Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Quality Report

Charles Hastings Way
Worcester
WR5 1DD
Tel: 01905 763333
Website: www.worcsacute.nhs.uk/

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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.

Ratings

Overall rating for this hospital

Urgent and emergency services	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department (ED) at Worcestershire Royal Hospital on 14 January 2019, in response to concerning information we had received in relation to care of patients in this department.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the ED. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

This was a focused inspection to review concerns relating to the department. It took place between 1pm and 9.30pm on Monday 14 January 2019. We found that:

- Patients could not access the service when they needed to due to overcrowding. The time of arrival by ambulance to the initial assessment had increased. The time to treatment had increased and was worse than the previous year.
- Due to overcrowding in the ED seen on the inspection, there were significant delays in handing over patients from ambulances to the ED.
- Whilst the service mostly had suitable premises, there was insufficient space to accommodate all the patients in the department at the time of the inspection. The department was overcrowded with many patients being cared for in corridors.
- Whilst risks to patients were generally assessed and their safety monitored and managed, not all patients received assessment and treatment in a timely manner due to overcrowding. We were not assured that all patients received treatment in a timely manner at the time of the inspection. The trust and these patients were reviewed and the trust reported no harm had been experienced.
- There were delays in some patients being assessed by speciality doctors.
- There was not always sufficient staff in the children's ED during the inspection. We raised this as a concern and the trust took action to address this.
- It was not clear that there were sufficient medical staff to manage the increased demand or activity of the ED at the time of inspection. Some doctors told us that they did not feel the department was safe due to overcrowding.

However:

- Staff cared for patients with compassion at all times during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department. Staff did everything within their capacity to maintain patient privacy and dignity in times of overcrowding.
- Feedback from parents and relatives confirmed staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.
- The service generally had suitable equipment which was easy to access and ready for use.
- There were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care in the adult ED.
- There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED.
- Staff worked collaboratively at all times during the inspection to provide patient care and treatment.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Summary of findings

- The service had a documented vision for what it wanted to achieve. Plans were being implemented to ease overcrowding in the department were in development with involvement from staff, patients, and key groups representing the local community.
- The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.
- Staff and managers across the service promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Reduce the number of ambulance handover delays.
- Ensure all patients receive timely initial clinical assessments.
- Ensure all patients are seen by emergency department doctors and speciality doctors when needed.
- Reduce the number of patients cared for in corridor areas.

In addition, the trust should:

- Fully implement the trust wide actions to reduce overcrowding in the department.
- Monitor that children using the service are not left unattended for periods of time.
- Implement additional training of staff who support the ED in times of surges in demand to complete the Global Risk Assessment Tool.
- Ensure that there is sufficient medical staff to ensure timely assessments and treatment.

Following this inspection, we considered enforcement action, however, we were not assured that conditions applied would benefit or improve the situation or manage the risks. The trust were therefore issued with a requirement notice.

Professor Edward Baker

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		We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection, the department was under adverse pressure with significant overcrowding. Whilst staff did their best to care for patients with compassion, we found some patients had delays to initial assessments and timely treatments. The trust was implementing a range of actions to reduce overcrowding. We did not inspect any other core service or wards at this hospital. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Worcestershire Royal Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Worcestershire Royal Hospital

We carried out an unannounced focused inspection of the emergency department (ED) at Worcestershire Royal Hospital on 14 January 2019, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection, the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital; however, we did visit the admissions areas to discuss patient flow from the ED. During this inspection, we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

The figures below are for attendances combined between both Worcestershire Royal Hospital and Alexandra Hospital emergency departments.

Trust activity for the emergency departments from August 2017 to July 2018:

- 191,555 A&E attendances (+2% change compared to the same time 2016/17).
- 38,170 Children attendances (-4% change compared to the same time 2016/17).
- 48,376 ambulance attendances (+3% change compared to the same time 2016/17).
- 6% patients left without being seen (+6% change compared to the same time 2016/17).
- 11.6% reattendances within 7 days (+11.6% change compared to the same time 2016/17).

