Gateshead Health NHS Foundation Trust

Queen Elizabeth 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

The Care Quality Commission (CQC) carried out an unannounced inspection at the Gateshead Health NHS Foundation Trust on 26 September 2018 following two serious patient safety incidents within the short stay unit within 18 months.

Gateshead Health NHS Foundation Trust was subject to a comprehensive inspection in Septemeber 2015. We did not gather sufficient evidence to impact upon trust ratings from that inspection. During this inspection we visited the emergency department and the short stay unit (ward 2) in the Queen Elizabeth Hospital.

This focussed inspection confirmed that lessons had been learnt following the incidents and in addition, processes and risk assessments had been put in place to reduce the risk of further serious patient safety incidents.

We will continue to monitor the trust's action plan through our routine engagement with the trust.

Professor Edward Baker

Chief Inspector of Hospitals

Queen Elizabeth Hospital

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Background to Queen Elizabeth Hospital

Gateshead Health NHS Foundation Trust provides healthcare services in Gateshead in the North East. The trust provides services from the Queen Elizabeth Hospital, Dunston Hill Day Hospital and Bensham Hospital. The trust also provides a range of services from Blaydon Primary Care Centre and Washington Primary Care Centre.

The trust employs about 3,850 staff and currently provides 464 hospital beds across Gateshead. The trust is a tertiary centre for gynaecological oncology and a provider of specialist screening services, for breast, bowel and aorticaneurysm. The screening services are provided to the populations of South of Tyne, Northumberland, Humberside, Cumbria and Lancashire.

The trust was inspected between the 28 September 2015 and the 2 October 2015. An unannounced inspection was completed on 23 October 2015. The trust received an overall rating of good.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Sarah Dronsfield, Care Quality Commission

The team included CQC inspectors from both acute hospitals and mental health.

How we carried out this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the trust was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service.

We were notified by the trust of two serious patient safety incidents on the same ward at the time they occurred but we were not assured that the trust had implemented all the actions identified in their investigations. To gain assurance regarding the safety of patients who presented with mental health concerns at the trust we decided to undertake a focused unannounced inspection of the emergency department and the short stay unit (ward 2).

We spoke with 18 members of staff and reviewed three patient records. We followed the patient journey between the emergency department and the short stay unit to gain insight into the processes in place for patients presenting who were at risk of taking their own life.

As part of this inspection we looked at the specific key lines of enquiry within the safe key question as such we did not rate the key question.

Urgent and emergency services

Safe

Overall

Information about the service

Gateshead Health NHS Foundation Trust provided urgent and emergency services at Queen Elizabeth Hospital where a purpose-built emergency care centre was opened in February 2015. The centre provided an emergency department, paediatric emergency assessment, ambulatory care and an emergency assessment unit. Patients attended through a single point of access and were streamed to the most appropriate service through triage by a qualified nurse. The department also had x-ray facilities and an ambulance receiving area.

The emergency provision in the department consisted of three cubicles for resuscitation of adults and one for paediatric cases (babies and children). If there was a major incident the number of resuscitation beds could be doubled. There were eight cubicles for treating major illness and injuries and eight complex minor illness and injuries cubicles. GP and nurse practitioner staff led a further eight minor injuries cubicles. The emergency assessment unit had 24 assessment cubicles: two of which had ensuite facilities for isolation and infection control purposes. The paediatric area consisted of eight assessment cubicles which also acted as a 24-hour short stay unit. The department operated 24 hours a day, seven days a week. The ambulatory care service had relocated to a different part of the hospital and consisted of eight trolley areas and a seating area.This service operated from 8am to 9pm, seven days a week.

At our previous comprehensive inspection in 2015 we reported that the emergency department saw an average of 1,600 patients a week over the year, with a total attendance of 79,848 patients. At this inspection the trust reported that in 2017/18 the emergency department had a total attendance of almost 85,000 patients.

We undertook an unannounced focussed inspection on 26 September 2018 because of concerns about risk assessment and safe care of mental health patients in the trust.

