion within the department, there remained occasions when patients were being nursed in corridors. In the majority of cases, patients were covered with blankets and their personal needs were reported to be met. We did observe on a number of occasions when blankets had fallen away from the upper parts of patient's bodies, leaving their skin exposed; staff were slow to respond to ensure patients were covered. We also observed on two separate occasions when patients were being supported to use the toilet located in the majors two area of the department. On both occasions, the patients' gowns had come open at the back, exposing the patients full back and underwear which was visible to those in the department, and those walking past the department; again, staff were slow to respond to this and therefore compromised the patient's dignity.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

- Compliance against constitutional standards remained a challenge. However, new models of care and the introduction of well-rehearsed escalation protocols were starting to show signs of some incremental improvement.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate however there was a sense of collective ownership of the challenges.

Access and flow

At the time of our inspection the hospital was on Operational Pressures Escalation Level (OPEL) 3. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; The local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care.

During this inspection we noted the department to be under immense operational pressure in part caused by poor weather conditions resulting in patients not being discharged over the preceding weekend due to unsafe road conditions. These poor conditions meant it was unsafe for patients to leave the hospital grounds. The result was a congested emergency department with multiple attendances, again in part due to the poor weather. We observed patients being cared for along the main corridor of the emergency department and some patients being in the department for extended periods due to a lack of beds across the hospital. We noted the bed position improved during the inspection resulting in patients being discharged across the hospital allowing patients in the emergency department to be admitted to inpatient beds.

Staff told us that following the introduction of the majors two area and the opening of the clinical decision unit, flow across the emergency pathway had improved but accepted it had not been entirely resolved. Staff told us it had not been necessary to nurse patients in the main

emergency department corridor because there had been sufficient capacity within the confines of the existing department and that what we observed on the day of the inspection had become the exception rather than previously accepted practice.

There were now improved systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. The clinical site team could see on the IT system the length of time patients had been in the ED, who had been referred and who required admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. This was all discussed at regular bed meetings throughout the day and plans made. The on-call manager and site practitioners worked closely with the consultant and nurse in charge of the department to facilitate communication to the operations team. We saw evidence of this during our inspection.

The department had also since introduced an operational lead whose remit it was to co-orindate patients through the department and to resolve any obstacles in relation to referring patients to specialities or for finding appropriate beds for patients. There had been progress reported against the total length of time patients spent in the emergency department and an improvement in the four-hour access target since this role had been introduced (although it is important to note the trust does still not meet the constitutional four-hour target which requires 95% of patients attending the emergency department to be admitted, transferred or discharged within four hours).

Clinical staff reported the benefits of the new operational role as they were now provided with more time to deliver patient care as compared to trying to resolve operational pressures. Informatic teams were also working to further enhance the patient record system to ensure the time at which patients were initially seen by a clinician within the rapid assessment area to help improve system wide reporting of performance.

The clinical site team provided 24 hour a day cover, seven days a week. They had an oversight of acute and emergency flow, along with ensuring capacity was maintained.

There remained a focus on ensuring no patient remained in the department for longer than twelve hours once a decision to admit had been made. On the day of the inspection the operational lead worked with clinical staff to determine which patients were most suitable for transfer to available beds. The decision to transfer patients was predominantly based on the total time spent in the emergency department as compared to the clinical needs of patients. We noted at the 13:00 board round one patient who was shortly due to exceed the twelve-hour constitutional target was to be transferred to the acute medical unit. This was despite the patient not long having experienced a seizure and subsequently dislocating a joint; staff opted to move the patient out of the emergency department in order they did not breach the twelve-hour target and to then organise for their dislocated joint to be treated once they had been transferred. This suggested the priority for the department was more focused towards performance as compared to quality.

Staff told us there was now greater support from both the executive team and speciality doctors for managing and restoring flow across the emergency access target. We observed speciality doctors responding to patients at the point of referral with only limited delays on the day of inspection. Staff working in the emergency department felt there had been a significant shift change in how the emergency pathway was now being managed with all specialities looking to own and support the pathway and to assist where they could.

