

Great Western Hospitals NHS Foundation Trust Great Western Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this focused inspection to follow up on the concerns identified in a Section 29A Warning Notice served on the trust in December 2015. This followed our comprehensive inspection of the trust in September 2015. The warning notice set out the following areas of concern where significant improvement was required:

1. The location, design and layout of the emergency department observation unit, combined with inadequate staffing levels and staff training, presented risks to patients and staff.
2. Systems to ensure accurate records were maintained in respect of patients' care and treatment were not effective. We could not be assured appropriate care and treatment was provided in a timely manner.
3. There was a lack of assurance that nurse staffing levels had been appropriately established or that planned levels of staffing were consistently achieved to ensure that patients attending the emergency department received timely, safe and effective care and treatment.
4. There were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. Planned staffing levels were not consistently maintained. This, combined with the design and layout of the department, presented unacceptable risks to patients. These risks were not addressed and steps to mitigate risks were not adequate or effective to ensure safe care and treatment.
5. There was inadequate oversight and monitoring of staff training to ensure that staff had the right qualifications, skills, knowledge and experience to provide appropriate care and treatment in a safe way
6. The governance systems and processes in place within the trust were not effectively operated and as such were not able to demonstrate effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints and mortality and morbidity reviews. This was particularly evident in the unscheduled care division and the planned care division.

The trust was required to make significant improvements by 31 January 2016. The action plan provided by the trust, detailing how improvements would be made, indicated that full compliance would not be achieved until April 2016.

The inspection was conducted on 21 and 22 April 2016 and was unannounced. Our inspection focused on the issues identified which occurred in the following areas:

- The emergency department, including the observation unit
- Governance arrangements in the planned care and unscheduled care divisions

The reporting period coincided with a very busy and challenging time for the emergency department and the hospital. The winter had seen a significant increase in ED attendances and unplanned admissions to hospital. This was compounded by significant staff shortage, ward closures due to infection and a high number of delayed discharges. Poor patient flow within the hospital and the wider health and social care community meant that the ED was frequently overcrowded and patients spent too long in the department. This was demonstrated by the consistent failure of the four hour target and the unprecedented number of patients waiting 12 hours or more for a hospital bed.

We had continuing concerns that safety concerns were not always addressed in a timely way. Key findings were as follows:

- Accurate and up-to-date records of care and treatment were not consistently maintained to ensure that patients were protected against the risk of inappropriate care and treatment.
- Staff did not consistently comply with safety systems in place to identify seriously unwell or deteriorating patients.
- The emergency department was not consistently staffed to ensure that defined safe staff to patient numbers were met. There was insufficient reporting or scrutiny of staff concerns with regard to staffing levels and capacity.
- We had continuing concerns about the safety of patients and staff in the emergency department observation unit. Plans to relocate or reconfigure the unit to improve safety had not been finalised.

Summary of findings

- There remained a significant number of gaps in nurse training. A training plan to address identified gaps had not been developed and management oversight of this had yet to be implemented.

However,

- Comprehensive improvement plans were in place and progress against these plans was overseen by executive management. Progress had been made against milestones.
- In recognition of the significant improvement agenda, temporary management support had been provided to the management team within the emergency department.
- Nurse staffing had been increased by approximately 20%. This included provision of staff to improve safety in the children's emergency department and in the observation unit.
- Staff had received specialist training to better equip them to care for patients with mental health needs who were at risk of causing harm to themselves or others. Security presence had been increased in the emergency department.
- Governance systems had been strengthened and reporting improved so that divisional and executive management had a more comprehensive overview of risks to safety and quality.

Whilst improvements had been made, the ongoing concerns identified during the follow up inspection mean the Warning Notice dated 2 December 2015 has only been partially met.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Great Western Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Surgery; Critical care

Detailed findings

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Background to Great Western Hospital

Great Western Hospitals NHS Foundation Trust provides a number of services across Wiltshire, to a population of around 480,000 people in Wiltshire and the surrounding areas, with acute services provided at the Great Western Hospital, Swindon. The hospital was built under the Private Finance Initiative at a cost of £148million and opened in 2002. The trust became a foundation trust in 2008.

Wiltshire Local Authority is in the 40% least deprived areas in the country. The proportion of the population who are under 16 years of age (equal to the percentage in England was 19.0%). The percentage of people aged 65

and over is 19.5% (higher than the England figure of 17.3%). There is a lower percentage of Black, Asian and Minority Ethnic (BAME) residents (3.6%) when compared to the England figure (14.6%).

The inspection team inspected the following core services:

- Urgent and emergency services
- Surgery
- Critical care

Our inspection team

Our inspection team was led by Amanda Eddington, Inspection Manager, Care Quality Commission

The team included a CQC inspector, and two specialist advisors (a senior emergency department nurse and a consultant physician).

How we carried out this inspection

The inspection was conducted unannounced. We visited the hospital on 21 and 22 April 2016. We spoke with nursing and medical staff, support staff, the divisional management team and the executive management team.

