Worcestershire Acute Hospitals NHS Trust

Alexandra Hospital

Quality Report

Alexandra Hospital
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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 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 were at risk because there were inadequate measures in place in relation to their security.

Medicines management

- The medicines in the resuscitation room were stored in a lockable cupboard, which was in constant use during our visit.
- The register for the controlled medications were completed and tallied with the actual medications in the controlled drug cupboard.

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.
- We saw evidence of the department 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.

Summary of findings

Environment and equipment

- All of the cubicles had nurse call bells available.

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 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].

Importantly, the trust must:

- 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

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		Children were not always safe as their cubicles were accessible by anyone. Not all children had a safeguarding assessment. Not all patients were safe at all times as there was a risk that staff would not detect that patients were clinically unwell, as not all patients were triaged within 15 minutes of arrival at the department. Patients' observations were not always taken and staff did not calculate patients' early warning scores. Staff did not always have a clear indication of the safety of the department as a tool devised to protect the safety of patients was not always completed, or used to escalate concerns. Patients were not always safe as there was not always enough nursing staff or consultants available to meet their needs. Staff knew how to report incidents, but they did not report all incidents due to time constraints. Staff took precautions to prevent infection. Nurse call bells were available in all cubicles. Medicines were locked away safely.

Alexandra Hospital

Detailed findings

Services we looked at
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Detailed findings

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Background to Alexandra Hospital

We inspected Alexandra Hospital on the evening of the 24 March 2015 as a part of a responsive inspection. The purpose of the unannounced inspection was to look at the accident and emergency department. The service was selected as an example of a high risk service 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 service provided at the hospital.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team of six included one CQC head of hospitals inspector, one CQC inspection manager, three CQC inspectors 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?

The inspection team inspected the core service at the Alexandra Hospital:

- Urgent and emergency care

Prior to the unannounced inspection, we reviewed a range of information we held about Alexandra Hospital and 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 responsive inspection of the emergency department Alexandra Hospital took place on 24 March 2015.

Detailed findings

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

Facts and data about Alexandra Hospital

The Alexandra Hospital in Redditch serves a population of approximately 200,000 people and has 360 beds

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Alexandra Hospital in Redditch was opened in 1985.

The hospital is the major centre for the county's urology service. The hospital has seven operating theatres, magnetic resonance imaging (MRI) and computerised tomography (CT) scanners and cancer unit status for breast, lung, urology, gynaecology and colorectal cancers.

There is a multi-disciplinary education centre with library, teaching and study areas.

Patients present to the department either by walking into the reception area or arriving by ambulance. If a patient arrives in the department on foot, they are seen at the reception by a senior nurse who triages them to the appropriate area. If a patient arrives by ambulance, they are transferred to the main emergency department (ED).

During our inspection, we spoke to approximately 30 patients and fourteen members of staff including: nurses; doctors; administrators; and senior management. We observed interactions between patients and staff, considered the environment and looked at care records.

Summary of findings

Children were not always safe as their cubicles were accessible by anyone. Not all children had a safeguarding assessment.

Not all patients were safe at all times as there was a risk that staff would not detect that patients were clinically unwell, as not all patients were triaged within 15 minutes of arrival at the department.

Patients' observations were not always taken and staff did not calculate patients' early warning scores.

Staff did not always have a clear indication of the safety of the department as a tool devised to protect the safety of patients was not always completed, or used to escalate concerns.

Patients were not always safe as there was not always enough nursing staff or consultants available to meet their needs.

Staff knew how to report incidents, but they did not report all incidents due to time constraints. Staff took precautions to prevent infection. Nurse call bells were available in all cubicles. Medicines were locked away safely.

Urgent and emergency services

Are urgent and emergency services 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.

Staff followed infection control practices. For example, staff were bare below the elbows' and washed their hands or used alcohol gel between patients.

The national 15 minute triage target was not routinely achieved for all patients. We found patients who had waited 35 minutes to be triaged which put patients at risk of not receiving medical care in a timely way. The clinical status of patients was not always recorded or accessible to the team to identify a deteriorating patient.

We found problems with patients being admitted to the hospital as there were no beds making it unsafe to admit more patients. Safety risk assessments for ED were not always completed and there was no evidence of escalating safety concerns when the ED became 'overwhelmed'.

