Liverpool University Hospitals NHS Foundation Trust

University Hospital Aintree

Inspection report

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Date of inspection visit: 28 and 29 October 2020
Date of publication: 29/01/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at University Hospital Aintree

Inspected but not rated

Key facts and figures

Services at University Hospital Aintree are provided by Liverpool University Hospitals NHS Foundation Trust. The trust was created on 01 October 2019 following a process of acquisition, in which Aintree University Hospital NHS Foundation Trust acquired Royal Liverpool and Broadgreen Hospitals NHS Trust.

Liverpool University Hospitals NHS Foundation Trust is a major city centre acute trust. During the week in which this inspection took place Merseyside was in a Tier 3 COVID-19 area and therefore facing higher community infection rates which would impact on the activity of the trust.

We carried out a focused, responsive inspection at Royal Liverpool University Hospitals on 28 and 29 October 2020 to review the processes, procedures and practices within the medical care core service. We looked at parts of the safe, effective, caring and well-led key questions. We did not rate services because this was a focused, short notice inspection in response to specific areas of concern.

We observed care and treatment and specific documentation in eight patient records, including do not attempt cardiopulmonary resuscitation (DNACPR), mental capacity assessment, care plans and intentional rounding documentation. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with 18 members of staff. We did not speak with any patients during this focused inspection however we conducted a short observational framework for inspection (SOFI), observed patient care, the environment within wards and safety briefings to capture patient experience.

Why we inspected

Over a three-week period in October 2020, CQC had received a number of enquiries from patients, relatives and staff which related to poor patient care and experience. These concerns related to nutrition and hydration, hygiene needs; staff being unable to provide care; infection prevention and control and staffing concerns.

There were continuing concerns about patient care and safety at the trust's two main hospital sites. We heard from patients, relatives and staff that:

- COVID -19 and non COVID -19 patients were mixed in ward areas, that there were increasing infection transmission rates within the trust and staff were not complying with requirements for use of appropriate personal protective equipment (PPE).

- staffing levels were unsafe in ward 22, ward 25 and other unidentified ward areas at University Hospital Aintree.

- basic care needs of patients, including nutrition and hydration needs, were not being met and there was neglect of vulnerable patients.

Our findings

We continued to receive concerns about patient care and safety at the trust's two main hospital sites, including two notifications of potentially unsafe discharge of patients from University Hospital Aintree to care homes. We also heard concerns that a patient at risk of falls had sustained an injury during admission after falling from their bed due to mitigating actions not being taken.

Immediately prior to the inspection we received further enquiry concerns from patients and relatives that:

- staff did not appear to be adhering to social distancing and that some staff were walking around wearing their masks under their chin and not covering their nose.

- basic care needs were not being met and patient care plans were lacking. Some patients did not receive pressure care resulting in them acquiring pressure sores and patient's hygiene and nutritional needs were not always being met adequately.

These concerns were mainly related to medical wards at both Royal Liverpool Hospital and University Hospital Aintree and specifically to wards 22 and 25 at University Hospital Aintree. In accordance with CQC procedures, due to the significant concerns raised, enquiries were also referred to local authority safeguarding services.

What we did

We initially raised the concerns with senior leaders and asked for information of how the trust was assured of patient safety at the point of delivery.

The trust provided details of their assurances about nurse staffing, senior nurse review of clinical areas, including the environment, patient experience, and infection prevention and control. However, there was no information provided to support that patients had their health needs assessed, appropriate risk assessments completed, or that care plans reflected the patient's needs. There was lack of clarity regarding any continued actions to ensure risk assessments were completed and reviewed in a timely way in response to changing patient needs. In addition, there was no detail of how any concerns identified from matrons' weekly checks would be monitored actions taken and followed up to ensure these actions had resolved the issues.

We carried out a focused, short notice inspection in response to the specific areas of concern. We inspected medical care core services at Aintree University Hospital on 28 and 29 October 2020 and our findings are summarised below. We did not inspect all the key lines of enquiry or domains and therefore have insufficient evidence to change the ratings.

What we found

We found evidence to support the serious concerns that had been raised regarding patient care, as follows:

The service did not always control infection risk well. Senior managers did not have clear oversight of infection control relating to bed spacing. The systems in place to manage infection prevention and control were not always followed by staff. There was no evidence of leaders taking action to ensure compliance and mitigate these risks, which meant patients could be exposed to the risk of harm. We observed doors to side rooms and bays on some wards were not consistently kept closed. We observed non-adherence to national guidance in relation to COVID-19 and social distancing.

Our findings

Staff inconsistently completed and updated risk assessments for each patient and action to remove or minimise risks was unclear. Staff did not always maintain accurate records to confirm how frequently patients required care.

Although managers regularly reviewed and adjusted staffing levels and skill mix the service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We saw this particularly affected ward 25, services for stroke patients, and ward 24 at night. We were not assured that patient acuity and dependency, or staff experience was always taken into consideration and this impacted on their ability to manage frail patients requiring additional support. The stroke ward had a high sickness rate following positive screening of COVID -19 with a number of staff who were required to isolate in line with government guidance.