We reviewed information provided by the trust, prior to, during and following the inspection. We spoke with NHS Improvement and reviewed the information we hold about the trust.

Facts and data about Great Western Hospital

The hospital has a total of 450 beds (including 12 critical care beds and 38 maternity beds). The workforce consists

Detailed findings

of 721.8 whole time equivalent (WTE) staff, who are employed to provide acute healthcare services to a population of around 480,000 people from Wiltshire and the surrounding areas.

Between July 2014 and June 2015 there were a total of 84,762 inpatient admissions including day cases, 490,740 outpatients' attendances (both new and follow-up) and 78,519 attendances at the emergency department.

At the end of 2014/15, the trust had a financial deficit of £6.2 million.

Bed occupancy was consistently above 92%, with occupancy 95% during quarter 4 2014/15. This was above

the England average (85.9%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

CQC inspection history

A comprehensive inspection of the trust was last carried out in September 2015. At this inspection, significant concerns were identified with the emergency department and governance processes and a section 29A warning notice was issued.

Notes

We have not rated services because of the limited focus of our inspection which did not include all domains or all components of each domain.

Urgent and emergency services

Safe	
Effective	
Well-led	
Overall	

Information about the service

The unscheduled care division provides urgent and emergency services at Great Western Hospital (GWH). The emergency department (ED) operates 24 hours a day, seven days a week.

Patients who present with minor illnesses may be redirected to the nurse-led urgent care centre located on the GWH site or to the co-located GP out-of-hours service. This unit is run by another provider and did not form part of this inspection.

Adult ED patients receive care and treatment in two main areas: minors' and majors'. Self-presenting patients with minor injuries are assessed and treated in the minors' area.

Patients with serious injuries or illnesses who arrive by ambulance are seen and treated in the majors' area, which includes a resuscitation room. The majors' area is accessed by a dedicated ambulance entrance.

There is a dedicated children's unit with a separate waiting area and a treatment area with five private cubicles.

The ED is a designated trauma unit and provides care for all but the most severely injured trauma patients. Severely injured trauma patients are usually taken by ambulance to the major trauma centres in Bristol or Oxford if their conditions allow them to travel directly. Such patients are otherwise stabilised at GWH before being treated or transferred as their conditions dictate. The ED at GWH is served by a helipad.

There is an eight-bed observation unit that allows for further assessment of patients who are likely to require treatment for between four and 24 hours but are unlikely to require admission.

We previously visited the Great Western Hospital in September 2015. We raised a number of concerns

following this visit in relation to the emergency department. Our concerns in relation to safety were significant and we judged that the governance systems and processes in place were not effectively operated and, as such, were not able to demonstrate effective management of risks, effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints and mortality and morbidity reviews.

In December 2015 we took enforcement action and required the trust to make significant improvements by 29 January 2016. The trust submitted a comprehensive improvement plan which described changes and improvements which had been put in place or were planned. We received monthly progress reports and we were assured that progress was being closely monitored by the executive management team.

We conducted a follow up visit on 21 and 22 April 2016 to review progress. We spoke with the matron and the clinical lead in the emergency department. We also spoke with medical, nursing and support staff. We observed care and treatment and looked at records. We reviewed a range of information provided by the trust prior to, during and following our visit.

The reporting period leading up to the inspection coincided with a very busy and challenging time for the emergency department and the hospital. The emergency department saw an increase of 13.2% in attendances from January to March 2016, compared with the same period in 2015. This equates to an average increase of 27 patients per day. In the same time period non-elective admissions to hospital increased by 13.1%, an average increase of 12 patients per day. This was compounded by significant staff shortage, a consistently high number of delayed discharges and the closure of wards in March and April 2016 due to infection. A number of changes were made to support patient flow during the winter; however, despite these changes, the unprecedented

Urgent and emergency services

demand on the service impacted on the delivery of the four hour target in the emergency department, and resulted in significant numbers of long waits for patients who required admission. There were a total of 82 twelve hour trolley waits during March and April 2016.

Summary of findings

The purpose of this inspection was to assess whether sufficient progress had been made by the trust in response to the Section 29A warning notice issued in December 2015, following a comprehensive inspection in September 2015.

The warning notice was not met because:

- We had continuing concerns that risks to patient safety were not always addressed in a timely way.
- Accurate and up-to-date records of care and treatment were not consistently maintained to ensure that patients were protected against the risk of inappropriate care and treatment.
- Staff did not consistently comply with safety systems in place to identify seriously unwell or deteriorating patients.
- The emergency department was not consistently staffed to ensure that defined safe staff to patient numbers were met. The department had not set out how safe staffing levels should be maintained when the department was over capacity. There was insufficient reporting or scrutiny of staff concerns with regard to staffing levels and capacity.
- We had continuing concerns about the safety of patients and staff in the emergency department observation unit. Plans to relocate or reconfigure the unit to improve safety had not been finalised.
- There remained a significant number of gaps in nurse training. A training plan to address identified gaps had not been developed and management oversight of this had yet to be implemented.