Upon arrival for this inspection we found a third similar incident had just occurred of which CQC had not yet been notified. During our inspection we visited the clinical areas where patients attended for urgent and emergency care. We conducted a walkthrough of the patient's journey through the emergency care centre and on to the emergency short stay wards.

During our inspection, we spoke with 18 members of staff including medical and nursing staff, senior managers and reviewed patient records related to the three patient incidents. We did not speak with patients during this inspection. We did not gather sufficient evidence to impact upon trust ratings.

Urgent and emergency services

Summary of findings

Following our review of the safety of current practices in the hospital to support the management of patients presenting with mental health concerns, we found:

- The department recognised as a result of the incidents that there was a need to develop more robust systems of risk assessment.
- A revised triage tool which reflected input from the psychiatric liaison team and across services for admission awaited implementation in the emergency department.
- There were some safety concerns about the toilets in the emergency department which were out of sight and had several ligature points and although some measures were in place to mitigate risks these may require review.
- The introduction of tools or related guidance to support the recording of patient observation in the short stay wards was recommended.
- The suitability of the clinical environment of the emergency assessment unit and short stay unit for patients with known mental health concerns or self-harm risks required further review.
- Staff training in mental health and suicide awareness involving the psychiatric liaison team and in collaboration with the 'Treat as one' initiative was planned but was still to be fully implemented.
- Staff training in record keeping may require review as information recorded about patients self-harming was mainly anecdotal and two further incidents staff reported to us were not recorded in the patient's notes.

However, we found:

- An open culture in the hospital and a strong reporting culture. Medical, nursing and support staff were aware of their responsibilities to raise concerns and they said they had no issues about raising concerns. Staff felt confident to escalate issues to senior managers.
- Serious incidents involving mental health concerns were investigated and learning was shared in which staff participated. Psychiatric liaison, an external team who worked in the department, confirmed that learning from the incidents had involved their team and emergency department staff becoming more joined up in their approach.
- The environment of the mental health room in the emergency department was suitable. There were no ligature points and the room was accessed by two separate doors.
- Safeguarding information and guidance was available for nursing and medical staff and safeguarding concerns were followed up appropriately.
- We did not identify any immediate concerns with staffing arrangements in the emergency department. Staff spoke positively about the benefits of the psychiatric liaison team being based permanently in the hospital.
- The patient record system used an electronic marker which identified patients who frequently attended the emergency department and may have mental health issues.
- A revised pathway for patients admitted for medical reasons in case of deterioration in mental health and in collaboration with the psychiatric liaison team was due to be implemented.

Urgent and emergency services

Are urgent and emergency services safe?