We previously inspected the ED at Worcestershire Royal Hospital in March 2018, when it was rated inadequate overall. We found that effective was rated good, safe and caring were requires improvement and responsive and well led were inadequate. Prior to that, inspections were completed in April and November 2017, to follow up concerns identified in a Section 29A Warning Notice and our comprehensive inspection in November 2017. Previously, the trust had been issued two Section 29A Warning Notices under the Health and Social Care Act 2008 and were required to make significant improvements in the quality of care provided. Concerns with the ED were raised in both Warning Notices, which were issued in January and July 2017.

Our inspection team

The team that inspected the service comprised of Phil Terry, Inspection Manager, one other CQC inspector, a national professional advisor with expertise in urgent and emergency care, a medical doctor and an emergency department matron specialist advisor. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department (ED) at Worcestershire Royal Hospital provides services 24-hours per day, seven days per week service. It is a designated trauma unit but patients with multiple traumas are taken directly to a major trauma centre in Birmingham.

The ED consists of a major treatment area consisting of 12 cubicles and three side rooms, a minor treatment area with seating and five assessment/treatment rooms and a resuscitation room with four bays. A “high care” area has been created consisting of four cubicles where patients can be monitored once they have been stabilised in the resuscitation room. The department has a paediatric area with a separate waiting room and three cubicles. There are two cubicles close to the ambulance entrance where patients can be assessed if there is no room in the major treatment area.

During the inspection, we visited the emergency department only. We spoke with 30 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 15 patients and three relatives. During our inspection, we reviewed 23 sets of patient records.

Summary of findings

As this was a focused inspection, we have not inspected the whole of each key question therefore there is no rating. We found that:

- Patients could not access the service when they needed to due to overcrowding. The time of arrival by ambulance to the initial assessment had increased. The time to treatment had increased and was worse than the previous year.
- Due to overcrowding in the emergency department (ED) seen on the inspection, there were significant delays in handing over patients from ambulances to the ED.
- Whilst the service mostly had suitable premises, there was insufficient space to accommodate all the patients in the department at the time of the inspection. The department was overcrowded with many patients being cared for in corridors.
- Whilst risks to patients were generally assessed and their safety monitored and managed, not all patients received assessment and treatment in a timely manner due to overcrowding. We were not assured that all patients received treatment in a timely manner at the time of the inspection. The trust reviewed these patients and reported no harm had been experienced.
- There was not always sufficient staff in the children’s ED during the inspection. We raised this as a concern and the trust took action to address this.
- It was not clear that there were sufficient medical staff to manage the increased demand or activity of the ED at the time of inspection. Some doctors told us that they did not feel the department was safe due to overcrowding.

Urgent and emergency services

- Specialty doctors were unable to respond to all patients in a timely manner.

However:

- Staff cared for patients with compassion at all times during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department. Staff did everything within their capacity to maintain patient privacy and dignity in times of overcrowding.
- Feedback from parents and relatives confirmed staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.
- The service generally had suitable equipment which was easy to access and ready for use.
- There were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care in the adult ED.
- There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED.
- Staff worked collaboratively at all times during the inspection to provide patient care and treatment.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a documented vision for what it wanted to achieve. Plans were being implemented to ease overcrowding in the department were in development with involvement from staff, patients, and key groups representing the local community.
- The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.
- Staff and managers across the service promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.

Urgent and emergency services

Are urgent and emergency services safe?

As this was a focused inspection, we have not inspected the whole of this key question therefore there is no rating. We found that:

- Due to overcrowding in the emergency department (ED), there were significant delays in handing over patients from ambulances to the ED.
- Whilst the service mostly had suitable premises, there was insufficient space to accommodate all the patients in the department at the time of the inspection. The department was overcrowded with many patients being cared for in corridors. There were significant delays in off-loading ambulances and resultant delays in assessment and treatment for some patients.
- Whilst risks to patients were generally assessed and their safety monitored and managed, not all patients received assessment and treatment in a timely manner due to overcrowding. We were not assured that all patients received treatment in a timely manner at the time of the inspection. The trust reviewed these patients and reported no harm had been experienced.
- Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding.
- There was not always sufficient staff in the children's ED during the inspection. We raised this as a concern and the trust took action to address this.
- It was not clear that there were sufficient medical staff to manage the increased demand or activity of the ED at the time of inspection. Some doctors told us that they did not feel the department was safe due to overcrowding.

