Weston Area Health NHS Trust

Weston General Hospital

Quality Report

Grange Road
Uphill
Weston-super-Mare
Somerset
BS23 4TQ
Tel: 01934 636363
Website: www.waht.nhs.uk

Date of inspection visit: 13 August 2018
Date of publication: 04/12/2018

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

Ratings

Urgent and emergency services

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this focused inspection to follow up on the concerns identified in a Section 29A Warning Notice served in March 2017, following an inspection of the trust. The warning notice set out the following areas of concern, where significant improvement was required:

- Systems or processes to manage patient flow through the hospital did not operate effectively to ensure care and treatment was being provided in a safe way for patients and to reduce crowding in the emergency department.
- There was inadequate hospital-wide support for the emergency department when in escalation. The escalation process was not responsive, and the bed management function was not operating effectively.
- The emergency department was the single point of entry to the hospital for both emergency and expected patients, contributing to crowding. There were no direct admission pathways. This meant all GP referrals were seen in the emergency department. The emergency department did not make optimum use of the ambulatory care unit to help to improve flow and reduce crowding.
- Patients spent too long in the emergency department. There were delays in specialist review of patients, particularly at night, and admission delays from decision to admit.
- Crowding in the emergency department was a frequent occurrence. Patients queued in the corridor when there were no cubicles available. This was not an appropriate or safe place for care and treatment. Patients had no access to supplied oxygen and suction, call bells or facilities to store their belongings keep their records secure.

We conducted our first follow-up inspection in December 2017. Although the trust had achieved progress in addressing our concerns, we judged that the requirements of the warning notice had not been fully met.

We conducted this second follow-up inspection on 13 August 2018. The inspection was unannounced. The inspection focused solely on the issues identified in the warning notice, as described above.

The trust had achieved good progress in addressing our concerns. We judged that the requirements of the warning notice had been met.

We found:

- A number of improvements had taken place since the comprehensive inspection published in March 2017. These included new systems, staff changes and reconfiguration of premises. Changes appeared to have yielded benefits, seen, for example, in improved emergency department performance. However, this improvement must be viewed in the context of an emergency department which was currently closed at night and systems had yet to be tested when the department was open 24 hours a day.
- There was a protocol for the management of accident and emergency patients waiting in the adjacent corridor which was understood by staff.
- For patients being treated in the corridor, records could be safely stored in lockable cupboards.
- Systems and processes to manage patient flow through the hospital had been reviewed and strengthened. Senior staff were driving change and improvement.
- There was evidence of regular dialogue between the patient flow team and the emergency department. There was a clear escalation process and action cards for individuals, teams and departments if demand outstripped capacity.
- A primary care practitioner streaming unit were established to support the emergency department, allowing low acuity patients to be diverted from the emergency department.
- The trust had improved its performance against the standard which requires that 95% of patients are discharged, admitted or transferred within four hours.

Summary of findings

- There had been a continual improvement from February 2018 in delayed specialist review of patients.
- Use of the corridor in the emergency department to accommodate patients at times of crowding had reduced, and curtains were available for use in the corridor to preserve the dignity of patients.
- The trust had employed 'progress trackers': administrative staff who were responsible for escalating any patients in the department who were at risk of breaching targets.

However:

- Nurse staffing at the time of our inspection was below establishment and recruitment and retention remained a challenge for the department.
- The capacity of the ambulatory emergency care unit was affected by vacancies within the unit.
- A recent upgrade to the IT systems within the department made it difficult for staff in the ambulatory emergency care and primary care practitioner streaming unit to take appropriate patients from the emergency department's waiting area.
- Staff in the emergency department and the ambulatory emergency care unit did not work together to resolve common issues.
- The communication device for discussing GP referrals was held by a non-clinical member of the patient flow team. Staff in the emergency department told us that this was inefficient as the non-clinical staff were not able to make clinical decisions about the most appropriate pathway for a patient.