Incidents

- The trust informed us following the serious incident in 2016 two policies were introduced related to assessing patients with mental health needs and assessment of the environment. An enhanced care and supportive observations policy identified triggers or behaviours that required risk assessment to determine the need for enhanced observations. The harm minimisation policy was also updated.
- Audit and reporting processes were in place and guidelines were regularly reviewed. The hospital required policies to include information about how adherence to the policy was monitored. Staff we spoke with told us they received information about new or updated policies by email.
- We spoke with medical, nursing and support staff about their understanding of their responsibilities to raise concerns, and to record and report safety incidents, concerns and near misses. Staff we spoke with included staff involved with the serious incidents in 2016 and 2018 and staff involved with the investigation of incidents.
- Staff told us there was an open culture in the hospital and a strong reporting culture. Staff were encouraged to report incidents or concerns and were comfortable with the recording of incidents using an electronic reporting system widely used in the NHS. Staff could select to receive feedback about the investigation of the incident they reported.
- Staff we spoke with provided details about the investigation of these incidents. We asked about the arrangements for reviewing and investigating the incidents and whether relevant staff, services, and partner organisations as well as patients or their representatives were involved in the investigations. The hospital informed us that it had arranged for 75 members of staff to attend external root cause analysis investigator training.
- We asked staff specifically about the three serious incidents involving patients with mental health concerns that occurred in the hospital. CQC received information about two of these incidents through the Strategic Executive Information System (StEIS) and the National Reporting and Learning System (NRLS). We learned of the most recent incident on arrival for this inspection. Two incidents had happened on the short stay unit (ward 2) and the most recent incident occurred in the emergency department.
- The hospital informed us that the 2016 incident was recorded using the incident reporting system imeadiately after the incident and was reported to NRLS on the same day. The root cause analysis was signed off by the serious incident panel and the clinical commissioning panel in 2017. All investiagations and reports were carried out within the aappropriate timescales.
- We spoke with the ward manager who was present at the 2016 incident. The manager did not provide information about the presentation of the patient but told us that they were aware of the patient's circumstances but that there had been no other concerns. Staff had responded to call alarms and doors were left open if patients were deemed to be at risk. There was considerable reliance on patients telling staff if they felt mentally unwell. Staff would make a referral to the psychiatric liaison team if a patient expressed that they intended to self harm.
- We spoke with a member of nursing staff in the emergency assessment unit who was aware of the incident in 2016 although this occurred before they joined the ward. The member of staff said there was evidence of learning from this incident on the ward. They expressed confidence in what to do if patients with mental health issues were identified. The member of staff felt confident to escalate issues to senior managers and gave an example where a patient had disclosed that they were experiencing mental health issues. A referral had been made to the psychiatric liaison team who assessed the patient and made recommendations. However, the member of staff felt that more guidance about levels of observation would have been welcomed.
- The hospital informed us that the 2018 incident was recorded using the incident reporting system and reported to NRLS via StEIS on the same day. The root cause analysis investigation was presented to the serious incident panel three months following the incident. At the time of our inspection we were informed that the investigation of the incident was nearing completion.
- The investigation report for the 2018 incident identified as a root cause that hospital staff were falsely reassured

by the outcome of the patient's mental health assessment undertaken earlier on the day of the incident. This influenced the decision of staff that the patient did not require any further monitoring of their mental health status during their inpatient stay. Threrfore, the patient did not have a mental health assessment.

- A full investigation was to be undertaken of the most recent incident. Investigations were undertaken by a senior member of nursing staff. The trust provided an immediate review report to CQC in relation to the incident which confirmed the details staff shared with us during the inspection, and the immediate actions taken in the emergency department and subsequently to support the patient's assessment and care, including observation. The outcome for the patient was positive. The initial investigation report following completion of a root cause analysis was to be presented to the trust's serious incident panel in following our inspection.
- We found themes were identified from the investigation of incidents, lessons were learned and action was taken to implement change in response to the incident. Learning was shared in which staff participated.
- The patient involved in the first incident was admitted without mental health issues being identified and was not deemed to be at risk. The trust informed us that at the time of the incident the risk register reflected action taken to ensure at-risk patients were not accommodated in single occupancy rooms with fixed overhead hoist tracking. However, lessons were not learned at that stage as to carrying out mental health assessments or the assessment of ligature risks on the short stay unit.
- The investigation report following the second incident recommended: the suitability of the emergency assessment unit and short stay unit for patients with known self-harm risks were reviewed; a clinical environment risk assessment of these ward areas was undertaken, and the pathway for patients admitted for medical reasons in case of deterioration in mental health was developed with the psychiatric liaison team.
- In addition the investigation report identified that those patients who had been assessed by the psychiatric liaison team and discharged from the service could still be deemed at risk of further self-harm. Staff training in mental health and suicide awareness was arranged with support from the psychiatric liaison team and in collaboration with the 'Treat as one' initiative.
- Staff involved with the second incident confirmed that following the incident managers undertook a debriefing for them and learning was shared at departmental meetings.
- From September 2018 a psychiatric liaison forum was to be held monthly. Membership included the psychiatric liaison team and staff from the acute hospital to discuss specific cases where there had been opportunity for learning.
- The immediate review report following the most recent incident showed that security staff had remained with the patient for the duration of their care pathway in the hospital. Staff involved in responding to the incident were debriefed by an on-call manager. The psychiatric liaison team were requested to review the priority assigned to patients waiting to be assessed at the time of the incident.
- Emergency department staff involved with the most recent incident we spoke with confirmed that they were undergoing learning from the ongoing review of the incident. Staff we spoke with felt supported, both formally and informally.
- We spoke with two specialist nursing staff within the psychiatric liaison team who were involved in the incidents. They confirmed that learning from the incidents had involved their team and emergency department staff becoming more joined up in their approach.
- We spoke with the emergency department medical lead who was involved in the incidents. They confirmed that staff felt able to raise concerns and learning from the investigation of incidents was shared. The department recognised as a result of the incidents that there was a need to develop more robust systems of risk assessment. They also told us that having very regular contact between colleagues was vital to capturing issues and improving safety. Lessons learned were discussed at regular and well-attended departmental meetings and business unit meetings and cascaded to staff. Action plans from these meetings were progressed and monitored.
- We spoke with a manager representing the commissioners with a role in clinical quality and patient safety. They confirmed work was being undertaken with hospital staff following the incidents, and staff were supported appropriately.