Are urgent and emergency services well-led?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

- Whilst there was no formalised vision or strategy for the department, the historic “Done to” and “Learned helplessness” which was present at the previous inspection had dissipated. Health professionals worked collectively to address the challenges within the emergency care pathway.
- Improved governance arrangements had led to increased oversight of risks and quality. Staff acknowledged that more needed to be done to ensure care was provided in a consistent way.

However:

- Strong medical leadership and the concept of practicing "Good medicine" continued to need improvement.

Vision and strategy for this service

At the time of our focussed inspection, the department was operating at an escalated state. Whilst an internal major incident had not been declared due to the poor weather, staffing had adopted the trust ED full protocol. Operational leads were present in the department to help improve flow across the hospital. Staff reported the local ambulance trust had instigated an internal divert of some patients to Royal Hampshire County Hospital over the previous weekend due to worsening road conditions and poor access to the Basingstoke and North Hampshire Hospital estate. There remained residual challenges regarding the discharge of patients from across the hospital due to patient transport operating at full capacity. However, we noted the bed state of the hospital improved throughout the inspection, aiding in improved flow across the emergency pathway.

Staff told us they now considered the trust escalation protocol to be a more effective process. Improvements were reported in terms of speciality doctors supporting the emergency department during times of surge. Improved working relationships with consultants from the children's department had also been reported, thus improving services afforded to children. The new paediatric assessment unit, co-located in the emergency department was further aiding in developing closer professional working relationships between paediatrics and emergency medicine.

Governance, risk management and quality measurement

With the appointment of a new consultant to the department there came a revision of governance structures across the emergency pathway. New nursing leadership had helped to enhance and improve the band seven nurse leadership level with greater accountability and responsibility devolved to band seven nurses regarding governance arrangements and processes. There was a cohesive approach to quality and safety although it was acknowledged by staff that more work was required.

There remained variation in compliance within audits across a range of measures including the use of the national early warning scoring system and completion of the patient safety checklist. The matron analysed weekly datasets to determine any trends of themes which could aid improving compliance. Some substantive staff reported the reliance on agency staff was a contributing factor to poor compliance; however, the matron had reviewed records and had concluded compliance was an issue across both the substantive and temporary workforce.

There was a sense the leadership team were more aware of the challenges they faced. Risks across the emergency care pathway had been considered and mitigations put in place for known issues. However, there remained risks for which mitigations were poorly thought through and implemented. This included addressing the concerns we identified in 2018 in regard to the management of patients who presented via the "walk-in" pathway. Clinical oversight of the waiting room had improved with the inspection team observing a consultant routinely visiting the area during the first three hours of our inspection but this then tailing off when the consultant had completed their shift. Compliance with national patient safety initiatives remained poor as described in the safe domain. There appeared to be little acknowledgement or awareness of departmental staff to review how the medical team led the department. However, trust representatives and senior leaders had identified this as an area for improvement and had commissioned an external agency to help support the department and clinical leadership moving forwards.

Culture within the service

In stark comparison to our inspection of the department in 2018, there appeared a more cohesive and committed workforce who had evolved and developed a "Can do" attitude. There remained an element of reactive working as compared to proactively thinking about the department and its future service provision however this is likely driven by the changes instigated following the previous inspection and operational demands on the service over the winter period.

Staff consistently reported there was a different feel to the department. There was acknowledgement of better nurse leadership. The department leadership team reported more cohesive working between professions with shared ownership of issues. Morale was reported to be better despite the department working under pressure

to resolve previous challenges whilst meeting operational demands. Staff acknowledged that more needed to be done but the sense of "Learned helplessness" no longer existed. Recruitment, patient pathways, system-wide working and the estate were all reported as key priorities for the department whilst also striving to improve the care provided across the emergency department in real time.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

Ensure patients receive a timely assessment of their care needs and that a plan of care is established and delivered in line with national best practice.

Ensure patients receive care and treatment in an environment which is fit for purpose and meets national standards.

Ensure staff consistently utilise safety measures as determined by trust policy.

Ensure the emergency department operates an effective and safe process for receiving and assessing patients who self-present to the department.