The trust should:

- Ensure executive staff are aware when the corridor is in use, as per the trust's policy.
- Improve systems to allow ambulatory emergency care staff to effectively take appropriate patients from the waiting area.
- Improve communication between the emergency department and ambulatory emergency care unit.
- Ensure the communication device for discussing GP referrals is held by a clinical member of staff to make appropriate decisions regarding pathways for patients.

Edward Baker

Chief Inspector of Hospitals

Summary of findings

Service	Rating	Why have we given this rating?
Urgent and emergency services		

Weston General Hospital

Detailed findings

Services we looked at
Urgent and emergency services;

Detailed findings

Contents

Background to Weston General Hospital

Weston General Hospital is run by Weston Area Health NHS Trust. The hospital, built in 1986, has 261 beds and provides a range of acute and rehabilitation services. The trust serves a resident population of around 212,000 people in North Somerset, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

In March 2017, we conducted a comprehensive inspection of the trust's services. We identified serious concerns in relation to hospital-wide patient flow and bed management and crowding in the emergency department. We took enforcement action and the trust was required to submit an action plan setting out how it would make improvements. We have received monthly updates from the trust and this inspection was undertaken to review the progress made.

Since our last full inspection in March 2017, the trust took the decision in June 2017 to temporarily close the emergency department to new admissions at night, due to safety concerns arising from a shortage of senior medical staff. This report does not specifically comment on staffing; however, it should be noted that medical staff shortage remained a problem. Recruitment was ongoing at the time of our inspection. The emergency department had also experienced a high turnover of nursing staff since the night-time closure and there was heavy reliance on temporary staff. Recruitment and retention of nurses continued to be an issue within the department. We will continue to monitor this and the plans to re-open the emergency department at night.

Our inspection team

The team that inspected the service included a CQC lead inspector, an additional CQC inspector and a specialist advisor: a consultant in emergency medicine. The inspection team was overseen by an inspection manager, and Mary Cridge, Head of Hospital Inspections.

Detailed findings

How we carried out this inspection

We conducted this inspection, unannounced on 13 August 2018. We spent one day in the emergency department. We visited the ambulatory emergency care unit, the discharge lounge and we spent time with the site management team.

During our visit we spoke with approximately 16 staff, including doctors, nurses, and managers.

Urgent and emergency services

Safe	
Responsive	
Overall	

Information about the service

Urgent and emergency care services are provided in the hospital's emergency department seven days a week, 365 days a year. The department is open from 8am until 10pm. Night time closure has been in place since July 2017 due to safety concerns relating to a shortage of senior medical staff.

Between April and July 2018, the emergency department saw 17,121 patients. Twenty-three percent of attendances arrived by ambulance and 23% were admitted to hospital. There is no paediatric cover at night or at weekends and children are taken by ambulance to Bristol or Taunton.

There are two treatment areas. Patients with serious injuries or illnesses, who mostly arrive by ambulance, are seen and treated in the major treatment area, which includes a resuscitation room. The major treatment area is accessed by a dedicated ambulance entrance. Patients with minor injuries are assessed and treated in the minor treatment area.

There is an adjacent ambulatory emergency care (AEC) unit and primary care streaming which provides same day urgent assessment and treatment for ambulant patients, who are not predicted to require admission to hospital. This includes patients directly referred by GPs or the ambulance service, or patients who have attended the emergency department and who meet the suitability criteria.

Summary of findings

- This was a second follow up inspection of urgent and emergency care to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in March 2017. We judged that significant progress had been made. We judged the requirements of the warning notice had been met.
- We have not reviewed the rating for this service because of the limited focus of this inspection. The rating therefore remains inadequate overall.

We found:

- Many changes had taken place since the comprehensive inspection published in March 2017 including new systems, staff changes and reconfiguration of premises. Changes appeared to have yielded benefits, seen, for example, in improved emergency department performance. However, this improvement must be viewed in the context of an emergency department which was currently closed at night and systems had yet to be tested when the department was open 24 hours a day.
- There was a protocol for the management of accident and emergency patients in the adjacent corridor which was understood by staff.
- For patients being treated in the corridor, records could be safely stored in lockable cupboards.
- Systems and processes to manage patient flow through the hospital had been reviewed and strengthened. Senior staff were driving change and improvement.
- There was evidence of regular dialogue between the patient flow team and the emergency department. There was a clear escalation process and action cards for individuals, teams and departments if demand outstripped capacity.