However,

- Comprehensive improvement plans were in place and progress against these plans was overseen by executive management. Progress had been made against milestones.
- In recognition of the significant management agenda, temporary management support had been provided to the management team in the emergency department.

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- Nurse staffing had been increased by approximately 20%. This included provision of staff to improve safety in the children's emergency department and in the observation unit.
- Staff had received specialist training to better equip them to care for patients with mental health needs who were at risk of causing harm to themselves or others. Security presence had been increased in the emergency department.
- Governance systems had been strengthened and reporting improved so that divisional and executive management had a more comprehensive overview of risks to safety and quality.

Are urgent and emergency services safe?

- Safety concerns were not always addressed in a timely way. We were concerned that lessons had not been learned in relation to protecting older people who were at risk of falling in the emergency department observation unit. Despite assurance that this patient group would no longer be admitted to the observation unit, we found that they continued to be admitted there. Furthermore, there were inadequate processes in place to protect them from the risk of falls.
- Following a serious incident in December 2015, the trust committed to monitor and report on the time to initial assessment of patients who self-presented in the emergency department. We had raised concerns about this following our inspection of the service in September 2015. We saw no evidence that this was being monitored and reported on.
- Investigations following incidents were not always thorough or robust. Following an incident in February 2016, where a patient received sub-optimal care while queuing in the emergency department corridor, the department undertook only a superficial investigation. We could not be assured therefore that adequate steps had been taken to prevent a further incident of this nature.
- Accurate and up-to-date records of care and treatment were not consistently maintained to ensure that patients were protected from the risk of inappropriate care and treatment. We found that contemporaneous records of nursing care in the emergency department were not consistently maintained. Nursing documentation had been revised and staff training had taken place. Regular documentation audits were taking place and the trust reported that record keeping was improving. However, we found there was significant room for further improvement.
- Patient observations were not undertaken with the required frequency in the emergency department and early warning scores were not consistently calculated and recorded so that deteriorating patients could be identified and appropriately managed.
- At our previous inspection in September 2015 we were not assured that the emergency department and the observation unit were consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure that people received safe

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care and treatment at all times. The department had not set out in a protocol to describe how safe levels of staffing would be achieved when the department was over capacity.

- The trust had taken a number of steps to improve patient and staff safety on the observation unit. We had previously raised concerns about the location, layout and staffing of this unit. Improvement actions had included staff training, increased security presence and the employment of a mental health registered nurse. However, the emergency department continued to report a significant number of incidents in relation to the management of mental health patients who were admitted to the observation unit. Plans to reconfigure the observation unit had not yet been finalised and the timescale for works to be undertaken were unknown.
- Following our previous inspection the emergency department's nurse staffing establishment was increased by approximately 20%. This included the employment of a registered mental health nurse in the observation unit and the employment of a healthcare assistant in the children's area so that children in the waiting area were observed and supported. We were told that safe staff to patient numbers had been defined, although we did not see this documented and we were not provided with a protocol which set out how these staff to patient numbers were maintained when the department was over capacity.
- Despite this significant uplift in staffing, staff in the emergency department told us the department continued to struggle to maintain safe staffing levels. This was also demonstrated by the number of incidents reported by staff relating to staffing levels. This was in the context of a department facing unprecedented demand and compounded by a significant number of vacancies. Temporary staff were employed to fill gaps in the rota, and planned levels were mostly achieved, albeit at times staffed by a large proportion of temporary staff.

Incidents

- At our previous inspection in September 2015 we saw limited evidence of learning from serious incidents. Following a patient fall on the ED observation unit in December 2014 when the patient sustained serious injury, the department committed to introducing falls

risk assessment and care planning documentation for all patients over 65 years of age admitted to the observation unit. In November 2015 the trust told us that elderly patients at risk of falling would no longer be admitted to the observation unit. Following the issue of a warning notice in December 2015, the trust's action plan stated that multifactorial risk assessment documentation in respect of falls would be built into ED documentation. This action was confirmed as complete in January 2016. During our inspection we found this documentation had not been introduced and we were not satisfied that adequate steps were taken to safeguard older people admitted to this unit from the risk of falls. We raised our concerns following our inspection.

- During our follow up visit we looked at the records for an elderly patient who had been admitted overnight to the observation unit following a fall. The emergency department observation unit patient pathway documentation identified that the patient was at risk of falls due to poor mobility. On the second day of the patient's stay we asked the nurse on duty in the observation unit if a full falls risk assessment had been undertaken and a falls care plan put in place for this patient. They showed us a care round document which was kept by the patient's bed. This document was designed to record regular checks of patients. The document required that the risk of falls was indicated by 'yes' or 'no', but this had not been completed. The nurse immediately updated the document. The document included two prompts associated with the risk of falls. These required that the nurse recorded the mental state of the patient (asleep, agitated, delirium or dementia) and whether they were wearing appropriate footwear. Regular checks on the patient had been documented with a tick. The nurse acknowledged that a full risk assessment should have been undertaken but told us that there was no documentation in use for this purpose. They told us later that they had raised this with a senior nurse in the emergency department and had been instructed to use a falls risk assessment pro-forma. This did not form part of the care documentation bundle we had been provided with earlier in the day and staff confirmed that it was not currently in use.
- Following a serious incident in June 2014 where a patient's head injury was not treated in accordance with guidelines produced by the National Institute for Health