Incidents

- Staff told us they knew how to complete incident reports and were encouraged to complete reports, including those for overcrowding of patients in the department. Staff reported that they were too busy to report incidents. This meant that incidents were not always reported appropriately.
- There were two incidents that had been reported in December 2014 where staff had reported a delayed assessment. The trust had investigated and found these to be near misses.
- Staff told us that feedback of any incidents were informal at junior doctors meetings.

Cleanliness, infection control and hygiene

- Staff were 'bare below the elbows' and we observed that staff either washed their hands or used alcohol gel between patients.
- There was personal protective equipment available for staff.
- Deep cleans of cubicle areas were carried out after two patients with diarrhoea were discharged.

Environment and equipment

- All of the cubicles had nurse call bells available. Five out of 20 patients had their call bell to hand; 15 patients had a visitor with them who said they could reach the call bell to summon help.

Medicines

- The medicines in the resuscitation room were stored in a lockable cupboard, which was in constant use during our visit.
- The register for the controlled medications were completed and tallied with the actual medications in the controlled drug (prescription medicines that are controlled under the Misuse of Drugs legislation such as morphine) cupboard.

Records

- Patient information was kept on the computer system and the assessments were carried out on paper.
- There was a process for storing patients' paper notes in the majors area which were easily accessible to all staff.
- There was no clear process for storing paper notes in the minors area, and a number of times staff could not tell us where patient notes were.

Safeguarding

- Six children had been triaged and seen by a doctor. Five of these children had had a safeguarding assessment. One child who was 14 years of age had received a sporting injury, did not have a safeguarding assessment completed. This meant that not all children were routinely screened for safeguarding concerns.
- There were three cubicles for children requiring treatment. These were in the majors section of the department. It was observed that there was no locking door between the main department and the designated children's cubicles, and patients and relatives were able to access the cubicles unchallenged either from a

corridor out of sight of any staff or from the main majors area. Standards for EDs state that children's areas should be monitored securely and zoned off, to protect children from harm.

- During the evening the cubicles were re-designated to become adult cubicles, resulting in children and adults being cared for in adjoining cubicles without a constant staff presence or any effective segregation of children or adult patients.
- The children's waiting room was accessible from the main waiting area, the room was private and had clean toys and furniture. There was a swipe card access from this waiting room to the major's area of the department. This meant that the waiting room was a safe place for children to wait for treatment.

Assessing and responding to patient risk

Triage

- An allocated nurse on each shift triaged all patients that arrived directly to the ED.
- Ambulance arrivals reported to the co-ordinator who allocated a nurse for initial assessment and on-going treatment.
- Between 4 January and 1 February 2015, 85% to 99% of patients who arrived by ambulance were triaged within 15 minutes of arrival. Between 4 January to 1 February 2015, patients who arrived by directly to ED were triaged within 15 minutes of arrival was between 66% and 82%.
- We looked at 20 patient records. Sixteen patients (80%) had been assessed within 15 minutes of arrival. The four patients had been assessed between 27 and 35 minutes of arriving at ED. This meant that the national 15 minute triage target was not routinely achieved for all patients.
- There was a lack of flexibility in the staffing numbers to triage patients that arrived at the same time. For example, three of the four patients that were triaged over 15 minutes had arrived within 14 minutes of one another. This meant that there was a risk of patients not receiving medical care in a timely way.

Safety Matrix

- The staff in the ED measured the safety risk of the department every 2 hours by recording the safety level of key areas of the department. For example, the number of ambulances arriving, the number of patients, the number of staff and how long patients were waiting. The levels of safety were either "Normal", "Busy", "Critical" or "Overwhelmed". There were clear guidelines for staff to follow for each of the levels. In particular if the ED was "Overwhelmed" the following actions were required:-

  All actions must prioritise patient care and safety.

  1. ED senior clinician to do round with dedicated nurse and junior doctor of majors/resuscitation/ambulance queue to expedite assessment.
  2. Ensure site manager has escalated the problem.