Urgent and emergency services

- A nurse-led primary care service and GP assessment unit were established to support the emergency department, allowing low acuity patients to be diverted from the emergency department.
- The trust had improved its performance against the standard which requires that 95% of patients are discharged, admitted or transferred within four hours.
- There had been a continual improvement from February 2018 in delayed specialist review of patients.
- Use of the corridor in the emergency department to accommodate patients at times of crowding had reduced, and curtains were available for use in the corridor to preserve the dignity of patients.
- The trust had employed 'progress trackers': administrative staff who were responsible for escalating any patients in the department who were at risk of breaching targets.

However,

- Nurse staffing at the time of our inspection was below establishment and recruitment and retention remain a challenge for the department.
- The capacity of the ambulatory emergency care unit was affected by vacancies within the unit.
- A recent upgrade to the IT systems within the department made it difficult for staff in the ambulatory emergency care unit and GP assessment unit to take appropriate patients from the emergency department's waiting area.
- Staff in the emergency department and the ambulatory emergency care unit did not work together to resolve common issues.
- The communication device for discussing GP referrals was held by a non-clinical member of the patient flow team. Staff in the emergency department told us that this was inefficient as they non-clinical staff were not able to make clinical decisions about the most appropriate pathway for a patient.

Are urgent and emergency services safe?

At our initial inspection in 2017, we were concerned about the safety of patients, who were frequently accommodated in the emergency department corridor, when all clinical areas were full. This was not a suitable or safe environment for patients to receive care and treatment. During our second follow-up inspection we found:

- Although use of the corridor for patient care and treatment had reduced, senior hospital managers were not aware that the corridor had been used from April to July 2018, despite staff being required to seek permission to accommodate patients in the corridor from an executive manager.
- Nurse staffing vacancy levels were high, and recruitment and retention remained a challenge for the department.

However:

- There was a protocol for the management of patients in the corridor. Senior clinical staff were required to risk assess patients in the major treatment area to ensure that the most suitable patients were identified for care in the corridor. The area was only used if it could be adequately staffed. There were defined staffing levels and patients in the corridor were not left unattended.
- For patients being treated in the corridors, records could be safely stored in lockable cupboards.

Environment and equipment

- At our initial inspection we reported that the emergency department was frequently crowded, with patients being held in a corridor until space became available in the major or minor treatment areas. This was a frequent and regular occurrence. We were concerned that patients in this area did not have access to call bells, piped oxygen or cardiac monitoring equipment, and there was nowhere to secure patients' records.
- While the same physical constraints still existed, the risks were mitigated to some extent by ensuring that patients were not left unattended. Staff we spoke with confirmed that the environment had improved.

Records

- At our initial inspection we reported that patients' records were not securely stored when patients waited in the corridor. During our follow-up inspection we

found this had been resolved. Lockable cupboards for patient notes had been provided specifically for use when the corridor was in use. These lockable cupboards were stored away at the time of the inspection but were clearly labelled for use in the corridor. Staff we spoke with were aware of the availability of these lockers.

Assessing and responding to patient risk

- There was a standard operating procedure for managing patients in the emergency department corridor. Staff were required to seek permission from executive managers to use the corridor and permission was only granted if safe levels of staffing were in place. This required that the nurse in charge and consultant should review all patients in the major treatment area and patients who had been assessed and were stable would be prioritised for the corridor above any unassessed patients. All staff we spoke with in the emergency department understood and could explain to us how and when the corridor should be used to keep patients safe.
- During our follow-up inspection executives and senior managers we spoke with told us use of the corridor had reduced and had not been used since March 2018. However, data supplied by the trust showed that it had been used 19 times in April, 40 times in May, and three times in both June and July 2018. Executive and senior managers did not know that the corridor had been used in this period, despite the use of the corridor requiring executive permission to open. This suggested that senior managers were unaware of corridor use, and the trust's policy was not being followed.