However:

- Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.
- The service generally had suitable equipment which was easy to access and ready for use.
- There were enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care in the adult ED.
- There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED.
- The service generally had enough medical staff with the right qualifications, skills, training and experience to provide the right care to meet the national recommended level of cover.

Environment and equipment

- **Whilst the service mostly had suitable premises, there was insufficient space to accommodate all the patients in the department at the time of the inspection. The department was overcrowded with many patients being cared for in corridors. There were significant delays in off-loading ambulances and resultant delays in assessment and treatment for some patients.**
- On arrival for inspection, we found that the hospital was under extreme pressure with many ambulances in attendance. We found that all cubicles, in all departments were full. Patients were being cared for in the main corridors and waiting in ambulances to be offloaded. Whilst the department provided suitable cubicle space for patient care, due to the number of patients in attendance, it was unclear if the department was large enough to manage on a daily basis.
- **Due to overcrowding in the ED, there were significant delays in handing over patients from ambulances to the ED.** On our arrival at 13:00, there were 28 patients in the corridor and five ambulances waiting to off load patients. Staff reported that on the afternoon of the inspection, up to 23 ambulances had arrived and were waiting to handover patients to ED staff. There was insufficient space surrounding each trolley to cope with an emergency. All patients in the corridor were nursed on trolleys. Trust data showed that there were the following number of patients in the department on the 14 January 2019:
  - 06.30 = 43.
  - 09.00 = 41.
  - 12.00 = 71.
  - 16.00 = 74.

- 18.00 = 65.
- 20.30 = 64.

- We looked at the records of 23 patients to identify how long they had been in the department. Records showed that:
  - Two patients had been in the department less than five hours.
  - Three patients had been in the department for five to ten hours.
  - Four patients had been in the department for ten to 15 hours.
  - Five patients had been in the department 15 to 20 hours.
  - Two patients had been in the department for 20 to 25 hours.
  - Three patients had been in the department for 25 to 30 hours.
  - Four patients had been in the department for 30 to 45 hours.
- Where possible, patients were placed in cubicles on beds to aid their comfort whilst waiting for a ward bed, however, this was not always possible. We saw that eight out of the 23 patients reported that they had been cared for in the corridor since admission to the department. Records showed that they had all been in the department between 11 and 29 hours. Patients who were cared for in the corridor were unable to be placed on a hospital bed, due to the width of the corridor and enabling safe access and passage.
- We spoke with staff regarding the duration of some patients wait in the emergency department (ED) and we were told that the patients were awaiting a speciality bed or a side room. We saw that the patients waiting for a bed included a patient who had been in the department for 44 hours and 19 minutes whilst waiting for a respiratory bed. Several patients waiting for beds were frail, and elderly. There were 12 out of 23 patients aged between 70 and 93 years, waiting between ten to 45 hours for a bed in a ward.
- The service had recently opened an additional corridor where patients could wait to be seen by the ED staff. This was a small corridor that ran adjacent to the main corridor. We saw that three patients were held here, on ambulance trolleys. These patients were cohorted and cared for by one ambulance crew, enabling the other crews to leave the hospital. We saw that the fire door at the end of this corridor was partially blocked by the trolleys. Staff told us that this area had been agreed for use approximately one week prior to the inspection as a temporary measure to enable ambulance crews to return to service.
- Patients cared for in the main corridor were provided with emergency call bells and therefore, could call for help if necessary. However, due to the number of patients in the department, there were insufficient call bells in the corridor for all patients. This meant that patients were reliant on staff being within earshot, if calling for help.
- The service had dedicated cubicles which were kept patient free to enable patient assessments to be completed in privacy. We saw that patients were moved temporarily to the assessment cubicle bay when assessments or personal care was completed. We also saw that privacy screens were used when cubicle space was not available.
- **The service generally had suitable equipment which was easy to access and ready for use.**
- Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys which were sealed with a tamper evident tag. Safety checks were carried out daily. Emergency equipment was portable, and therefore available to all areas of the department, including the corridor where care was being provided.
- There was no resuscitation equipment within the paediatric waiting room; however, equipment could be accessed from the majors' area in the event of a patient deteriorating. We were told that any child requiring resuscitation were transferred into the resuscitation area which was not specific to paediatrics. The resuscitation area (resus) had paediatric specific equipment available in all bed spaces. There was sufficient space for a child on a trolley to be taken to the resuscitation area if required. Staff said that the most stable patient in resuscitation area would be moved to alternative locations in the event of a paediatric emergency, ensuring that a space was available.
- We saw staff continually moving patients to other parts of the department to try and accommodate patient's needs. The nurse in charge had oversight of all patients, their location and their needs.

