Worcestershire Acute Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust

Are services at this trust safe?	
Are services at this trust effective?	
Are services at this trust caring?	
Are services at this trust responsive?	
Are services at this trust well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Worcestershire Acute Hospitals NHS Trust on the evening of the 24th March 2015 as a part of a responsive inspection. The purpose of the unannounced inspection was to look at the emergency departments (ED) at Worcestershire Royal Hospital and Alexandra Hospital. The services were selected as examples of a high risk services according to our intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

We did not inspect any other services provided at the trust.

The inspection focused on the safety of patients. We found that improvements were needed to ensure that the EDs were safe.

We also looked to ensure each ED was effective, caring, responsive and well led. However, we did not have sufficient evidence to rate domains.

Our key findings were as follows:

Incidents

- Systems were in place for reporting incidents. However, incidents were not always reported. This meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in these services.

Safeguarding

- Children were not routinely screened for safeguarding concerns. At Alexandra Hospital we found one child who had received an injury, did not have a safeguarding assessment completed.
- We found paediatric patients at both sites were at risk because there were inadequate measures in place in relation to their security.

Medicines management

- The systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, were not robust or in line with requirements.
- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.

Staffing

- There was a shortfall in nursing staff numbers. There was no evidence shifts were being planned to reflect the patients' acuity and therefore the planned staffing did not always meet the needs of the patients in the department.
- Senior staff told us they had escalated concerns about staffing and capacity in the department to senior managers as they considered the department was "not safe" at times due to the high volume of patients.
- At both sites we saw evidence of the departments being "Overwhelmed". However the escalation process could not always been carried out because there were no more staff available. This meant that the department was not able to manage the situation safely.

Medical staffing

- Forty percent of the senior staff were locum.
- There was one consultant on site after 5pm covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This was raised as a concern during a peer review from NHS England. If two trauma patients were admitted at the same time on each site, the protocol was that one of the trauma calls would be led by the orthopaedic doctor.

Environment and equipment

- We found that staff had not documented daily equipment testing for the resuscitation trolley at Worcestershire Royal Hospital to ensure equipment was fit-for-purpose.
- We found single use items on the resuscitation trolley and in the resuscitation room that had expired. Staff told us they did not always have time to check equipment.

Summary of findings

- There was insufficient space within the department to assess patients. When all the cubicles and bays were full, patients were cared for in the corridor. This put patient safety at risk because of reduced visibility of patients when in the corridor.

Ambulance Handovers

- There were delays in handover time from ambulance crew to the emergency department team. This meant that patients, including clinical unstable patients, remained under the care of the ambulance crew longer than expected which delayed initiation of treatment.
- In the past 12 months the trust had not consistently met its 15 minute triage target or its target for patient handovers being carried out within 30 minutes of arrival by ambulance.

There were areas of poor practice where the trust needs to make improvements.

We found breaches with the following regulations:

- Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].
- Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].
- Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Importantly, the trust must:

- Ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff mix in the EDs to ensure people who use the service are safe and their health and welfare needs are met.
- Ensure that all equipment is in date and is checked consistently.
- The trust must ensure that service users are protected against the risks associated with unsafe or unsuitable premises, by means of appropriate measures in relation to the security of the EDs.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust provides acute hospital services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery, paediatrics, maternity care and a range of outpatient services.

Urgent and emergency services are provided across three sites with EDs at Worcestershire Royal Hospital and the Alexandra Hospital in Redditch; and a minor injuries unit (MIU) at Kidderminster Hospital and Treatment Centre. In addition the trust provides regulated activities from two other locations in Evesham Community Hospital and Tenbury Community Hospital.

Worcestershire Acute Hospitals NHS Trust is a non-foundation trust.

The trust employs over 5,500 staff and has an annual turnover or more than £320 million.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team of seven included one CQC Head of Hospitals Inspector, two CQC inspection managers, three CQC inspectors, an emergency department consultant and a clinical fellow.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust, including information that we had requested from the trust to assure us of patient safety. We asked other organisations to share what they knew about the trust. These included the Clinical Commissioning Groups, the Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

The inspection team inspected the following core service at the Worcestershire Royal Hospital and Alexandra Hospital:

- Urgent and emergency care

The responsive inspection of the EDs at Worcestershire Royal Hospital and Alexandra Hospital took place on 24 March 2015.

We talked with patients, carers and/or family members and staff from the EDs. We observed how people were being cared for and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Worcestershire Acute Hospitals NHS Trust.