Nursing staffing

- There remained a shortage of band five registered nurses in the department. To ensure safe staffing levels within the department the hospital required 29 registered nurses. At the time of this inspection there were 16 registered nurses in the department, plus five new starters, and eight vacant roles. The emergency department was using a high number of agency staff – up to 50% of nurses on each shift were agency staff. We were given copies of minutes from the last three emergency directorate governance meeting. Staffing was on the standing agenda, but only covered sickness and training. There were no references to the departments shortage of trained nurses. However, a lack of trained nurses was on the departments risk register.
- Three 'safety sisters' had been employed in the emergency department. Safety sisters provided additional support to the nurses on duty, ensuring timely care, including observations were undertaken, and offer support to the junior members of the nursing team to aid retention of staff. Staff we spoke with were extremely positive regarding this addition.

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

At our initial inspection we were concerned that patient flow in the hospital was not effectively managed to reduce crowding in the emergency department. The emergency department was not well supported by the rest of the hospital when they were in escalation. Specialist review of patients in the emergency department was frequently delayed, particularly at night. The emergency department was the single point of entry to the hospital for both emergency and expected patients, contributing to crowding. There were no direct admission pathways. This meant all GP-referred patients were seen in the emergency department. The emergency department did not make optimum use of the ambulatory emergency care (AEC) unit to help to improve flow and reduce crowding. Patients spent too long in the emergency department, particularly when they were waiting for a bed. Patients were frequently cared for in the corridor, because of a lack of space in clinical areas. This impacted on their comfort, privacy and dignity.

During our follow-up inspection we found:

- Systems and processes to manage patient flow through the hospital had been reviewed and strengthened. The patient flow team had been reconfigured and bed management meetings re-structured to ensure focus on creating capacity within the system. Senior staff were driving change and improvement.
- There was evidence of regular dialogue between the patient flow team and the emergency department. There was a clear escalation process and action cards for individuals, teams and departments if demand outstripped capacity.
- The trust had done a lot of work to develop alternative admission pathways. A nurse-led primary care service

and primary care streaming were established to support the emergency department, allowing low acuity patients to be diverted from the emergency department.

- The trust had improved its performance against the standard which requires that 95% of patients are discharged, admitted or transferred within four hours.
- There had been a continual improvement from February 2018 in delayed specialist review of patients.
- Use of the corridor in the emergency department to accommodate patients at times of crowding had reduced, and curtains were available for use in the corridor to preserve the dignity of patients.
- The trust had employed 'progress trackers': administrative staff who were responsible for escalating any patients in the department who were at risk of breaching targets.

However,

- The capacity of the ambulatory emergency care unit was affected by vacancies within the unit.
- A recent upgrade to the IT systems within the department made it difficult for staff in the ambulatory emergency care unit and primary care streaming to take appropriate patients from the emergency department's waiting area
- Staff in the emergency department and the ambulatory emergency care unit did not work together to resolve common issues.
- The communication device for discussing GP referrals was held by a non-clinical member of the patient flow team. Staff in the emergency department told us that this was inefficient as they non-clinical staff were not able to make clinical decisions about the most appropriate pathway for a patient.

Meeting people's individual needs

- We previously reported concerns that patients were frequently accommodated in the emergency department corridor when there were no suitable clinical areas available. This was not a suitable area for patients to receive care and treatment. We were pleased to note that this practice was much less frequent.
- On the day of our inspection the corridor was being not used to accommodate patients. However, we observed curtain tracking in place along the corridor so that temporary curtains could be hung if the corridor was used to preserve the dignity of patients.