Staff did not always keep up to date fully completed records of patients' care and treatment. Records were not stored securely on all wards that we visited, and staff used different documents in ward areas within the same hospital.

The service used systems and processes to prescribe, administer, record and store medicines. However, we saw that medicines were not always administered on time and controlled drugs were not always checked in line with trust standard operating procedures**.** Agency staff did not always have access to the electronic patient medication system.

Not all patients requiring dietetic review received this in a timely way, including some with significant nutritional needs. Through our review of the information we were not assured the trust had a robust system in place to manage patients' nutritional and hydration needs meaning patients may be exposed to the risk of harm. However, from our observations on ward 20 during inspection we saw staff gave patients enough food and drink to meet their needs; but patients requiring one-to-one supervision on other wards did not always receive adequate support for nutrition and hydration needs.

Staff cared for patients with compassion and dignity; however, we observed a number of call bells were not always answered in a timely manner due to the high number of patients and low levels of staff on all wards inspected. During the inspection we noted delays in responding to patient call bells in different ward areas.

Local leaders were not always visible and approachable in the service for staff. Although local leaders were supported by Trustwide quality matrons who completed regular walkarounds there was a lack of senior leadership oversight in the service.

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Ward based quality information boards were inconsistently completed and no action had been taken to address this. Although the trust was facing a surge of demand, leaders had taken a decision not to escalate their status through the NHS Operational Pressures Escalation Framework, however we were informed that local arrangements were in place with system partners and being co-ordinated through NHS E/I's specific Covid incident control function.

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. The trust's response to specific concerns about wards 22 and 25 provided limited information about the effective monitoring of patient risks.

However:

The design and maintenance of facilities kept people safe and most areas had enough equipment for staff to carry out their role.

Our findings

We observed staff working extremely hard to provide treatment and care under difficult circumstances during the current COVID - 19 pandemic, which had impacted on the numbers of patients and their acuity. During October 2020 the North West region saw an increase in COVID-19 patient activity and through October this trust had the highest levels of COVID-19 activity across the region. As of 19 October 2020, the percentage of beds occupied by COVID-19 patients was 24% (34% including suspected COVID-19 patients), compared to 15.4% in the previous week. The percentage of beds occupied by non-COVID patients was 50% as of 19 October. The number of beds available overall had been below expected since September and numbers decreased further in October.

We spoke with senior leaders on the day of inspection about our concerns and to request that the trust took action to ensure immediate patient safety. The trust identified immediate actions in response to the concerns identified.

Following the inspection, we reviewed information the trust had provided to CQC before the inspection and our evidence gathered during our onsite inspection. We found there was a lack of robust systems and processes to monitor the quality of the care patients received at both hospital sites in the medical core service.

We formally wrote to the trust following our inspection and clearly identified the significant patient safety concerns we had found with regards to nutrition and hydration; infection prevention and control; staffing; assessment of health needs, implementation of care and documentation and operational oversight and governance. We asked the trust to take urgent action and provide a detailed response with action plans to mitigate the risks to patients.

Provider response

The trust provided a detailed response with immediate actions they had taken to mitigate the risks to patients. These included: -

- Identification of additional senior leadership capacity and support for the Specialist Medicine Division.

- A briefing with the Matrons and Ward Managers from the Chief Nurse, focusing on infection prevention and control, staffing, risk assessments and nutrition and hydration.

- Establishment of an overview and scrutiny meeting with the Divisional Director of Nursing and matrons, for review of staffing and quality metrics related to falls, pressure ulcers, nutrition and hydration and the matrons' checklist.

- Development of a "Safe Nursing" strategy as part of the trust's approach to quality and safety.

In addition to their assurances of the immediate improvement actions taken, the trust provided further details of their continuing actions to improve the safety and quality of medical care services.

The Trust also informed us it intended to introduce a Paper Lite system in February 2021 which would standardise documents and mitigate the risk of records were not stored securely on all wards.

Following the inspection, we issued the trust with seven requirement notices with actions they must complete.

We will continue to monitor the trust through our engagement to ensure that the risks to patient safety have improved, that there is evidence of continuing and sustained improvements and that these improvements are embedded across the service.

Medical care (including older people's care)

Inspected but not rated

Key facts and figures

The medical care services at Aintree University Hospital span across two divisions (acute and emergency medicine and specialist medicine). Medical care specialities include cardiology, nephrology, respiratory, gastroenterology, frailty, stroke, diabetes and endocrinology are provided 24 hours a day, seven days a week and primarily serve the population of Liverpool and the wider Merseyside area.

Between 28 and 29 October 2020 we carried out a focused inspection at Aintree University Hospital that covered parts of four key questions: is the service safe, effective, caring and well-led? In a three-week period prior to inspection, serious concerns about patient safety and care had been raised to us. These included concerns regarding the provision of adequate nutrition and hydration, the meeting of people's hygiene needs, staff being unable to provide care, the effectiveness of infection prevention and control practices, and staffing concerns. In response to the concerns, we carried out a focused inspection to review the processes, procedures and practices within the medical division at University Hospital Aintree. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We visited ward 20 (General Medicine), ward 22 (Respiratory), ward 24 (general medicine), ward 25 (General Medicine) and ward 33 Hyper Acute Stroke Unit (HASU).