- There was sufficient equipment such as adult, infant and paediatric pulse oximeters, blood pressure machines, thermometers, oxygen and suction for the number of patients requiring these. Patients had access to call bells to call for staff if required.
- All staff both clinical and non-clinical were aware of the location of the emergency equipment. Nursing staff told us that its location and how to use it was included the in induction of all staff.

Assessing and responding to patient risk

- **Whilst risks to patients were assessed and their safety monitored and managed, not all patients received treatment in a timely manner. The trust reviewed these patients and reported no harm had been experienced.**
- The department operated a 'streaming' system. Patients who self-presented were assessed according to their presenting condition and directed to either minor injuries or majors. We saw that all self presenting patients were assessed within 15 minutes of arrival to the department by a nurse. This assessment included completion of clinical observations and any other relevant investigation, for example, an electrocardiogram for those complaining of chest pain.
- **Triage times were not always in line with guidance. Some patients waited considerable time to be assessed due to overcrowding.** The department had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours.
- Standards set by the Royal College of Emergency Medicine states that this initial clinical assessment should take place within 15 minutes. This was achieved for 79% of attendances by ambulance. Records showed that 15 out of 19 patients were assessed within 15 minutes of arriving by ambulance in the department. The remaining four were triaged between 38 minutes to three hours and 53 minutes of their arrival by ambulance. The four patients who did not have a triage within 15 minutes were those who were held in an ambulance for a length of time prior to being admitted to the department. Data showed that the time from arrival by ambulance to initial assessment was recorded at nine minutes for September 2018. This had increased from seven minutes in September 2017.
- The national early warning score (NEWS) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). NEWS is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. Patient with any patient with an elevated NEWS score being referred immediately to the doctors. We saw that the notes of patients with a NEWS score over five, or a single reading generating a score over three, were placed in a blue folder and placed at the top of the "for assessment" pile. Nursing staff were also observed informing doctors of the patients' observations, and the need to assess as soon as possible.
- We looked at eight NEWS/PEWS charts and saw that they were completed correctly and regularly. On the charts reviewed, clinical observations were repeated in line with the previous score and escalated when scores were elevated. Compliance with escalation of NEWS was audited in the ED and was at 85% with an action plan to support improvement.
- **There were delays in patients being assessed by ED doctors due to overcrowding in the ED.** We looked at 23 patient records. We saw that 15 had been reviewed by a doctor. The times of review showed that three patients had been seen by a doctor within 30 minutes of admission to the department, a further four were reviewed within 60 minutes of admission, three more reviewed between 60 and 120 minutes from admission and the remaining five over 120 minutes. The longest wait for a doctor review was three hours and four minutes.
- Further breakdown of data, showed that over half of patients were seen within 30 minutes of being triaged by a nurse (eight out of 15). Except for two patients, those found to have an elevated NEWS score on triage were seen by a doctor within 30 minutes of triage. The two exceptions included one patient with a NEWS score of nine, who was reviewed by a doctor after one hour and forty minutes. Another patient, with a NEWS score of five was reviewed after 47 minutes.