Summary of findings

What people who use the trust's services say

Family and Friends Test December 2014 response rates were worse than the England average. However, 95% of responses at Worcester Royal Hospital and 99% of responses from Alexandra Hospital indicated that most patients would be very likely or likely to recommend the trust as a place to have care and treatment.

The CQC inpatient survey was conducted between September 2013 and January 2014. A questionnaire was sent to inpatients that had used the EDs. The trust was average when compared with similar trusts for patients receiving enough privacy and enough information about their condition and treatment within the ED. It was noted that people rated 'being asked to give their views about the quality of the care they received in hospital' and 'information about complaints' at the lower end of the scale.

Facts and data about this trust

Worcestershire Acute Hospitals NHS Trust serves a population of approximately 550,000 people in Worcestershire and the surrounding areas. Over 95,000 patients are cared for each year with more than 130,000 A&E attendances and approximately 500,000 outpatient appointments. The county contains a mixture of urban and rural population.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Paediatric patients were not routinely screened for safeguarding concerns and were at risk because there were inadequate measures in place in relation to their security. Incident reports were not always completed. Staff told us that they were encouraged to complete incident reports but that they were often too busy to complete reports. There was a shortfall in nursing staff numbers. There was no evidence shifts were being planned to reflect the patients' acuity and planned staffing did not always meet the needs of the patients in the department. Senior staff told us they had escalated concerns about staffing and capacity in the department to senior managers as they considered the department was "not safe" at times due to the high volume of patients. When all the cubicles and bays were full, patients were cared for in the corridor. The escalation process could not always been carried out because there were no more staff available. Staff had not documented daily equipment testing for the resuscitation trolley at Worcestershire Royal Hospital to ensure equipment was fit-for-purpose. We found single use items on the resuscitation trolley and in the resuscitation room that had expired. In the past 12 months the trust had not consistently met its 15 minute triage target or its target for patient handovers being carried out within 30 minutes of arrival by ambulance. This meant that patients, including clinical unstable patients, remained under the care of the ambulance crew longer than expected which delayed initiation of treatment.	
Are services at this trust effective? Staff reported good multidisciplinary team working and we found confirmation to support evidence based treatment for one patient. However, we found inconsistencies with patients being able to access fluids.	
Are services at this trust caring? We observed a mix of positive and negative interactions between staff and patients. We found that patient privacy and dignity was not always protected. Patients reported that they did not know what was happening regarding their care and treatment.	

Summary of findings

Are services at this trust responsive? We found that the capacity of the EDs and the lack of patient flow within the trust did not meet patient demand.	
Are services at this trust well-led? Staff reported lack of senior support within ED.	

Overview of ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	N/A	N/A	N/A	N/A	N/A	N/A

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve
Action the hospital MUST take to improve

- The trust must ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff mix in the ED to ensure people who use the service are safe and their health and welfare needs are met.
- The trust must ensure that all equipment is in date and is checked consistently.
- The trust must ensure that service users are protected against the risks associated with unsafe or unsuitable premises, by means of appropriate measures in relation to the security of the ED.

Action the hospital SHOULD take to improve

- The trust should ensure all staff are aware of their roles and responsibilities to report incidents.
- The trust should ensure that the initial assessments of all patients are in line with national standards.
- The trust should ensure that all patients are appropriately monitored and receive timely observations and medication.
- The trust should address the concerns regarding patient flow through the hospital, to prevent overcrowding of patients in ED.
- The trust should review the paper records to ensure that the recordings are accurate and are always fully completed to prevent risk to the delivery of safe patient care and treatment.

This section is primarily information for the provider

Enforcement actions

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. The trust did not ensure that at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff mix in the ED to ensure people who used the service were safe and their health and welfare needs were met.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises (1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of— (a) suitable design and layout; (b) appropriate measures in relation to the security of the premises; and (c) adequate maintenance and, where applicable, the proper— (i) operation of the premises, and (ii) use of any surrounding grounds, which are owned or occupied by the service provider in connection with the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

(2) In paragraph (1), the term "premises where a regulated activity is carried on" does not include a service user's own home.

Patients, including children, were at risk because there were inadequate measures in place in relation to their security in ED. For example, the doors leading into the emergency department were left open during our inspection allowing unauthorised access.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

(1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is—

(a) properly maintained and suitable for its purpose; and

(b) used correctly.

Staff had not documented daily equipment testing to ensure that the resuscitation trolley in ED was fit-for-purpose. We found out of date single use equipment on the resuscitation trolley and within the resuscitation room.