We observed care and treatment and specific documentation in eight patient records including do not attempt cardiopulmonary resuscitation (DNACPR), mental capacity assessment, care plans and intentional rounding documentation. We also interviewed key members of staff and the senior management team who were responsible for leadership and oversight of the service. During the inspection we spoke with four members of staff who were a mix of matrons and quality matrons, eight qualified nursing staff of differing grades and six healthcare assistants.

We completed a short observational framework for inspection (SOFI) to assist our inspection surrounding patient and staff interaction and communication. SOFI is a tool developed between the Centre for Applied Dementia Studies and the Care Quality Commission (CQC) and is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves.

We did not speak with any patients during this focused inspection.

The inspection was carried out by a CQC inspection manager, and two CQC inspectors.

Overall summary

We found the following issues needed improvement:

The service did not always control infection risk well. Senior managers did not have clear oversight of infection control relating to bed spacing. The systems in place to manage infection prevention and control were not always followed by staff. There was no evidence of leaders taking action to ensure compliance and mitigate these risks, which meant patients could be exposed to the risk of harm. We observed doors to side rooms and bays on some wards were not consistently kept closed. We observed non-adherence to national guidance in relation to COVID-19 and social distancing.

Medical care (including older people's care)

Staff inconsistently completed and updated risk assessments for each patient and action to remove or minimise risks was unclear. Staff did not always maintain accurate records to confirm how frequently patients required care.

Although managers regularly reviewed and adjusted staffing levels and skill mix the service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We saw this particularly affected ward 25 and services for stroke patients, and ward 24 at night. We were not assured that patient acuity and dependency or staff experience was always taken into consideration and this impacted on their ability to manage frail patients requiring additional support. The stroke ward had a high sickness rate following positive screening of COVID-19 with a number of staff who were required to isolate in line with government guidance.

Staff did not always keep up to date fully completed records of patients' care and treatment in accordance with trust policies and procedures. Records were not stored securely on all wards that we visited and staff used different documents in wards and sites within the same hospital.

The service used systems and processes to prescribe, administer, record and store medicines. However, we saw that medicines were not always administered on time and controlled drugs were not always checked in line with trust standard operating procedures**.** Agency staff did not always have access to the electronic patient medication system.

Not all patients requiring dietetic review received this in a timely way, including some with significant nutritional needs. Through our review of the information we were not assured the trust had a robust system in place to manage patients' nutritional and hydration needs meaning patients may be exposed to the risk of harm. However, from our observations on Ward 20 on inspection we saw staff gave patients enough food and drink to meet their needs but patients on other wards requiring one-to-one supervision did not always receive adequate support for nutrition and hydration needs.

Staff cared for patients with compassion and dignity; however, we observed a number of call bells were not always answered in a timely manner due to the high number of patients and low levels of staff on all wards inspected. During the inspection we noted delays in responding to patient call bells in different ward areas.

Local leaders were not always visible and approachable in the service for staff. Although local leaders were supported by Trustwide quality matrons who completed regular walkarounds there was a lack of senior leadership oversight in the service.

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Ward based quality information boards were inconsistently completed and no action had been taken to address this. Although the trust was facing a surge of demand, leaders had taken a decision not to escalate their status through the NHS Operational Pressures Escalation Framework, however we were informed that local arrangements were in place with system partners and being co-ordinated through NHS E/I's specific Covid incident control function.

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. The trust's response to specific concerns about wards 22 and 25 provided limited information about effective monitoring of patient risks.

However:

Medical care (including older people's care)

We observed staff working extremely hard to provide treatment and care under difficult circumstances during the current COVID 19 pandemic, which had impacted on the number of patients and their acuity. During October 2020 the North West region saw an increase in COVID-19 patient activity and through October this trust had the highest levels of COVID-19 activity across the region. As of 19 October, the percentage of beds occupied by COVID-19 patients was 24% (34% including suspected COVID-19 patients), compared to 15.4% in the previous week. The percentage of beds occupied by non-COVID patients was 50% as of 19 October and 15% of beds were unoccupied (compared to 12% in the previous week up to 12 October). The number of beds available overall has been below expected since September and numbers decreased further in October (over a hundred beds were still available in the week up to 14 October)

The design and maintenance of facilities kept people safe and most areas had enough equipment for staff to carry out their role.

Is the service safe?

Inspected but not rated

Infection prevention and control

The service did not always control infection risk well. Senior managers did not have clear oversight of infection control relating to bed spacing. The systems in place to manage infection prevention and control were not always followed by staff. There was no evidence of leaders taking action to ensure compliance and mitigate these risks, which meant patients could be exposed to the risk of harm.

We observed doors to side rooms and bays on some wards were not consistently kept closed. We observed non-adherence to national guidance in relation to COVID-19 and social distancing**.**

Prior to the inspection we received enquiry concerns that COVID and non COVID patients were mixed in ward areas, that there were increasing transmission rates within the trust and staff were not complying with appropriate personal protective equipment (PPE).