Access and flow

- At our initial inspection we were concerned that patient flow in the hospital was not effectively managed to reduce crowding in the emergency department. The emergency department was not well supported by the rest of the hospital when it became crowded.
- Flow in the hospital had improved to reduce crowding in the emergency department (ED). At this inspection, there were regular meetings to look at flow through the hospital. These meetings were held regularly throughout the day and were well structured and well led. We attended the two bed management meetings of the day, at 8.30am and 3pm. The meetings followed a set format which was clearly visible to all on the site management office wall. Meetings focused differently depending on the time, day and operational pressures. For example, the 8.30am meeting considered 'yesterday', current escalation (OPEL) status and bed state with ED following as next item. Operational Pressures Escalation Framework (OPEL) flags up pressure within the health system and aims to bring national constancy in times of pressure. Then at the 12.30pm meeting, ED was first on the list. Later meetings had ED as the first agenda item. There was a reminder on the 3pm meeting to focus on the use of the discharge lounge and specific beds such as for stroke patients and patients with a fractured neck of femur (broken hip).
- Accountabilities were clear within the meeting and responsibility for tasks were confirmed before the meeting ended. Staff were also aware of their responsibilities from aide memoires used. We found the meetings were calm, mutually respectful and professional.
- The four 'bed management' meetings clearly prioritised patient flow. We saw that staff 'looked ahead' to consider what areas might have beds free later in the day as well as in next few days. This information was displayed on an electronic system, but staff also shared verbal information at the meeting which was the used to update electronic systems. For example, nurses brought patient information, where patients were rated either

red, amber or green in relation to their risk, to support priorities around discharge. The electronic systems which tracked patient flow were visible in the site management office and included current emergency department flow and types of patient and potential future needs such as bed or admissions.

- Senior managers regularly attended bed management meetings. They included the emergency department deputy general manager, and when possible, the director of nursing. Staff we spoke with said the director of nursing attended the first bed meeting up to three days per week. Attendance varied throughout the day depending upon the time of the meeting. For example, the morning meeting might include the director of nursing and the deputy general manager for urgent care. Attendance also depended upon the Operational Pressures Escalation Levels Framework (OPEL) status.
- When we attended the 8.30am meeting as part of the unannounced inspection we saw the director of nursing, deputy general manager and deputy director of planning and strategy were present, as well as senior nurses. The meeting was led by the integrated discharge service lead. When we attended the 3pm meeting the attendance was different due to reduced workload for that meeting and lower OPEL status. Staff who attended the meeting included administrative, senior management and clinical staff including nurses and doctors.
- When we attended the meeting in the afternoon at 3pm, ideas were discussed to manage a predicted bed state of a shortfall of six beds across the hospital. This included using the medical admissions unit's beds. However, this option was argued against as it did not follow an agreed protocol. Therefore, other areas were focused on to ensure that all patients fit to discharge were followed up. Staff we spoke with later described how the meeting considered all needs of the hospital where relevant.
- The trust had employed 'progress trackers', who were staff to provide administrative support to the emergency department. Trackers were responsible for escalating any patients who could potentially breach waiting-time targets. We saw one member of this team speaking with doctors and other staff in the emergency department to understand potential delays and to refocus priorities for admission. This was a two-way conversation which we noted was mutually respectful between the staff.
- We previously reported that patients spent too long in the emergency department, particularly when they were waiting for a bed. There were delays in specialist review of patients in the emergency department, particularly at night. In December 2017, we requested data in respect of delayed specialist review, but the trust was not able to provide this. At our inspection in August 2018, the trust supplied us data regarding specialist review breaches. We saw that there had been continual improvement from February, where 43% of patients had breached, to 5.5% in July 2018.
- There was a registrar physician based in the emergency department to support the early review of patients. There was no senior surgical resident doctor cover after 8pm, although there is a consultant on call. An emergency care consultant remained in the department until midnight, and junior doctors remained in the department until 2am to care for any remaining patients and refer them for admission, if required, into the hospital.
- Performance data showed that the trust's performance against the national standard, which requires that 95% of patients are admitted, discharged or transferred within four hours, had improved since our last inspection. The hospital trust achieved 94.5% in June; 90.1% in July; and 94.5% in August 2018. In the same period, 95% of patients or less spent 6.3 hours in the emergency department. The trust consistently met the standard which requires that the time patients wait for treatment is less than one hour. In July 2018, performance was 24 minutes. Data about the time that patients waited for admission from the decision to admit showed that on average time to admit patients was between 1 hour 14 minutes to 1 hour 20 minutes between May and July 2018. However, this performance should be viewed in the context of an emergency department which had been closed at night to new admissions since July 2017.
- We reported at our initial inspection that the emergency department was the single point of entry to the hospital for both emergency and expected patients, contributing to crowding. There were no direct admission pathways.