- **We were not assured that all patients received treatment in a timely manner at the time of the inspection.** We asked the trust to provide us with information relating to three patients identified with potential delays in treatment. We were provided with reviews of the patients' notes and an update on their clinical condition. Details of the patient records indicated that there had been some delays in treatment, but no harm experienced.
  - One patient was admitted with chest pain, with observations recorded at 11:15 (with a NEWS of one). Observations were not repeated until 18.00 when NEWS had deteriorated to four. The national recommendation is that observation should be repeated four to six hourly. The trust reviewed this case and said that two hourly care and comfort rounds had confirmed that the patient remained pain free. The patient had been seen by a junior doctor after 3.5 hours at 14:30 which was longer than the national standard. 18:00 observations showed a deterioration, which had been escalated immediately.
  - A second patient was admitted at 12:56, triaged at 14:02 and reviewed by a doctor at 14.30 with suspected sepsis. With antibiotics not administered until 15.15. The trust reviewed this case and said that the patient's observations at 12:30 and 13:30 showed NEWS of one which did not trigger the sepsis screening process. The patient was seen by ED doctor after 3hr 30minutes treatment was started within 20 minutes of this review. Sepsis was not the diagnosis and antibodies were later given due to an elevated white blood count found on blood tests.
  - A third patient was admitted at 12:20 and care given initially in an ambulance. Noted (by the ambulance crew) to have elevated blood glucose at 13:00. Observations at 15:15 showed a very high blood sugar level. The trust reviewed this case and said that the patient was risk assessed at 45 minutes from arrival and was transferred to the ED corridor and triaged by an ED nurse at 15:15. These observations at 15:15 showed a very high blood sugar level and this was escalated immediately to ED consultant and treatment started.
- The department had an agreement with the ambulance service that those patients who were unable to be 'off loaded' into the department would remain on the ambulance under the care of the ambulance crew. Patients would be assessed using an assessment tool to identify their risk of deterioration and prioritised according to their score. This meant that those patients at a higher risk were admitted into the department as soon as space became available. Whilst this process ensured that those patients at the greatest risk were admitted into the department sooner, it also meant that those who were more stable, potentially had longer waits in ambulances.
- There was a hospital ambulance liaison officer (HALO) employed to work in the department. Their role was to assist with the management of ambulances attending the department, liaising with the ED staff and the ambulances operating in the region. We were told that staff worked proactively to manage the flow of patients into the department.
- Patients waiting under the care of an ambulance crew for one hour or more are called a black breach. From 31 December 2018 to 10 January 2019, there were 298 black breaches recorded at Worcestershire Royal Hospital.
- Trust wide, more patients waited over one hour under the care of an ambulance crew than the England average. In October 2018, 12% of ambulances waited more than 60 minutes compared with the national average of 5%. From 24 December 2018 to 6 January 2019, 15% of all ambulance crews were delayed by more than an hour.
- In January 2019, the average time for ambulances to handover their patients to ED was 33 minutes. This was worse than the previous month, December 2018, when it was 29 minutes. From April 2018 to January 2019, average ambulance handover times had increased steadily.
- **There were processes in place to escalate concerns regarding patients' safety/care or treatment. The trust had policies in place for responding when demand exceeded capacity in the ED. The service had introduced a tool for recognising patients at risk which promoted actions to be taken to prevent deterioration.** Staff in the ED recognised the increased risks associated with patients remaining in the department for considerable lengths of time. To reduce the risk, they had introduced the Global Risk Assessment Tool (GRAT) which required nurses to assess and record whether each patient was in an appropriate clinical area, for example, and if they had experienced

treatment delays or had prolonged immobilisation. If a risk was present, the GRAT indicated the action staff had to take. Actions included informing the nurse in change and where appropriate, a senior doctor. Following the inspection, the trust said that the GRAT was based on complexity of condition and management a move to within the department would have been advisable at the time of the first GRAT. The process for GRAT was applied as per standard operating process for the cases it had reviewed. However, the trust had identified that in complex situations, additional training of staff who support the unit in times of surges in demand to complete the GRAT was required. This training would focus on applying clinical judgement in the escalation process.

- We raised our concerns that not all patients received timely assessment and treatment at times when the ED was overcrowded. The trust said there was a number of assessment tools, policies and audits relating to processes it had implemented when there was increased capacity and demand in the ED. These tools and processes had been implemented to provide the ability to prioritise timely treatment for those patients at greater risk of deterioration. These included:
  - 'Standard Operating Procedure for ED covering the (GRAT), which included:
    - GRAT for patients waiting more than 60 minutes for formal handover from ambulance crew.
    - GRAT for patients waiting more than six hours in the ED.
  - Recognising and responding to early signs of deterioration in hospital patients.
  - The 'Full Capacity Protocol' included the process for risk assessing patients that were boarded on wards'.
- Reception staff logged walk in patients details and had received training on 'red flag' presenting complaints and the deteriorating patient. Red flags are signs and symptoms that indicate the possible or probable presence of serious medical conditions that can cause irreversible disability or untimely death unless managed promptly. We saw that reception staff appropriately escalated any concerns regarding self-presenting patients to the nurse.
- All staff we spoke with knew how to raise the alarm and seek urgent help in an emergency.
- **Patients received a comprehensive assessment in line with clinical pathways and protocols. Risk assessments were completed accurately, and actions taken to address any concerns.** Patients were assessed using a combined form which contained a medical admission and nursing admission template. This included sections for clinical observations (national early warning score), Glasgow coma scale and details of past medical history, complaint history and a section for treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. We saw the records of five patients in the department who had the sepsis pathway implemented. Four out of five charts reviewed showed diagnostic and initial treatment was completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) 'Sepsis: recognition, diagnosis and early management'. Sepsis toolkits were available. Following inspection, the trust confirmed that one of the patients who had not received treatment for sepsis was not suspected of being septic, however, the doctor wished for antibiotic treatment as a precautionary measure.
- Staff did not all have access to mandatory training on mental health issues or palliative care. However, they did have access to mental health liaison service 24 hours a day, seven days a week. Staff knew how to make an urgent referral and patients were seen promptly. There were end of life care champions in the department who provided advice and bespoke training sessions for staff.