During the inspection we saw that doors to side rooms and bays on some wards were not consistently kept closed and that staff did not always follow national guidance in relation to COVID-19, use of personal protective equipment and social distancing.

During inspection we met with the infection control lead for the hospital and discussed the trusts response and adherence to COVID-19 government guidance. During the pandemic, wards had been colour coded to reflect the COVID status of all wards. Of the five wards we visited during this inspection, only one ward was classified as a non-COVID ward.

All wards we visited had ‘donning and doffing’ stations at ward entrances with hand washing sinks, foot pedal bins with clinical waste bin liner, hand wash lotion, alcohol hand gel and masks. Infection control posters were displayed at each ward entrance, explaining the need to adhere to strict infection control guidance.

Medical care (including older people's care)

We observed non-adherence to national guidance in relation to COVID-19 and social distancing. Patient bays did not adhere to national guidance and maintain a two metre bed space on all wards that we inspected. However, the trust informed us that these areas had been risk assessed. We also observed doors to side rooms and bays on some wards were not consistently kept closed. There was no evidence that additional mitigating actions had been taken to reduce the risk of infection.

During inspection we noted that quality boards on individual wards containing infection control rates, such as clostridium difficile, and hand hygiene compliance were not consistently updated. The quality board on ward 25 was blank and had last been updated in July 2020 and the quality board on the hyper-acute stroke unit had last been updated in August 2020. The trust informed us, but we did not see, that they had an electronic ward quality dashboard on its Light system. This had been utilised across all wards during Covid when it was important to limit the number of staff accessing wards and updating boards regularly became more difficult.

Each ward we visited had a resuscitation trolley and sepsis box. The resuscitation trolleys had daily, and weekly checks performed. The sepsis box was checked weekly and after use.

Clinical waste was stored securely until collected for disposal. We observed collection of clinical waste which was managed in line with trust policy.

There were general cleaning staff on wards 20, 22, 24 and 33, carrying out enhanced cleaning of the areas although we did not observe cleaning staff whilst we inspected ward 25. However, we did observe an occupational therapist cleaning a walking frame on ward 22 and a healthcare assistant cleaning a saturation probe and blood pressure monitor on ward 20, to comply with infection prevention and control measures.

Environment and equipment

The design and maintenance of facilities kept people safe and most areas had enough equipment for staff to carry out their role.

We found the ward environments used keypad door locks to secure access, and wards were mostly clutter free, wheelchair accessible, with clear signage which indicated the areas that were COVID-19 positive (called ‘red zones’) and COVID-19 negative (called ‘green zones’). Staff we spoke with told us they received daily coronavirus updates and were supported with an area they could go to as a quiet zone, through occupational health and a wellbeing service. Most areas we visited had enough equipment for staff to carry out their role.

The wards that we visited consisted of a mixture of single side rooms and bays with five beds in each.

Resuscitation trolleys were checked and recorded in accordance with trust policies. We found the trolleys were adequately stocked with PPE.

Waste was separated and disposed of in appropriate colour coded bins for management of clinical and non-clinical waste streams.

Sharps waste bins we saw were assembled correctly, labelled, not over filled and stored safely when unattended.

Emergency exit signage was clear and exits were free of obstructions. All the fire extinguishers we checked were clearly signposted and within date of their next scheduled maintenance check.

Medical care (including older people's care)

Assessing and responding to risk

Staff inconsistently completed and updated risk assessments for each patient and action to remove or minimise risks was unclear. Staff did not always maintain accurate records to confirm how frequently patients required care or the care they had received.

There were risk assessments in place for staff to complete to identify patients who were at risk of such things as falls, and to identify care needs. The service had risk assessment booklets to complete for patients and risk management care plans in line with national guidance. We reviewed eight patient risk assessments and found inconsistent recording of dates, times and details recorded. We could not always judge if care had been instigated in a timely manner.

The named nurse for each patient should, in the "combined 7-days chart" be document by circling the numbers 1, 2 or 3 to indicate to staff providing care how frequently each patient should receive care. Whilst we did observe instances where these were completed correctly, we also observed instances where no number was circled or where more than one number had been circled. We observed, and were told, that health care assistants routinely provided care based on the frequency that each nurse had prescribed daily on each patient's form. There was a system in place to ensure all staff were aware of the frequency of care required, however staff did not always use the system appropriately.

Ward staff reported use of morning handovers and afternoon safety huddles. They were supported by matrons with responsibility for specific wards and quality matrons who work across the Trust

Staff had access to a critical care outreach team 24 hours a day, seven days a week.

Medical staff on each ward looked after any patients who were there as medical outliers, with input from the specialist medical team concerned. We discussed medical outliers with a quality matron who said they thought the medicine division had 18 medical outliers on the day of the inspection; however, this number could not be clarified at the time of inspection. Quality matrons told us that they did not take part in bed meetings to review and discuss patient flow the matrons attended.

Nurse staffing

Although managers regularly reviewed and adjusted staffing levels and skill mix the service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We saw this particularly affected ward 25 and services for stroke patients, and ward 24 at night. We were not assured that patient acuity and dependency or staff experience was always taken into consideration and this impacted on their ability to manage frail patients requiring additional support. The stroke ward had a high sickness rate following positive screening of COVID-19 with a number of staff who were required to isolate in line with government guidance.