- The 2 hourly assessments of the safety matrix were not always carried out.
- At the time of our visit (7.30pm) we found that only the first six assessments of the day had been carried out. The last assessment that had been carried out at 12pm stating that the ED was "Overwhelmed" by the ambulance arrivals and that there were 39 patients (six more than the ED was designed for). There had not been any safety level assessment of the ED from 12pm onwards.
- There was no evidence in the duty rota, the co-ordinators report or speaking with staff that the actions that required when the ED was "Overwhelmed" had been carried out. However, using the same criteria for their safety assessment we found that the department would have been assessed as "Normal" at 7.30pm.
- We looked at the safety matrix that had been completed for the previous two weeks. We found that the safety risk was only assessed 75% of the time. Staff had at times assessed the risk in the individual areas such as ambulance arrivals and staffing, however, they had not calculated the risk for the ED. In particular on 9 March, there were assessments that showed that the department was "Overwhelmed" by ambulance arrivals and five patients were cared for in the corridor. The staff had not recorded the risk to the ED for the next six hours. The co-ordinator had recorded that there were no more beds in the hospital and that 11 patients had exceeded the recommended waiting time of eight hours from time to admission. This meant that staff in ED did not have a clear indication of the safety risk of the department as they did not always measure the safety risk and they did not record their actions when the ED was "Overwhelmed".

Bed management

- The shift co-ordinator's reports and the safety matrix for 2 weeks before our inspection demonstrated that there were problems with patients being admitted to the hospital as there were no beds. We found evidence of the clinical decisions unit (CDU) being closed during part of eight days in March 2015 due to lack of staff. We found that the medical admissions unit (MAU) had been closed on one day in March 2015 and unable to admit a patient from ED due to pressures within their own department. This meant it became unsafe to admit any more patients.
- The nurse on-call for the hospital and the bed manager told us that there were surgical beds available on the night of our inspection, but no medical beds. The nurses planned to move medically fit patients to surgical wards to enable clinically unstable medical patients to be admitted to medical wards. The conversation took place at 10pm. This meant that patients may be required to move wards at night.

Ambulance handover

- The trust and the ambulance service had a written agreement that when the ED had more than four patients in the corridor, that the ambulance service would supply their own staff to look after any extra patients. The agreement included protocols to ensure that ambulance staff would look after patients who were at lower risk (i.e. had not received morphine or had observations that demonstrated that the patient was clinically unstable).
- The agreement stated that the escalation procedure for a deteriorating patient (where the early warning score was 3 or above) was via the corridor nurse and the lead ED clinician. However, we found that in this event, the ED would be at capacity and the risk of the lead ED clinician already attending an emergency was high. There was no clear emergency plan and the ED co-ordinator was not involved.
- All the ambulance and nursing staff we spoke with said that they had a good working relationship with each other and when there were more than four patients in the corridor that they worked together.
- The co-ordinator reports showed that there were occasions when the ambulances had been diverted from Worcestershire Royal Hospital to Alexandra Hospital. There was a protocol that high dependency patients could not be diverted as their care could not be carried out at the Alexandra, for example a patients who had suffered a stroke.

Recognising the deteriorating patient

- The ED used an early warning score system to assess whether patients observations indicated they were clinically well. A score of 3 or above indicated that patients were clinically unwell.
- The trust had an escalation procedure where patients who had an early warning score of 3 or above would be seen by a senior doctor. We found 10 out of 20 patients records we looked at had observations recorded. Of these, only four had had an early warning score recorded. This meant that there the clinical status of patients was not always recorded or accessible to the team to identify a deteriorating patient.
- One patient in the resuscitation room had an early warning score of 6. The junior doctor had alerted a senior doctor of the patient's condition. The junior doctor told us that they would refer the patient to the medical team on-call in the hospital if the patient deteriorated.
- There was no evidence of rapid assessment and treat processes.

Nursing staffing

- The duty rota demonstrated that the department planned to have:
  - a co-ordinator, eight registered nurses (RN) and two healthcare assistants (HCA) on every early shift;
  - a co-ordinator, nine RNs and two HCAs on every late shift and;
  - a co-ordinator and five RNs on a night shift.
- The duty rota demonstrated that there was not always a band 7 nurse on duty to support the band 6 nurses who were co-ordinating the ED. For example, the duty rota from 9 to 22 March demonstrated that there were 28 out of the possible 42 shifts where there was no ward sister or matron on duty. This meant that the responsibility of the ED and co-ordinating the patient flow lay with a junior sister (band 6) most of the time.
- The co-ordinator was counted in staffing numbers, they were not supernumerary. On the day of our inspection

the co-ordinator on the morning shift had recorded that they looked after the patients on trolleys in addition to their co-ordinating role. This did not allow for dedicated oversight of the flow of patients through the ED.