- We saw duty of candour had been considered and was being progressed following the most recent incident. Staff we spoke with confirmed they had received training in duty of candour.
- Medical and nursing staff we spoke with confirmed their annual statutory mandatory training included reporting and recording incidents. Some aspects of this used e-learning. Staff confirmed they had received this training and spoke positively about its benefits.
- Staff we spoke with confirmed mortality and morbidity meetings were held monthly which were attended by medical and nursing staff.

Environment and equipment

- During our inspection we reviewed whether the design, maintenance and use of the premises and facilities kept patients safe. We visited the emergency department, which had opened in 2015, particularly the areas used to care for patients experiencing mental health issues in order to assess the environment and equipment used.
- In the refurbished emergency department staff informed us the mental health room was previously located next to the reception desk. We were informed it was recognised within two weeks of the department opening the location of the mental health room was unsuitable and the facility was moved to the former relative's room. The mental health room was subsequently relocated next to the nurse station and close to the ambulance entrance, making it well positioned for security access. A separate triage area was used for paediatric patients, with a segregated waiting area. Security screens gave an overview of the entire emergency department.
- The environment of the mental health room was suitable. There were no ligature points and the room was accessed by two separate doors. We were informed mental health patients may need to wait for significant periods of time to be assessed and so the department had installed a reclining chair in the mental health room. Following psychiatric liaison team assessment typically the patient may face a further wait for the crisis team to arrive and the mental health room provided a place for the patient to lie down.
- We found there were some safety concerns about the toilets in the emergency department. The toilets were out of sight and had several ligature points. We identified with staff an issue may arise between the patient arriving and receiving triage if they used the toilet. We were informed reception staff were experienced in recognising patients with potential issues and would speak to the triage nurse if they had concerns. Although reception staff would not intervene they would raise concerns.
- We visited the emergency assessment and short stay units in the hospital where patients experiencing mental health issues may be transferred from the emergency department, to assess the environment and equipment used. A 24 bedded area arranged in single patient pods of eight provided for patients stays of up to 24 hours. Typically patients may be admitted to the emergency assessment unit to become medically fit for assessment by the psychiatric liaison team. Typically patients who had suffered an overdose would be admitted to the short stay unit. The short stay unit had been assessed to review ligature risks.
- In the emergency assessment unit staff could observe each room from the nurses' station. The unit consisted of single occupancy rooms and although nursing staff could see into the room the patient could also close the blind from inside. Within each room an en-suite bathroom was located to the right of the entrance door. Each room was provided with anti-ligature curtain rails.
- We spoke with specialist and general nursing and support staff who worked in the emergency department and emergency assessment as to whether they had concerns about any aspects of the ward environment. Specialist nursing staff told us they felt the environment on Ward 2 increased risk to the patient. We spoke with senior nursing staff about the use of the blinds within the viewing panel. Staff told us if the patient was identified as high risk the door to the room was left open. Staff said they were more vigilant to check the room during ward rounds if concerns or risks had been highlighted.
- An environmental ligature audit had been completed for the short stay unit (Ward 2). Managers informed us ligature risks were identified in the patient rooms. This was confirmed by our observation of the ward, which obviously was not intended to be a mental health hospital. Managers told us if the identified risks were removed, the ward area would not be compliant with the Disability Discrimination Act.