The service monitored nurse staffing levels for patients nursed on the hyper acute stroke unit (HASU) receiving level two care; the service could not provide information to show that patients were nursed according to British Thoracic Society guidelines and the National Institute for Health and Care Excellence guidance, which recommend one nurse to two patients. However, on the day of inspection HASU had three patients requiring level two support, supported by one Registered General Nurse (RGN) and one healthcare assistant (HCA) which did not meet the guidance.

The acute stroke unit which had four beds with the potential to escalate to five beds should have had a planned staffing of two RGNs on each shift for the expected acuity of patients if the standard four beds were used. However, staff told us

there was usually one registered nurse on duty during the day and two on night shift. Registered nurse gaps were filled with HCAs. Staffing on the stroke unit was of particular concern as this was where patients receive thrombolysis – a time critical procedure and the limited number of registered staff could impact on this. The service had substantive specialist stroke nurses; however, these nurses worked within the emergency department managing the initial investigation and management of the acute stroke patients in the acute phase. This often impacted on the availability to support the unit during peak times.

Staff told us that they used planned agency staff within this area with experience within stroke management. The stroke ward had a high sickness rate following positive screening of COVID 19 with a number of staff who were required to isolate in line with government guidance.

During our visit we spoke with four matrons who told us that they met three times daily at 8.30am, 11.30am and 4pm Monday to Friday to review staffing and take actions to mitigate staffing risks. We were told there was always a matron on site up until 9pm Monday to Friday and outside of these hours there was an on call service.

During the inspection, we visited ward 24 which was an escalation ward for general medicine patients. We observed staffing figures were not visible on this ward as the unit did not have a quality board. Staff told us that this had been ordered. We found there were large numbers of agency staff in use on all wards that we inspected. For example, on ward 24 (night shift) there was one substantive registered nurse on duty for a 36 bedded unit, with three agency RGN staff and two healthcare assistants.

On the day of the inspection ward 25 was staffed by two substantive registered nurses, supported by four healthcare assistants. The registered nurses were of a lower grade than expected with only six months preceptorship experience. The nurse in charge told us they were new to the ward within the last six months and had felt under pressure due to the acuity of patients and insufficient registered nurse support on the ward. The nurse had escalated this concern to the duty matron however no additional support was offered and in addition dedicated support to them had been moved to another ward area. We escalated this at the time of the inspection to the deputy chief nurse. We were advised that the deputy chief nurse visited ward 25 immediately following inspection and had met with the nurse in charge due to the seriousness of the concerns we had raised.

Staff told us that ward 25 had been allocated three RGN's and two HCA's for the night shift on 27 October 2020 to care for 36 patients. We were not assured that patient acuity and dependency was taken into consideration to manage frail patients requiring additional support. Some staff also told us that doctors including consultants had concerns regarding the number of nursing staff on the ward and had escalated this to the clinical director although we were unable to confirm this at the time.

During inspection we also saw on ward 32, a 27 bedded respiratory medical ward, was staffed by two registered nurses and health care assistants, and ward 34, a 29 bedded medical ward was staffed by two registered nurses and health care assistants.

We observed staff working extremely hard to provide treatment and care under difficult circumstances during the current COVID-19 pandemic, which had impacted on patient numbers and their level of need for care. During October 2020 the North West region saw an increase in COVID-19 patient activity and through October this trust had the highest levels of COVID-19 activity across the region. As of 19 October, the percentage of beds occupied by COVID-19 patients was

24% (34% including suspected COVID-19 patients), compared to 15.4% in the previous week. The percentage of beds occupied by non-COVID patients was 50% as of 19 October and 15% of beds were unoccupied (compared to 12% in the previous week up to 12 October). The number of beds available overall has been below expected since September and numbers decreased further in October (over a hundred beds were still available in the week up to 14 October)

We reviewed incident data on the national reporting and learning system (NRLS) for the trust covering the time period 01 April 2020 - 07 October 2020 and found that between 01 April 2020 and 14 October 2020, the below incidents were reported through the NRLS system in relation to staffing at the Aintree hospital site:

- 26 incidents with ward 22 mentioned

- 29 incidents with ward 20 mentioned

Through our review of the information and our onsite inspection we could not be assured that patients were always being cared for by sufficient numbers of suitably skilled, qualified and experienced staff.

Records

Staff did not always keep up to date fully completed records of patients' care and treatment. Records were not stored securely on all wards that we visited and staff used different documents in ward areas within the same hospital.

We observed unsecured records stored outside patient bays on all wards inspected.

Notes trolleys were open topped with no provision to lock for safe storage and were not adhering to General Data Protection Regulation (GDPR) guidance. The trust informed us that this was a conscious, risk assessed decision advised by the Trust's IPC team during the COVID pandemic in order to limit flow in and out of bays to help prevent the spread of infection.