- On 24 March there had been a co-ordinator, six RNs and one HCA. The co-ordinator told us that the department had run without one triage nurse as they were two members of nursing staff short. The co-ordinator had recorded that there were 39 patients, the department was overwhelmed by ambulance arrivals and there were patients being cared for in the corridor. There was no indication that more staff had been requested and there had not been any more staff supplied. This meant that there had not been enough nursing staff on the shift to safely assess all patients within 15 minutes of arrival, or to look after 39 patients.
- On 9 March the duty rota showed that the department had its full complement of staff when the department was deemed as a safety risk of "Overwhelmed". There was no indication that any more staff had been requested or supplied.
- The co-ordinators reports for the previous two weeks showed that at times staff worked 12 hour shifts without a break.
- From 18 to 23 March the duty rota and the co-ordinators reports demonstrated that not all the nursing shifts were covered. There was evidence of borrowing of staff from other departments for short spells and the CDU closing due to lack of staff. There was no nurse allocated to look after the minors part of the department on the evening of 23 March.
- During the two weeks before our inspection, when the duty rota showed that there was not the full complement of staff, there had been diverted ambulances from the Worcestershire Royal Hospital. 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.
- We found that the managers had recognised where there was a nursing staff shortage and booked agency nurses in advance. However, staff told us that they did not always turn up. We saw that staff were going off sick hours before their shift or during shift, where there was no system for finding a replacement.

Medical staffing

- The duty rota demonstrated that 40% of the senior staff were locum.
- During the hours of 12pm and 7am there was one senior and one junior doctor on duty.
- Most of the medical staffing was provided between the hours of 2pm and 7pm.
- The duty rota showed that a consultant was present in the department for between four and six hours a day.
- Access to consultants relied on an on-call rota shared with Worcestershire Royal Hospital. Locum consultants were available on weekends. We saw that medical staff referred to the surgical or medical teams on call for escalation of care.
- Four consultants have resigned from the department and were due to leave between May and August 2015. After our inspection, the trust told us that all posts had been filled with a mixture of substantive and locum appointments.

Are urgent and emergency services effective?

(for example, treatment is effective)

We found patients we offered fluids. However, we found that there was a risk that children would be given analgesia but continue to be in pain as the effectiveness of the analgesia had not been assessed.

Pain relief

- Four of the paediatric patients we saw had experienced pain. All of them had been asked about their pain, and been offered analgesia within an hour of their arrival to hospital. Staff routinely assessed paediatric patients for pain and provided prompt analgesia, but did not assess the effectiveness of the analgesia. None of the patients had their pain reassessed and we found one paediatric patient experienced worsening pain. This meant that there was a risk that paediatric patients would be given analgesia but continue to be in pain as its effectiveness was not assessed.

Nutrition and hydration

- Three out of 20 patients we saw had water within reach. However, all of the patients we spoke with had been offered water.

Patient outcomes

Urgent and emergency services

- There was a mental health co-ordinator that was available during the day. We saw that one patient would have to be in ED overnight as there was no facility to be assessed until the next morning.
- During our inspection nurses told us that there was no access to children's and young adults mental health services. However, after our inspection the trust informed us that there was access to children's and young adults mental health services within core working hours and access outside of these hours could be sourced via the adult mental health team.

Seven-day services

- Biochemistry services were available 24 hours a day, with a 30 minute wait for results. There was a telephone system in place to alert any urgent or abnormal results.
- Haematology services were available 24 hours a day. There was a 40 minute wait for results and a process in place to telephone through any urgent or abnormal results.
- X-ray and scanning were available 24 hours a day. Staff told us that the maximum wait in X-ray was 40 minutes.
- There was an alcohol liaison nurse employed weekdays from 9am to 5pm. They also followed up patients after discharge.

Are urgent and emergency services caring?

We did not have enough evidence to rate the domain of 'caring' for the services inspected.

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

We did not have enough evidence to rate the responsiveness of the services inspected.

Are urgent and emergency services well-led?

We did not have enough evidence to rate the domain of 'well-led' for the services inspected.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- 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

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 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 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 review the paper records to ensure that they can be located promptly 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 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. (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.