- We discussed with hospital managers the implications of managing these risks to patients. Managers informed us whilst two anti-ligature rooms were being planned for the ward, more guidance was required as to how the how patients at risk were identified.
- We reviewed the clinical environmental risk assessment undertaken for the short stay unit (ward 2) in August 2018. Most fixtures and fittings within the ward were identified as representing a ligature risk. The environmental risk assessment for ward 2 set out a range of options, including removing fixtures and fittings identified in the report from 'one or two' of the bedrooms and the en-suite to make them ligature free. The risk assessment report confirmed that in this case the selected bedrooms would no longer be suitable to meet Disability Discrimination Act (DDA) standards.

Records

- We spoke with staff about the systems used for recording information about patients in the emergency department and within the hospital. We undertook an initial case note review of the patient records for the most recent incident in order to track the patient's journey during their time in the department and to identify if some relevant information was not available from the patient record. The patient's medical record contained the appropriate information supported by risk assessments. The record of waiting times confirmed the patient was seen and treated promptly. However, information recorded about the patients self-harming was mainly anecdotal and two further incidents staff reported to us were not recorded in the patient's notes.
- The patient record system included an electronic marker which identified patients who frequently attended the emergency department and had mental health issues.
- We spoke with two specialist nursing staff within the psychiatric liaison team who were involved in the incidents. The specialist staff worked for another trust and they confirmed they could access the hospital patient records; details for mental health patients were stored in a different IT system. Hospital managers we spoke with told us work was in progress to make the planning and sharing of patient information with external partners more joined up.
- Medical, nursing and support staff we spoke with told us they received training in record keeping as part of their annual statutory mandatory training and they felt comfortable undertaking reporting tasks. Staff also told us they received update training and they were aware when training was planned. However, some staff expressed the need for further training in recording aspects of the care and treatment they delivered to higher risk patients.

Safeguarding

- We reviewed the hospital's arrangements for safeguarding to check whether staff identified adults and children who may be at risk, or suffering significant harm. We also checked how the hospital worked in partnership with other agencies to ensure patients were protected and supported appropriately. We reviewed how patients were protected from discrimination, which might amount to abuse or cause psychological harm, which included harassment and discrimination in relation to protected characteristics under the Equality Act.
- We reviewed the records following the most recent incident and saw safeguarding concerns were identified; conversations with the nominated safeguarding lead and external agency were recorded appropriately.
- Medical and nursing staff we spoke with told us there were effective safeguarding links both within and external to the hospital and they were alerted appropriately about patient concerns. Staff erred on the side of caution when raising a safeguarding alert to ensure patients and their contacts were kept safe.
- The member of nursing staff raising the concern remained the principal handler in any investigation but senior nursing staff and the psychiatric liaison team were involved in any investigation and provided support.
- Safeguarding information and guidance was available for nursing and medical staff through the staff intranet, which staff told us they found helpful. A separate dedicated system was used for paediatric patients, overseen by a paediatric matron.
- Medical and nursing staff we spoke with confirmed they had received safeguarding training and this was up to date.

Mandatory training

- We reviewed the training staff received to check it supported the care and treatment of patients effectively. In particular we reviewed mandatory training undertaken by clinical staff to support their response to

patients with mental health needs and related conditions. The hospital confirmed all staff had a level of awareness in relation to supporting patients with mental health needs. Further specialist training had been undertaken for staff in high risk areas which included how to manage patients with increased agitation.