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and Care Excellence (NICE), refresher training took place and the trust committed to undertake an audit of the management of head injuries in intoxicated patients by October 2014. When we inspected the service in September 2015 the trust confirmed that this audit was still outstanding. At our follow up inspection the trust provided us with a report following a local audit of the management of head injuries which was undertaken in January 2015. Although this was not in response to the incident mentioned above and was not specific to the management of head injuries in intoxicated patients, it nevertheless reviewed the management of head injuries against NICE guidelines. The audit identified that the department's management of head injuries was mostly compliant with NICE guidance.

- A staff survey conducted in the emergency department in early 2015 had revealed a significant number of staff had dealt with verbal or physical abuse from patients or relatives and had concerns for their safety and the safety of patients. Sixteen incidents had been reported relating to the management of mental health patients in the six months ending October 2015. The department had committed to providing conflict resolution training for all staff. At the time of our previous visit in September 2015, staff told us they continued to feel vulnerable, particularly when they worked in the observation unit. We raised concerns that many staff had not received conflict resolution training. The trust had committed in its improvement plan to roll out this training to staff. The trust's most recent action plan (March 2016) confirmed that advanced and ED-specific conflict resolution training had been completed by 61% of staff. However, 29 incidents had occurred since our last visit in relation to the management of mental health patients. This was significantly more than had been reported in the previous six months and we judged that there was more to be done to improve the safety of this unit. Our concerns were demonstrated by two incidents described below.
- It was reported at the emergency department clinical governance meeting in February 2016 that a recent incident had occurred on the observation unit. The unit had been staffed by only one registered general nurse (RGN). The planned staffing should have been one RGN and one registered mental health nurse. It was reported that "the observation ward became dangerous with a patient who was aggressive." A second incident was reported relating to a patient who became aggressive. A patient in the co-located surgical admissions unit discharged themselves because they were upset and several elderly patients needed reassurance because they were afraid. Security staff and police attended.
- A serious incident occurred in December 2015 when a patient collapsed in the ED waiting room and subsequently died. The patient had been alerted to the clinical staff due to their medical history but had not been triaged when they collapsed, 49 minutes after their arrival in the department. The investigation of this incident concluded that staffing levels in the emergency department meant that patients were not consistently triaged within 15 minutes of arrival in the department. Staffing levels were increased following our last visit in September 2015. In addition, an electronic whiteboard had been installed in the minors' area, enabling real time monitoring of patients awaiting triage. It was recommended that performance against the national triage standard be monitored, assurances provided at local governance meetings and that shortfalls in capacity should be escalated. We asked the trust how and where this performance was reported because we could not see any evidence of this in the minutes of local governance meetings. The operational performance data the trust provided reported performance against this standard for ambulance-borne patients only. We were not assured that adequate safeguards had been put in place to prevent a similar incident.
- It was reported in the minutes of the emergency department governance meeting in February 2016 that a patient with known chronic obstructive pulmonary disease had been cared for in the corridor and administered oxygen from a portable cylinder which had run out. We asked the trust to provide details of this incident and the patient's care. The response we received from the trust indicated that the investigation of this incident had been superficial. We were unable to judge from the original investigation report, what the prevailing circumstances were that led to this incident occurring. We requested further information which the trust subsequently provided. This showed that the patient had not had their vital signs recorded for nearly two hours prior to the incident occurring. The staff to patient numbers in the corridor was not evident. The trust told us that the incident was highlighted to staff via

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daily safety briefings which took place the following week; however, we were not assured that adequate steps had been taken to prevent a similar incident occurring.

Environment and equipment

- At our previous inspection in September 2015 we raised concerns about the location, design and layout of the observation unit. The department was physically separate from the emergency department and this led to a feeling of isolation and vulnerability of staff working there. The unsuitability of the premises had been highlighted by the Emergency Care Intensive Support Team when they visited in May 2015. The trust had recognised the risk and a project group had been established to review the short and long term direction of the observation unit, including admission criteria, location and facilities. We were concerned about the lack of pace of this project. There were no timescales agreed in which any improvements would take place.
- The trust's improvement plan dated March 2016 confirmed that a mental health working group had considered all potential options and a preferred option was currently being costed. A decision on the way forward was expected by the end of April 2016. The timescale in which work would be undertaken was unknown.
- All staff in the emergency department, including the observation unit, had been issued with personal alarms; however, at the time of our visit the alarm system in the observation unit was not operational, pending some further installation work. Support from security guards had been increased and registered mental health nurses were employed on every shift to provide close support for patients who were identified as being at risk of harming themselves or others.
- We raised concerns at our previous visit about the safety of the children's emergency department. This was a dedicated children's facility located adjacent to the main ED. The department consisted of a waiting room at the end of a corridor, on which four cubicles and a nurses' station were situated. There was no line of sight from the nurses' station to patients in the waiting room or in cubicles (except the cubicle nearest the station which had a window). The trust's improvement plan stated that a healthcare assistant had been employed at

all times to directly observe children and their families in the waiting room. We saw this was the case during our return visit. Staff confirmed that this had improved patient safety.