The service had a paper-based patient record system. There were several paper booklets for nursing staff to complete to record patient care. When the patient was admitted to a medical ward a nursing admission booklet was completed which identified the risk assessments and care plans required for the patient. The nursing risk assessment booklet record included (nursing care evaluation booklet, combining seven-day charts, care plans, observation and NEWS2 chart, inpatient fluid prescription and balance chart, peripheral intravenous cannula (PIVC) and intentional rounding. The care records were kept in folders in an open topped trolley outside individual patient bays. Medical notes were stored in separate folders in the same trolley.

We reviewed eight care records during inspection which included; fluid balance charts, do not attempt cardiopulmonary resuscitation (DNACPR), observation charts, intentional rounding and EPMA electronic records. We saw there was inconsistent recording of dates, times and amounts recorded. We could not always judge if care had been instigated in a timely manner. Medical notes were clearly written following patient review. We saw the records were dated and signed with multidisciplinary input from other specialities and supporting clinicians.

We noted DNACPR records were completed in line with trust policy, with evidence of best interest decisions and records of discussions with relatives in medical notes.

Medical care (including older people's care)

During our inspection we saw evidence of staff delivering care, but this was not subsequently documented in care records.

During inspection we saw there were different documents used across the both sites and different ward areas within the same hospital. This meant staff could not find information about the patient's health needs readily and this was further emphasised when staff were not working on familiar wards or environments.

From our review of information, we found between 01 April and 07 October 2020 there were four incidents of records being returned from offsite scanning due to wrong patient information in the record, and another incident of documents for three different patients being filed in a patient's folder.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. However, we saw that medicines were not always administered on time and controlled drugs were not always checked in line with trust standard operating procedures. Agency staff did not always have access to the electronic patient medication system.

On inspection we visited ward 25, a general medicine, 'COVID red' ward with 36 beds of which six were side rooms. Staff told us that due to staffing shortages this had impacted on the timely administration of intravenous medications. However, the trust informed us post inspection that checks had assured them that intravenous medication was provided on time. This had been escalated to the matron at the time; however, no additional support had been provided. We raised this at the time of the inspection to the Director of Nursing. We were advised that they had visited ward 25 and had met with the nurse in charge due to the seriousness of the concerns raised. We reviewed incident data on the national reporting and learning system (NRLS) for the time period 01 April to 07 October 2020 and found that across the medical division there were four incident reports specifically referencing delays in administering patient medicines.

During inspection we observed a medicine trolley was left open and unattended during a medicine round on ward 20, (a 'COVID red' ward). We observed a medication round; the nurse did not take the medicine trolley into patient bays. The trolley was left open and unattended in the ward corridor.

We observed nurses wearing 'do not disturb' tabards and administering medications using the EPMA electronic system. We noted a patient requiring medication via a percutaneous endoscopic gastrostomy tube (PEG) had been prescribed medicines in line with guidance. A PEG insertion procedure is where a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus.

Staff told us that some agency staff were unable to access the electronic prescribing and medicines administration (EPMA) electronic system if they had not undertaken training competency and sign off for this. This impacted on patient care where agency use was high as agency staff could not access the EPMA record to undertake medicine administration rounds. Staff told us this then impacted on the timeliness of medicine administration adding additional pressure to substantive nursing staff.

The trust informed us that the majority of Trust Agency Nurses were supplied via the agreed Framework Agencies. All agency staff provided in this way were up to date with the Mandatory Training that is expected at the Trust. However,

when an agency is supplied via an off-framework agency, assurances regarding mandatory training would be required to be supplied via the agency. If an Agency Nurse was new to the Trust, they would be booked in for EPMA (Electronic Prescribing and Medicines Administration) training via the IT department to ensure they have sufficient training to allow them to administer medication.

Is the service effective?

Inspected but not rated

Nutrition and Hydration

Not all patients requiring dietetic review received this in a timely way, including some with significant nutritional needs. Through our review of the information we were not assured the trust had a robust system in place to manage patients' nutritional and hydration needs.

However, from our observation on Ward 20 on the days of inspection we saw staff gave patients enough food and drink to meet their needs, but patients requiring one-to-one supervision on other wards did not always receive adequate support for nutrition and hydration needs.

Staff identified patients at risk of nutritional and dehydration risk or requiring extra assistance; however, patients were not consistently offered support when required due to staffing challenges. Before the inspection we had received a number of concerns about ward 25 and the lack of adequate management and provision of patient support with regard to assisting patients to eat and drink. Night staff distributed breakfasts, staff on the early shift were expected to provide support for patients requiring assistance. Staff we spoke with confirmed this and told us that due to staffing challenges some patients requiring assistance were left to manage by themselves and this impacted on them receiving adequate nutrition and hydration. Food was often cold by the time day staff were able to assist those that needed assistance.

There was no evidence of clinical goal setting or actions recorded, such as referral to dietetics, or identified feeding plans for those with high risk scores.

We reviewed incident data on the national reporting and learning system (NRLS) for the time period 01 April 2020 - 07 October 2020 and found that across the trust:

- There were seven incidents which included parenteral feeds not received as prescribed; the trusts' standard operating procedures were not followed.
- For one patient to meet their nutrition and hydration needs there was a two-day delay in referral to speech and language therapy.
- There were 42 incidents which included one patient who had a 10% weight loss whilst waiting for percutaneous endoscopic gastrostomy (PEG), a 17-day delay in receiving feed via nasogastric tube, one patient was nil by mouth for five days before a PEG was inserted and there had been no referral for assessment before feed was commenced.