Nursing staffing

- **There were enough nursing staff with the right qualifications, skills, training and experience to keep adult patients safe from avoidable harm and to provide the right care in the adult ED. However, there was not always sufficient staff in the children's ED. We raised this as a concern and the trust took action to address this.**
- The ED used a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) ED staffing recommendations, to ensure the department was staffed appropriately. This outlines how many registered nurses they needed to safely staff the department. The department had also

taken into consideration the nursing of patients in the corridor as a result of poor flow in the main hospital. This had enabled them to increase their nursing staffing numbers to accommodate staff to care for patients in the corridor.

- At all times throughout our inspection, we found the skill mix of staff to be suitable for the needs of the ED, with actual staffing levels meeting the planned levels. We saw that duty rosters showed consistent staffing numbers, with no shortages. Senior staff had oversight of the staffing within the department and moved staff around to ensure all areas were safe and they could manage surges in demand. The wider hospital teams supported the ED team at periods of high activity. Senior nursing staff and specialist nurses, attended the department and offered support, either with patient transfers or patient care.
- Staff told us they largely covered any vacant shift amongst themselves either through adjustments to staffing rosters or additional shifts. The department had both bank staff and agency staff who were used regularly. All the ones we spoke to had completed an induction and were familiar with the department.
- There were not sufficient registered sick children's nurse to cover every shift. There were two dual trained nurses (for both adults and children). To address this, several staff had undertaken competencies and training to provide a safe environment when caring for children with advice sought for the paediatric wards when necessary. We were told that there was always at least one nurse who had received paediatric immediate life support training on duty. Information received from the trust after the inspection confirmed this.
- Off duty rotas showed that nurses with additional children competencies were always on duty each shift. There were two days where this was not accomplished in the four weeks off duty rotas reviewed, because of staff sickness.
- There was a regular programme of paediatric study days and practical simulations to increase the skills and knowledge of ED nursing staff.
- Nursing handovers included all nurses working in the department. Medical staff held separate handovers to nursing staff. We saw that doctors and nurses communicated effectively regarding patients, treatment and care required.
- There was one nurse allocated to care for children attending the department. This meant that when the nurse left the paediatric waiting room/ treatment area, the child was left with their parents/responsible adult. We spoke with the senior nursing team who told us that the nurse always informed the adult of how to summon help is necessary; however, we were not assured that this was safe. Staff said that a healthcare assistant could also assist the paediatric nurse if they were busy, however we did not see this during the inspection. At times during the inspection, we saw the children's ED was left unstaffed when children and parents were in this area. We raised this with senior managers as a concern.
- The trust provided information that showed at the time of the inspection there were two children's trained emergency practitioners on duty to cover the paediatric area. The rota illustrated that the establishment facilitated either a children trained nurse accompanied by an emergency practitioner with enhanced skills training in children's care to be on every shift. This ensured there was the ability to have oversight and presence in the children's areas. The practice of risk assessing the department at times of surge or clinical requirement was in place should the children's nurse be required to leave the department. Senior managers recognised that clearer communication and a review of standard operating procedures (SOP) for this area for staff was required and this would be in place by Monday 21 January 2019. This SOP would also cover the requirements for a computer to be available, so staff did not have to leave the area. Arrangements for this installation had been made for this to be in place by 25 January 2019. When required to provide support to families, the children's' trained nurse will be directed to the resuscitation area due to their specific skills in providing family centred care to parents at a time of distress. he children's nurse had the appropriate training in paediatric immediate life support. Staff in the resuscitation area is trained at advanced paediatric life support. This was in addition to medical staff training who also support the resuscitation area.