Records

- At our previous inspection we raised concerns about the standard of record keeping. Records audits were not taking place frequently or regularly.
- The trust's improvement plan stated that a review of nursing documentation had taken place and new documentation issued. Monthly records audits were taking place. An audit undertaken in December 2015 and reported to the unscheduled care division's governance meeting, highlighted record keeping deficiencies, including failure to document the time that observations took place, failure to document the early warning score (EWS) and inadequate completion of patient demographics. The emergency department matron confirmed; however, that a sample of 10 observation charts was audited at least weekly. Results were reported to the emergency department steering group. At a meeting of the steering group held on 10 March 2016 it was reported that most sections of the audit were performing at between 70% and 100%. We were provided with the audit results for 16 and 20 March, 3, 6, 8 and 10 April 2016. Compliance with standards for completion was variable and showed there was still significant improvement required. In particular, the results showed that observations were not consistently carried out with the required frequency. In a sample of five audits, each sampling 10 patient records, compliance for this metric ranged between zero and 70%, with the average being 42%.
- During our follow up visit we reviewed a sample of patients' records in the emergency department. Nursing documentation was generally poor. For example:
 - a patient admitted to the resuscitation unit had no nursing care or interventions recorded (apart from irregular observations) in a period of four hours.
 - a child in the resuscitation area was being closely monitored but no nursing care or interventions were recorded in a period of two hours and 45 minutes. When we queried this with nursing staff we were told by one staff member that notes were recorded on the electronic patient record system. We checked and found nothing recorded. Another staff member told

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us that notes would be documented before transferring the patient to the ward. This meant that records were not contemporaneous and we could not therefore be assured of their accuracy.

- a patient who had been in the department for more than six hours had no pain scores, nursing care or interventions recorded, except for irregular observations.
- a patient in the department for one hour and twenty minutes had no nursing care or interventions, apart from one set of observations recorded.
- a patient observation chart recorded hourly observations but the patient's details were missing (name, date of birth).
- In the observation unit documentation had also been reviewed since our last visit and new documentation had been introduced. Each patient had a set of paper records which documented risk assessments and identified their care pathway, including any interventions/treatments to be carried out. Nursing care was documented electronically; however registered mental health nurses completed paper records. Observation charts and care round documentation were kept at the end of patients' beds. In addition, the registered mental health nurse kept close observation documents on a clipboard. The numerous sources and location of information resulted in some confusion with regards to patients' care needs. For example, one patient's notes stated that they required regular fluids, to be monitored hourly. A fluid balance chart at the patient's bedside had not been completed. When we queried this with a nurse they told us they did not know why the care plan stated monitoring was required (they said they thought it had been completed by a student nurse). When we checked the records the following day, the fluid balance chart had been scored through to indicate it was not in use but the care plan had not been amended. We looked at the records for a patient who was under close observation by a mental health nurse. The nurse in charge told us that the patient was categorised as a moderate risk, based on the risk assessment documentation in their folder. This information was out-of-date; the close support documentation was with the mental health nurse, who confirmed that the patient was categorised as high risk.
- We found that records were generally poorly completed within the observation unit. For example, one patient

who was admitted the day before our visit had no information recorded in relation to their current medication or allergies. A safeguarding assessment had not been recorded, investigations were not recorded (the patient was undergoing infusion treatment) and risk assessments in respect of infection control, and nutritional risks had not been documented. It was not clear whether the patient had been referred to the mental health liaison service because the relevant section had not been completed.

- Regular audits took place of nursing documentation in the observation unit and results were plotted on run charts and displayed in the staff room. Results were variable and showed room for improvement, with the exception of the recording of visual checks for mental health patients which were consistently documented, scoring 100% compliance.

Assessing and responding to patient risk

- During our inspection in September 2015 we raised concerns that observations of patients' vital signs and early warning scores were not consistently recorded or taking place with the required frequency. Early warning scores are used to identify the severity of a patient's illness and to identify deterioration in their condition. The department did not audit the completion of observation charts. We were also concerned that risk assessments were not consistently recorded on the observation unit in respect of patients' risk of falling or self-harm through use of a ligature. The department did not audit the completion of observation charts.
- Following our inspection the trust introduced revised observation charts and nursing documentation. Staff received training to use the new documentation, which was refined several times in response to staff feedback. Regular audits were undertaken to monitor compliance with the new documentation. An audit undertaken in December 2015 looked at the number of initial observations undertaken within 15 minutes of arrival and whether follow up observations were undertaken in accordance with the early warning score or when clinically indicated. The overall compliance score was 57.2%, showing significant room for improvement.
- At our follow-up inspection we looked at a sample of observation charts. Again we found that patients' vital signs were not consistently recorded and early warning

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scores were not consistently calculated or recorded.