- The hospital provided records of staff training for the emergency department and the emergency assessment and short stay wards we visited. The records confirmed the members of staff had completed training, and dates when refresh or other training was arranged. Nursing staff we spoke with in these areas confirmed they had received their mandatory training as part of induction. Staff also received refresher training, and were notified when this was planned.
- Managers involved with training arrangements confirmed mental health awareness was to be made available to all staff through e-learning. A package of training to support self harm awareness and prevention was planned which would be supported by external mental health partner organisations. Self harm awareness training for staff in the emergency department, emergency assessment unit and short stay unit was planned to commence in October 2018. Nursing staff we spoke with confirmed they were to receive face-to-face mental health awareness training planned for October 2018. Simulation training was to be implemented in the emergency department with external partners from November 2018.
- Training staff received included coping with violence and aggression as part of mandatory training. For the emergency department, we reviewed the training action plan for additional training which confirmed staff who had undertaken violence and aggression level two training and the dates of planned training for level three. Training records showed violence and aggression training level three was also arranged for the emergency assessment unit and short stay unit. The hospital confirmed security staff received training in restraint techniques.
- The training records we reviewed for the emergency assessment unit and the short stay unit showed staff who had completed conflict resolution training and planned training dates. The hospital confirmed managing patients with increased agitation was included in this training.The hospital did not provide information as to the overall percentage of staff trained.
- Nursing staff we spoke with confirmed they had received training in violence and aggression although some staff expressed concerns as to the expectations placed on them in caring for patients who displayed these behaviours.
- Respond scenario training for emergency department staff involved in caring and treating patients with mental health concerns included external partners for example the police and ambulance services. Respond training supported the different roles each professional staff member played in response to a patient with mental health concerns. At the time of our inspection the reintroduction of respond training was under review.
- The hospital delivered training for all frontline staff in dealing with people in distress. ‘Sage and Thyme’ training workshops for clinical and non-clinical staff used evidence-based communication skills to support patients and other people with emotional concerns. Training rates of staff who have undertaken the 'Sage and Thyme' training confirmed the number of attendees for sage and thyme training sessions in 2018 (31) and in each of the previous three years (56). The hospital did not provide information as to the overall percentage of staff trained.
- The ‘Treat as one’ initiative followed the publication of a report published by the National Confidential Enquiry into Patient Outcomes and Death in 2017 to close the gap between mental and physical healthcare in general hospitals. We spoke with a member of commissioning staff seconded to the hospital to support this initiative. ‘Treat as one’ aimed to improve care for patients with mental health needs as they received treatment for their physical needs.
- The ‘Treat as one’ initiative had completed at the time of our inspection. A formal launch had raised awareness with hospital staff and identified medical and nursing staff with an interest in becoming mental health champions. Staff involved with ‘Treat as one’ supported clinical supervision and staff development. Further training was planned aligned with the hospital’s ‘Treat as one’ action plan. Planned training included mental health awareness training (Health Education England) and, for senior nursing staff from emergency department clinical areas, ‘A life worth living’ (Washington Mind). The hospital informed us the training programme was planned to commence in December 2018 and staff attending were expected to cascade the training to their teams.