Medical care (including older people's care)

In this time period there were two incidents reported by the dietetics team who were concerned about the significant reduction in the number of referrals. These incident reports detail that in the five-week period from 20 April 2020 to 22 May 2020 the dietetic team had identified 140 patients needing a referral to a dietician based on their MUST scores. This was an average of 28 patient referrals a week, who should have been referred to a dietician and who otherwise would not have been identified.

Through our review of the information and our onsite inspection we were not assured that that the trust had robust systems in place to manage patients nutritional and hydration needs. Following the inspection, the trust informed us that a review of dietetic referrals for October 2020 had met expected levels.

Is the service caring?

Inspected but not rated

Compassionate care

Staff cared for patients with compassion and dignity; however, we observed a number of call bells were not always answered in a timely manner due to the high number of patients and low levels of staff on all wards inspected. During the inspection we noted delays in responding to patient call bells in different ward areas.

On ward 20 we undertook an observational SOFI and observed five patients during a lunchtime service. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the patients, the type of activity or non-activity they were engaged with and the style and number of staff interactions with patients. In each time frame there may be more than one type of engagement and multiple interactions with staff. Staff interactions are categorised as positive, neutral or poor. Some examples of positive interactions would include displaying respect, warmth and providing enablement for patients. Negative interactions may include withholding behaviour, such as refusing to give asked for attention, or not meeting an evident need; or failing to acknowledge the reality of a patient.

We observed that interactions on the whole were positive, friendly and informal. Three patients required assistance to eat and drink. During the observational assessment we noted that a call bell was left unanswered within the five bedded bay for eight minutes. Staff eventually attended and assisted the patient to change position in bed.

One patient who required assistance and support due to mobility concerns was not offered a cleansing wipe to wipe their hands pre meal service. The SOFI demonstrated positive interactions between patients and staff. Staff were friendly and supporting towards patients respecting their privacy and dignity.

During the observational assessment we saw staff supported patients to eat their meals offering them choice and supporting patients at their own pace.

Is the service well-led?

Inspected but not rated

Medical care (including older people's care)

Leadership

Local leaders were not always visible and approachable in the service for staff. Although local leaders were supported by Trustwide quality matrons who completed regular walkarounds there was a lack of senior leadership oversight in the service.

We received concerns about patient care and safety at both sites prior to the inspection. We raised these with the trust and asked for assurance of how they were assuring patient safety at the point of delivery. We received information from the trust which provided some assurance about senior nurse review of clinical areas such as environment, patient experience and infection prevention and control. However, there was no information provided to support that patients had their health needs assessed, appropriate risk assessments were completed, and care plans reflected that person's needs.

The trust provided details of matron reviews which indicated some concerns regarding infection prevention and control and social distancing of patients in five bedded bays, provision of hand wipes/ gel for patients and cleaning of equipment between uses. However, there was no information provided on the actions taken to mitigate these risks.

During the inspection quality matrons were site based and did walkarounds, however there was a lack of senior leadership oversight in the service. We saw a significant number of quality metrics unrecorded at ward level, which would impact on the ability of quality matrons and safety leads to monitor and take appropriate actions to ensure safe care and treatment.

CQC formally wrote to the trust to notify them of the serious patient safety concerns that had been identified and to provide further information on the immediate actions put in place to mitigate the risks to patients, Following the inspection, the trust told us of the immediate actions they had taken, which included additional senior leadership capacity and support for Specialist Medicine Division; circulation of communications to all staff how they value their staff and encouraging them to raise concerns.

In addition, the trust informed us that to ensure a level of independent scrutiny, an additional regulatory compliance meeting would be held every two weeks to seek assurance and ensure progress was achieved. This would be reported through to the Quality Committee in due course. The Director of Operations for Specialist Medicine would be chairing an overview and scrutiny meeting with the Divisional Director of Nursing and Matrons to provide enhanced oversight and scrutiny. The forward plan for staffing and quality metrics related to falls, pressure ulcers, nutrition and hydration and the matron's checklist would be reviewed at this meeting. The Chief Nurse and the Director of Patient Safety were developing an overarching "Safe Nursing" Strategy which would form part of the Trust approach to Quality and Safety.

Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Ward based quality information boards were inconsistently completed and no action had been taken to address this. Although the trust was facing a surge of demand, leaders had taken a decision not to escalate their status through the NHS Operational Pressures Escalation Framework, however we were informed that local arrangements were in place with system partners and being co-ordinated through NHS E/I's specific Covid incident control function.

Medical care (including older people's care)

Ward based quality information boards were inconsistently completed. During inspection we noted that quality boards on individual wards containing infection control rates, clostridium difficile and hand hygiene compliance were not consistently updated. The quality board on ward 25 was blank and had last been updated in July 2020 and the quality board on the hyper-acute stroke unit had last been updated in August 2020.