This meant we could not be assured that seriously unwell patients or deteriorating patients were promptly identified and appropriately managed. We found:

- a patient admitted to the resuscitation unit following a fall from a height had only one set of observations recorded in a period of over four hours.
- the records of a child in the resuscitation area with a high early warning score showed that, although they were being closely monitored, there was a period of two hours and 45 minutes when no observations were undertaken.
- a patient with a high early warning score (6) had irregular observations recorded (hourly and two hourly intervals). An early warning score of 6 indicates more frequent observations are required.
- a patient referred by their GP, presenting with a headache, vomiting and confusion had one set of observations recorded on arrival. No early warning score was recorded, no neurological observations were recorded (as indicated by the patient's presentation) and no repeat observations were recorded when we checked the records at one hour, 20 minutes after the patient had arrived.
- During our inspection in September 2015 we were concerned that risk assessments were not undertaken in relation to the safety of the environment for patients who were at risk of harming themselves. Staff told us they had received no training or guidance on how to make the environment safe for people who were at risk of self-harm, for example by removing items of equipment which could be used as ligatures. The trust's improvement plan (March 2016) confirmed that 80% of ED nursing staff had received mental health training. Training included guidance in making the environment safe, including the removal of ligatures. During our follow-up visit we saw that ligature risk assessments and checklists had been completed for patients at risk of self-harm on the observation unit. The department was also supported by a registered mental health nurse who provided close support to high risk patients.

Nurse staffing

- At our previous inspection in September 2015 we were not assured that the emergency department and the observation unit were consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure that people received safe

care and treatment at all times. There was no overarching document, such as a standing operating procedure which outlined the minimum safe staffing levels and skill mix in the department and how and when these should be reviewed and amended to meet fluctuating demand.

- At our follow up visit we remained concerned that the emergency department was not consistently staffed with adequate numbers of staff. In the context of unprecedented demand on the service, the department continued to struggle to maintain safe staffing levels at times of extreme pressure. We were told that over the winter months the emergency department was regularly and frequently overcrowded, with patients queuing on arrival in the department and queuing whilst waiting for transfer to a ward.
- We were told that the emergency department had developed a documented protocol for ensuring safe staffing levels were maintained at times of increased activity. The emergency department matron told us that a new staffing model had been introduced which was based on a ratio of one nurse to four patients in majors' and one nurse to two patients in the resuscitation area. Additional staff were employed to maintain this staff to patient ratio for queuing patients when the department had reached capacity. The matron told us that when the hospital was in black escalation the emergency department would employ additional staff in anticipation of queues developing. However, staff told us that safe staff to patient numbers were frequently not achieved because of unprecedented numbers of patients in the department. It was reported to the emergency department steering group on 26 February 2016 that "staff are no longer coping with the demands of the levels of activity in ED". It was reported that on one day in the previous week the department had been 150% over capacity.
- Staff were encouraged to report concerns about staffing and capacity. There was a 'red flag' system which described situations considered to be unsafe and the actions staff should take when these situations occurred. Triggers included delays in patient assessment and review, patients queuing, patients' essential needs not being met, staff not being able to take adequate rest periods and staff feeling overwhelmed, stressed or unable to cope. Staff reported

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their concerns to the nurse in charge, who in turn compiled an incident form, summarising all the red flag concerns raised on a particular shift. Data provided by the trust showed that red flag incidents were raised on 24, 32, 41 and 24 occasions in the months of January, February, March and April 2016. We asked the trust how the information was being used to inform staffing levels. They told us that incident trends were monitored. We did not see evidence that this data was reviewed at local governance meetings or at the ED steering group so could not be assured that learning was taking place.

- However, staffing levels had been increased by 18 whole time equivalent (WTE) staff, which represented an uplift of approximately 20%. Staffing to this new establishment remained a challenge because there were 9.6 WTE vacancies. Recruitment was ongoing and in the meantime, temporary staff (bank and agency) were utilised where possible.
- Data provided by the trust showed that in the period 1 March to 28 April 2016 the average shift fill rate for registered nurses was 112% for day shifts and 103% for night shifts. This showed the department was staffed over planned levels to cope with high demand. There was heavy reliance on bank and agency staff. In the same time period, 23% of registered nurse shifts and 19% of unregistered nurse shifts were filled by temporary staff. This was higher at night when 44% of registered nurse shifts and 26% of unregistered nurse shifts were filled by temporary staff. The average fill rate for unregistered nurses was 91% for day shifts and 85.3% for night shifts.
- At our previous inspection we were concerned that there were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. Planned staffing levels were not consistently maintained. The department was sometimes closed at night because there were insufficient suitably trained staff to run it. The department had recognised the risk posed by inadequate staffing levels and the risk was on the unscheduled care risk register. The only mitigating action recorded was the continued attempt to recruit a further registered children's nurse. The department had introduced 'in house' training for adult trained nurses to gain heightened awareness of common conditions in children presenting in the ED but only nine staff had

received this training. There were also plans to rotate staff from the hospital's paediatric department but this had not yet been possible due to unsuccessful recruitment.