This meant all medical, surgical or oncology patients were initially seen in the emergency department. We also reported that the emergency department did not make optimum use of the ambulatory emergency care (AEC) unit to help to improve flow and reduce crowding.

- Since our initial inspection the trust had worked hard to develop alternative admission pathways and to reduce congestion in the emergency department. A nurse-led primary care service had been established to support the emergency department. The service operated from 8:30am to 6pm, seven days a week. There were surgical clinics (where patients could be seen the same or the next day, to prevent admission) and GPs were able to refer directly to AEC, as were the ambulance service and outpatient clinics, if suitability criteria for the patient were met. A primary care practitioner service opened in January 2018. The primary care service saw on average 14 patients a day from May to July 2018, of which around six were emergency patients. Emergency patients spent an average of three hours in the unit.
- There was a 'streaming nurse' employed in the emergency department reception area, who could direct appropriate patients to be seen by an advanced nurse practitioner. However, staff told us in busy periods this nurse would be reallocated into the emergency department. This meant the process became less efficient in busy periods. The primary care nurse and primary care practitioners could see the emergency department systems and were permitted to proactively take appropriate patients from the queue, by identifying which patients could be diverted from ED. However, the information staff had access to had recently changed – patients could be categorised on admittance as 'Unwell Adult' or 'Limb problem'. This made it difficult for staff to identify which patients in the waiting room could be effectively seen by the primary care team. Primary care service staff also told us that they remained unable to refer to patients to other departments in the hospital. Patients requiring a review in a different department (a specialty review) in the hospital were referred back to the emergency department, which appeared inefficient. It was explained to us that this was because the requirement for specialty review would indicate that the patient was not low risk and therefore the streaming process had failed.
- The patient flow team handled the communication device for discussing GP referrals and could advise on the most appropriate admission route. However, emergency staff expressed frustration that the device was held by a non-clinical member of the patient flow team. Staff told us that this was inefficient as the non-clinical staff were not able to make clinical decisions about the most appropriate pathway for a patient.
- Use of the medical assessment unit (MAU) had improved to divert patients from the emergency department. The MAU was located adjacent to the emergency department. There were 10 assessment beds and four observation beds. The MAU accepted expected patients referred by their GP, once triaged in the ambulatory emergency care unit. The aim was to ensure there were two bed spaces on the unit in order that the rapid assessment function, which provides early assessment for some patients, could be maintained. Patients were expected to stay on the unit for six to 12 hours only to ensure it could have a regular movement of patients through the unit. Data from May to July 2018 showed that the average length of stay on the unit was 10 hours 53 minutes, and there was improving performance with 91% of patients discharged from the unit within 24 hours. Patients were accepted 24 hours a day, even when the emergency department was closed. Staff followed a 'Standard Operating Procedure for the Direct Admission of GP-referred medical patients to MAU following ED overnight closure' (July 2017), which set out the referral and admissions process, suitability and exclusion criteria.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure executive staff are aware when the corridor is in use, as per the trust's policy.
- Improve systems to allow ambulatory emergency care staff to effectively take appropriate patients from the waiting area.
- Improve communication between the emergency department and ambulatory emergency care unit.
- Ensure the communication device for discussing GP referrals is held by a clinical member of staff to make appropriate decisions regarding pathways for patients.
- Ensure there are enough staff in the nurse-led primary care unit. to effectively reduce congestion in the emergency department.