Urgent and emergency services

Assessing and responding to patient risk

- We reviewed risk assessments undertaken and risk management plans developed for patients who arrived at the hospital with concern about their mental health. We checked whether psychosocial assessments and risk assessments were undertaken for patients thought to be at risk of self-harm.
- We visited the emergency department reception where walk-in patients arrived at the department and spoke with reception staff. On arrival the administrative staff in reception searched for the patient's date of birth to link their record with any previous visits to the hospital. At a patient's first visit their date of birth, name and address were registered and reception staff recorded a brief overview of their presenting complaint.
- Staff told us patients with mental health concerns frequently arrived at reception. We were informed reception staff were experienced in recognising issues with patients and if they had a concern they contacted clinical staff immediately. If the patient presented in trauma with obvious mental health needs reception staff told us they would ring the triage team. If the patient used the toilet they were not accompanied. Reception staff told us patients with mental health needs may also have an alert recorded for known patients if they were a risk to themselves or other people.
- From reception, patients were triaged by nursing staff. We were informed triage took from five to 20 minutes to complete. If the triage nurse called for a patient and they failed to answer staff checked toilet and refreshment areas, supported by security staff and the CCTV in use in the department. Staff undertaking triage used a triage tool which identified patients representing high risk. Triage nurses we spoke with confirmed reception staff contacted them if the patient was displaying abnormal behaviour.
- A mental health assessment may be indicated for example, by frequent attendances or evidence of self-harm following a physical assessment. Triage nurses told us they could refer the patient directly to the psychiatric liaison team based in the emergency department, or to the mental health crisis team. They could also refer to these specialist teams for advice, and some patients already had plans in place for their care.
- If the patient needed medical intervention they were transferred to the short stay unit where they would also receive their psychiatric assessment. If the patient was not stable enough medically for admission to the short stay unit they may be streamed to ambulatory care if they were otherwise medically stable. For patients transferred to the emergency assessment unit, consultant medical staff assessed the patient prior to them being transferred to the most appropriate department, which may include the short stay unit.
- The 'Manchester' triage flow chart for triaging a patient presented with a mental health problem was being used at the time of inspection, although the use of the triage tool was under review. The Manchester triage was undertaken by senior nursing or specialist staff (band 7). Medical staff we spoke with told us in the triage tool currently used there was a disconnect in the documentation of risk assessments for mental health patients who had a medical need. We reviewed the revised triage flow diagram currently in draft based on the 'Cambridge model' which reflected input from the psychiatric liaison team and across services for admission. At the time of inspection the revised triage flow was at the approval stage.
- The psychiatric liaison team based at the hospital were employed by another local trust. The psychiatric liaison team provide cover twenty four hours a day seven days a week and had a planned response time of one hour for any referrals. Members of the psychiatric liaison team told us they were meeting the planned response time. The psychiatric liaison staff we spoke with told us they felt their team had become more recognised over the previous year by acute hospital staff and referrals had increased.
- We spoke with the psychiatric liaison nurse who had been involved with the most recent incident. A referral was made to the liaison team by the emergency department and the psychiatric liaison nurse attended. In the second incident the member of specialist staff had assessed the patient and had discharged them from the service. The psychiatric liaison team told us they were due to deliver some training to the acute hospital staff but no dates had been confirmed. The team felt some learning related to mental health would be beneficial for the hospital staff.

Nursing staffing

- We checked how staffing and skill mix were planned and reviewed by comparing actual staffing levels and skill mix with planned levels.

- For the emergency department, we discussed the arrangements for nursing staffing with managers and senior staff. The department used national quality benchmarking guidance to review nursing acuity in the department at the time of inspection. The emergency department worked closely with the emergency assessment unit in planning staffing.
- The department had recently increased the staff on duty. The department used bank staff, who were frequently hospital staff undertaking an extra shift. The department did not use agency staff. Our review of staffing arrangements in the department did not identify any immediate concerns.
- For the emergency assessment unit, we found staff handovers at shift changes were undertaken on a one to one basis outside the patient's room to support continuity of care.
- The hospital informed us it had taken steps to increase the staffing on the short stay unit which included registered nurses at night and health care assistants for early and late shifts. We reviewed staffing information for the short stay unit for July and August 2018, which were the latest months for which staffing fill rate information was available at the time of inspection. The average fill rates for July and August 2018 for qualified and non-qualified nursing staff showed fill rates exceeded 80% of establishment for qualified staff. For non-qualified staff numbers met or exceeded establishment.
- The psychiatric liaison team were based in the hospital twenty four hours a day and seven days a week. This arrangement had been in place for 12 months at the time of inspection. Staff spoke positively about the benefits of the psychiatric liaison team being located in the hospital.

Medical staffing

- We spoke with consultant medical staff on duty in the department and clinical managers. We did not review medical staffing arrangements as part of this inspection. However, managers spoke positively as to the contribution and 'buy-in' of medical staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Develop more robust systems of risk assessment for patients arriving at the hospital with indications of concern.
- Implement a revised triage tool which reflects input from the psychiatric liaison team and across services for admission to the emergency department.
- Review the measures in place to mitigate risks in the environment around and including the toilets in the emergency department which are out of sight of the main department and have identified ligature points.
- Introduce tools or related guidance to support the recording of patient observation in the short stay ward.
- Review further the suitability of the clinical environment of the emergency assessment unit and short stay unit for patients with known self-harm risks.
- Implement in full staff training in mental health awareness involving the psychiatric liaison team and in collaboration with the 'Treat as one' initiative.
- Consider and review arrangements for emergency department staff training in record keeping to support appropriate recording of patients self-harming and related behaviours.