- At the time of our return visit, there were still insufficient numbers of registered children's nurses employed to ensure that there was always one on duty. However, the staffing establishment in the children's ED had been increased by 6.7 whole time equivalent registered children's nurses. This was so the department could consistently staff the department with two nurses, one of whom was a registered children's nurse or an adult-trained registered nurse who had undertaken additional training to care for children. However, the department had not been successful in recruiting to the new establishment. Recruitment was ongoing and the department continued with its in house training programme. Twenty-nine percent of nurses had now completed additional training. In addition, a healthcare assistant was now employed on every shift to observe and support children and families in the waiting room. We were told that the staffing of this department was monitored on a shift by shift basis to ensure that the agreed staffing was protected. This was reported on regularly to the ED steering group.
- Staff working in the children's ED during our follow up visit were pleased with the uplift in staffing and told us their concerns about safety had been addressed. The trust provided data to show that the department was consistently staffed with at least one suitably qualified nurse, supported at times by adult-trained nurses.

Are urgent and emergency services effective?

(for example, treatment is effective)

- At our previous inspection in September 2015 we saw limited evidence that learning took place following participation in national audits. At our follow up inspection the trust provided us with updated action plans which demonstrated that outstanding actions were mostly complete.
- At our previous inspection we reported that there was inadequate oversight and monitoring of nurse staff training. Nurse education and clinical supervision was

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not provided in a structured way and we could not be assured that staff had the right qualifications, skills, knowledge and experience to provide appropriate care and treatment in a safe way.

- At our follow up inspection the trust told us that the training matrix had been updated so that skills gaps could be identified. However, a training plan to address the identified gaps had not been developed. It was planned that from June 2016 protected time would be provided in the staff rota for education. Resources were to be allocated from within the staffing budget to release senior nurse time to facilitate and oversee this. In addition, the two emergency department matrons were to undertake regular operational shifts in order to provide educational support and supervision.

Patient outcomes

- Following our inspection in September 2015 we reported that improvement actions were not always completed promptly following clinical audits. At our follow up inspection we asked for a progress report in a number of audit areas and found an improved picture, with actions arising from audits completed. For example:
 - Sepsis: monthly audits took place and improvements in the recognition and management of this condition were reported.
 - Asthma in children: A completed action plan was provided which showed that improvement actions had been undertaken, including teaching sessions for junior medical staff and paediatric nurses and the production of a patient advice leaflet.
 - Mental health in ED: The action plan following the 2014/15 RCEM audit recorded an action to amend the mental health assessment documentation by July 2015. This action was recorded as “in progress”. A re-audit was documented as due to take place in December 2015. This re-audit took place as planned and the results were reported to the unscheduled care governance committee. The results showed a significant worsening of performance. Overall compliance had reduced from 60% to 42%.
 - Paracetamol overdose: education sessions had been delivered to staff as indicated by the audit results.
 - Assessing for cognitive impairment in older people: Some actions arising from the 2014/15 RCEM audit were incomplete.

- Management of the fitting child: Although the trust performed well in this 2014/15 RCEM audit, a number of areas for improvement were identified. A completed action plan showed that the findings of the audit had been shared with staff at meetings and teaching sessions.

Competent staff

- At our previous visit in September 2015 we raised concerns about the lack of oversight and management of nurse staff training. Nurse education did not take place in a structured or consistent way and we could not be assured that nurses were able to regularly update their skills.
- At our follow-up inspection we found some progress had been made. The trust’s improvement plan confirmed that a review of the training matrix had been undertaken to ensure that it was up-to-date and skills gaps were identified. It further stated that oversight and monitoring of training would be reported through departmental governance meetings, with exceptions reported to divisional performance meetings. We were not provided with any evidence that this had occurred.
- At our follow up inspection we were provided with the department’s training matrix. There remained a significant number of unexplained gaps. We asked the trust to provide a training plan to address the identified gaps. They told us that departmental training would be rostered from June 2016 onwards supported by a clinical facilitator (see below).
- The business case developed to increase staffing in emergency department following our last visit had included the establishment of a clinical facilitator to oversee nurse education and clinical supervision; however this part of the business case had not been approved. There were plans to use some of the additional staffing budget to release 18.5 hours a week of a senior nurse to provide nurse education and clinical supervision. In addition, with the appointment of a temporary matron to support the existing ED matron, there were plans for each of them to operate ‘on the floor’, alongside staff in a supportive educational role.

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Are urgent and emergency services well-led?