Medical staffing

- **The service generally had enough medical staff with the right qualifications, skills, training and experience to provide the right care to meet the national recommended level of cover. However, it was not clear that there were sufficient medical**

staff to manage the increased demand or activity of the department at the time of inspection. Some doctors told us that they did not feel the department was safe due to the overcrowding.

- There was a consultant present in the department for 16 hours a day, seven days a week, with a registrar (ST4) available 24 hours a day. We saw that a substantive consultant was on duty between 8am and 7pm, with a regular locum consultant covering 4pm to midnight. A substantive consultant was on call between midnight and 8am. Between midnight and 8am, the registrar was the senior doctor supported by two junior doctors. This was in line with the Royal College of Emergency Medicine (RCEM) minimum standard of 16-hour consultant presence each day. The medical staffing rotas seen showed that there were 16 hours of consultant cover provided by the permanent and temporary staff in post.
- There were 6.2 whole time equivalent ED consultants in the department. One of which had sub specialist training in paediatric emergency medicine. There were 14 middle grade doctors, including three locums. Locum staff were used regularly. There was a clear induction process in place.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed. Handovers between different teams of doctors was well-structured and detailed. We observed early senior involvement in the treatment of patients throughout our inspection.
- All doctors spoke positively about working in the ED and confirmed that they were supported and received appropriate training. They told us that the lead consultants were supportive and always accessible. Junior doctors told us that they received good supervision and senior support. Teaching was provided weekly and attendance at teaching sessions was not compromised by service activity. However, some doctors expressed concerns that at times of overcrowding, the ED did not feel safe. The trust told us that during times of escalation, the trust secured specialty doctors to support the ED and the lead ED consultant undertook the rapid assessment and triage process.

Are urgent and emergency services effective?
(for example, treatment is effective)

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating. We found that:

- Staff worked collaboratively at all times during the inspection to provide patient care and treatment.

Multidisciplinary working

- **Staff worked collaboratively at all times during the inspection to provide patient care and treatment.**
- Throughout the inspection, we saw effective communication between individual staff members and groups. When staff were concerned about a patient's condition, they escalated concerns to the consultant, or nurse in charge. For example, we saw one nurse ask for a one patient to be reviewed next, as they had concerns.
- It was clear from interactions, that there was mutual respect for all team members. Staff were listened to, and senior team members made time for all staff, despite the increased activity and demand.
- Doctors and specialist practitioners were considered part of the team, with many specialty doctors basing themselves within the department. This ensured that they were on hand to discuss patients and offer support.
- When activity increased, we saw that senior nursing staff, such as matrons, divisional leads, deputy and chief nurses attended the department to offer support. The assistance was coordinated by the nurse in charge and ED matron. The additional assistance helped staff to take breaks, as well as helping with transfers and patients care.

Are urgent and emergency services caring?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating. We found that:

- Staff cared for patients with compassion at all times during the inspection. Staff were friendly, professional and caring at all times even when under extreme pressure due to overcrowding in the department.

- Feedback from parents and relatives confirmed staff treated them well and with kindness.
- Staff did everything within their capacity to maintain patient privacy and dignity in times of overcrowding.
- Staff involved patients and those close to them in decisions about their care and treatment.