Medical staff on each ward looked after any patients who were there as medical outliers, with input from the specialist medical team concerned. We discussed medical outliers with a quality matron who said the medicine division had 18 medical outliers on the day of the inspection; however, this number could not be clarified at the time of inspection.

During the inspection we met with senior leaders who told us of the trust's response and latest planning during COVID-19. Prior to the second surge in demand, the trust had begun to implement reset plans following the first wave of COVID-19. During COVID-19 the trust reviewed information in dashboards to monitor overall activity, including bed occupancy; critical care bed availability; staff absence and community prevalence. From this monitoring, a building picture of demand was identified during September 2020. The trust's senior leaders met three times a week to agree decisions in response to the changing needs, including transfer of surgical beds for medical care; use of the elective care facility for patients requiring level 2 critical care; and redeployment of theatre staff to critical care and high dependency areas. Leaders described the support through 'mutual aid' working, which was continuing from across the wider health care system, in agreement with other stakeholder organisations. Although the trust was facing a surge of demand, leaders had not taken a decision to escalate their status through the NHS Operational Pressures Escalation Framework, to provide additional system support for the emergency response.

Leaders reflected the differences in attendance at emergency departments between the first wave of COVID-19 compared with the current surge in demand; with the continuing high rates of attendance having additional impact on patient access and flow through the hospital. This was also adding to delayed transfers of care and patient discharges. Although there were some plans in development with community partners and other initiatives, including NHS 111, the impact of these was not anticipated to begin until early 2021.

During the call leaders shared examples of collaborative system working in areas, such as maintaining cancer services to meet targets, effective transfer of patients by the NHS ambulance service and working with the local mental health provider to secure services for patients with mental health needs.

Management of risk, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. The trust's response to specific concerns about wards 22 and 25 provided limited information about effective monitoring of patient risks.

Prior to the inspection we had received concerns about patient care and safety at the trust's two main hospital sites and specifically regarding wards 22 and 25. We raised these with the trust and asked for assurance of how they were assuring patient safety at the point of delivery. The information did provide some assurance about senior nurse review of clinical areas- such as environment, patient experience, and IPC however there was no information provided to support that patients had their health needs assessed, appropriate risk assessments completed, and care plans reflect that person's needs. Through our review of the information and our onsite inspection we were not assured that the trust has robust systems and processes in place to monitor the quality of the care patients receive.

Following the inspection, we formally wrote to the trust and raised significant concerns regarding the oversight and management of safe nurse staffing. The trust provided details of actions they had taken, including the establishment of

a virtual nurse control centre (VNCC) in October 2020 to manage the nursing, AHP and Healthcare Assistant workforce and related matters during the second in-patient COVID-19 surge. The divisional triumvirate lead on the re-allocation of resource following clinically assessed reduction in activity. The VNCC supported any cross divisional actions ensuring appropriate re-deployment of staff. The VNCC also provided appropriate routes for rapid escalation of key issues.

In response to concerns about staff adherence to infection prevention and control practices, the trust provided a specific improvement plan for the medical wards at the Aintree and Royal Liverpool sites. This identified actions including completion of a daily COVID checklist; peer matron spot checks on a daily basis; frequency of monthly matron audits increased to weekly; and increased frequency of senior nurse walkabouts across medical wards.

In response to concerns about access and flow through the hospital, the trust provided details of a range of meetings and reports to monitor access and flow across the organisation. These included meetings to support the flow of non-elective and elective admissions whilst maintaining safe and effective care within their pathway. There were patient level meetings, unit, divisional and trust wide governance systems to oversee and respond to patient capacity, demand and activity.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure risk assessments and care plans are reviewed and updated for patients to ensure they mitigate risks to patient safety. This includes ensuring tools to identify patients at risk of deterioration are used in an accurate and timely manner by staff (Regulation 12: Safe Care and Treatment).
- The service must ensure the proper and safe management of medicines particularly in relation to timely administration and recording of medicines. (Regulation 12: Safe Care and Treatment).
- The service must ensure they are detecting and controlling the spread of infections, including those that are health care associated. (Regulation 12: Safe Care and Treatment).
- The service must ensure Malnutrition Universal Screening Tool (MUST) risk assessments are completed correctly and reviewed in accordance with national guidance. The service must improve patient access to food and drink which is served and maintained at the right temperature for the whole mealtime and receive appropriate support to eat and drink, where needed. The service must review and act on the 42 incidents relating to nutrition and hydration, to ensure patients receive timely nutrition and hydration. (Regulation 14: Meeting Nutritional and Hydration Needs)
- The service must ensure records of care and treatment for patients are accurate, complete and contemporaneous and that patient records are stored securely. Records must be accessible to all authorised staff as necessary in order to deliver people's care and treatment (Regulation 17: Good governance)
- The service must ensure they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. (Regulation 17: Good governance)
- The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed (Regulation 18: Staffing).

Medical care (including older people's care)

Action the service SHOULD take to improve:

- The service should improve care and treatment to meet the needs of service users and that patient call bells are responded to in a timely way.

Our inspection team

The inspection was carried out by a CQC inspection manager, and two CQC inspectors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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

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