- At our previous inspection we reported that governance systems were not effectively operated. Risks identified as a result of incidents were not always dealt with in a timely way and we saw limited evidence of audits being used to drive service improvement.
- At our follow up visit we saw that the emergency department had reviewed and developed its governance systems arrangements as part of a trust-wide review of governance arrangements. Standardised reporting ensured that divisional and executive management had a more comprehensive overview of risks to quality and performance. There were plans to further develop and embed governance systems and reporting and to improve staff engagement with processes.
- Alongside “business as usual” governance, there was an executive-led emergency department steering group which oversaw the improvement plan in response to the warning notice we issued in December 2015. There was also a transformation board which was reviewing hospital-wide patient flow issues.
- In recognition of the significant improvement agenda, temporary management support had been provided to the emergency department. Improvement plans showed significant progress had been achieved against identified milestones, although it was acknowledged that some improvements were not yet achieved and some were not yet embedded. This would require further time and management focus. Progress had undoubtedly been constrained and overshadowed by capacity. The emergency department had experienced an extremely challenging winter, with unprecedented demand; this was compounded by staff shortage and heavy reliance on temporary staff. In this context, improvements achieved to date were commendable.

Governance, risk management and quality measurement

- At our previous inspection in September 2015 we raised concerns about the effectiveness of governance arrangements in the emergency department. We judged that risks to service provision were well understood; however, the multifactorial risks to patient safety and quality were not fully captured in the service risk register

or in the minutes of governance meetings. There was limited evidence that risks identified through incidents, complaints and audit were consistently used to drive improvement.

- In response to the section 29A warning notice which we issued in December 2015, the trust developed an improvement plan which was submitted to us on 29 January 2016. The plan outlined remedial actions to address areas of serious concern. A number of work streams were identified within the overall improvement plan and progress was monitored by the emergency department steering group, which met weekly and was chaired by the chief executive. The steering group ran in parallel with the transformation board, which was established to focus on outward flow from the emergency department. Both of these committees reported to the trust’s executive committee and ultimately to the trust board. Reports also went to the unscheduled care division’s governance meeting.
- A trust-wide review of governance arrangements was underway, supported by a management consultancy firm. A standard agenda for divisional and departmental governance meetings had been developed along with a standard performance dashboard. The emergency department held monthly governance meetings attended by senior nursing and medical staff. A standard agenda had been introduced across the trust following the section 29A warning notice and included operational performance, audit, patient feedback, including complaints, staffing and training. Minutes were much improved since our last visit and provided a more comprehensive overview of performance, quality and safety. However, we noted that the risk register was not discussed. Minutes were circulated to staff via email and filed in a ring binder kept in the staff room, where staff signed to confirm they had read them. An action tracker was used to ensure actions from previous meetings were followed up. The clinical lead told us that there were plans to roster protected time for staff to attend governance meetings.
- There was a clear line of reporting from departmental, through divisional governance, to the trust’s executive committee and ultimately, the trust board.
- Prior to our follow up inspection we were contacted by a relative and also by a patient, both of whom had complained about care and treatment in the emergency

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department and both of whom had not received a response within an appropriate timescale. The relative had originally complained in late January 2016 and was contacted by the service in early April to be told that their complaint had only just been allocated to an investigating manager. The patient had complained in early March and was still waiting for a response seven weeks later. We raised our concerns about these delays with the matron and the clinical lead in the emergency department. They acknowledged that there was no oversight of the complaints within the emergency department as a whole and they were taking steps to address this through the governance committee going forward.

- In the planned care division a review of governance arrangements had taken place. A divisional clinical governance half day meeting had been introduced, to meet each quarter. This meeting oversaw governance matters and fed in to departmental and divisional governance meetings, as well as the trust-wide patient quality committee. A standard agenda included incidents and learning, patient feedback, including complaints, clinical audit, feedback from mortality and morbidity meetings and review of NICE guidance. There was also a review of the divisional risk register. A divisional newsletter had been introduced in January 2016 and was produced bi-monthly to cascade information about important governance/quality matters.
- Terms of reference for speciality and divisional governance meetings had been reviewed and standardised agenda and minutes templates were to be adopted by all specialities. This was work in progress. Reporting standards had been developed and audit tool had been developed so that specialities could measure themselves against these standards. This was to be reported by speciality to the quarterly clinical

governance meetings. At the time of our inspection, trauma and orthopaedics and audiology had completed the audit of their governance arrangements and presented to the divisional half day meeting.

Leadership of service

- Following our visit in September 2015, and in recognition of the significant management agenda, the local management team had been given some short term assistance. A senior nurse and a programme manager had recently been appointed to support the ED matron. The clinical lead for the department had recently changed and the newly appointed clinical lead was receiving coaching in the role. A new associate medical director had also recently been appointed, who was described as both visible and supportive. The local management team told us they felt supported by divisional and executive management. However, staff below the management team told us the executive management team were neither visible, nor supportive within the department.

Culture within the service

- Staff told us that they continued to feel supported by the local management team. Staff were aware of the improvement programme but they told us that, unless they were directly involved in the various work streams, they were not familiar with improvement plans, had not been engaged in the improvement journey or consulted about changes. For example, staff working in the observation unit during our visit, were aware that there were plans to reconfigure the department but were not familiar with the detail of the plans and had not been asked for their views.
- The matron in the emergency department told us that there were plans to provide a weekly newsletter for staff. In the meantime, from time to time, key messages were displayed on a flip chart in the staff room.