Compassionate care

- **Staff cared for patients with compassion at all times during the inspection. Staff were friendly, professional and caring at all times, even when under extreme pressure due to overcrowding in the department.**
- We saw that all staff did their utmost to ensure patients were comfortable. We saw that all staff, including administrative staff attended patients, and answered any calls for help. Additional blankets, pillows and refreshments were offered to try and enhance comfort.
- It was impossible for staff to maintain the privacy and dignity needs of the patients cared for in the corridor due to overcrowding. However, staff used screens to provide privacy for treatments if a cubicle was not available. Nursing staff were attentive to patient's needs at all times. For example, one patient was observed attempting to get off their trolley frequently. The healthcare assistant caring for the patient assisted them to reposition and ensured their comfort before leaving them with great compassion.
- Due to the proximity of other patients, it was not always possible for staff to have private conversations with patients without being overheard. However, we saw that staff spoke quietly, and took relatives to the side to ensure that confidential information was not shared.
- Staff were friendly, professional and caring at all times. We saw that staff interacted positively with patients and their relatives. All attempts were made to ensure that the patients' experience was a positive one. Staff remained good humoured, engaged in conversations and promoted discussions with patients and relatives, throughout the inspection.
- Nursing handover was completed in a separate room, which enabled sharing of confidential information without being overheard.
- **Feedback from parents and relatives confirmed staff treated them well and with kindness.** Patients said they were very happy with how happy they were treated by the staff. They said staff were always "very caring", "worked very hard" and "were very friendly". They understood how busy the department was and said staff were 'doing their best' and 'giving 100%'. Feedback from relatives was almost all positive and they were very complimentary about how hard all staff worked especially during times of overcrowding in the department.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients told us they generally felt well informed about their care and treatment, although a few referred to delays in updates. The service had developed a patient information leaflet, which gave details of what to expect when attending the department. We saw that this was shared with patients and information explained if necessary.
- The service performed similar to the national comparison in relation to patient audits relating to reassurance when distressed, being treated with respect and dignity and pain management. There was one indicator where the service scored worse than the national comparison, which was in the provision of privacy during examinations. This indicator scored worse than the national comparison.

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

As this was a focused inspection, we have not inspected the whole of this key question therefore there is no rating. We found that:

- Patients could not access the service when they needed to due to overcrowding. The time of arrival by ambulance to the initial assessment had increased. The time to treatment had increased and was worse than the previous year.
- Specialty doctors were unable to respond to all patients in a timely manner.

Access and flow

Urgent and emergency services

- **Patients could not access the service when they needed to due to overcrowding. The time of arrival by ambulance to the initial assessment had increased. The time to treatment had increased and was worse than the previous year.**
- There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. There was an electronic system which detailed the length of time patients had been in the department, who had been referred and required admission. Bed availability and patient flow through the hospital was discussed at regular bed meetings throughout the day and plans made. However, despite the regular meetings and plans, the demand on the service was much greater than that which was available.
- Due to the increased demand on the service, the trust had completed a review of every patient in hospital on the morning of our inspection. This was a process which was completed regularly, and involved a senior clinician reviewing every patient to identify if they could be discharged. We were told that there were very few patients well enough to be discharged, which meant that flow through the hospital was almost impossible.
- ED escalation levels were determined by the regional health economy Escalation Management System (EMS). EMS levels were graded one to four. EMS, one is normal working, and three is when the department is under severe pressure. In the week commencing 30 December 2018, the department reported three days when it was EMS three or above.
- The status of the ED was reported to the bed management team via an electronic system. Bed management meetings took place four times per day and were attended by senior staff from across the hospital, including ED. We did not attend a bed meeting but saw that staff worked together to review capacity and identify ways to improve flow and minimise the impact on patients.

Activity

- NHS Trusts are required to monitor and report nationally the percentage of patients who attend ED and are seen, treated and discharged or admitted within four hours of arrival. This is known as the Emergency Access Standard (EAS). The NHS standard requires 95% of patients to spend less than four hours in ED. Trust data for 31 December 2018 to 10 January 2019 showed that the EAS for Worcestershire Royal Hospital was between 49 to 60%.
- Trust data showed that activity, from example days in the period 31 December 2018 to 10 January 2019, was as follows:
  - 31 Dec 2018: Attendances - 172; 4-hour breaches - 69; EAS (%) - 59.9; 12-hour breaches - 10; >60-minute ambulance delays - 40.
  - 3 Jan 2019: Attendances -193; 4-hour breaches -96; EAS (%) - 50.3;12-hour breaches -4; >60-minute ambulance delays - 33.
  - 7 Jan 2019:Attendances - 211; 4-hour breaches - 85; EAS (%) - 61.9; 12-hour breaches - 13; >60-minute ambulance delays - 42.
  - 10 Jan 2019: Attendances - 173; 4-hour breaches - 91; EAS (%) - 49.7; 12-hour breaches - 4; >60-minute ambulance delays - 31.
- Data showed that the service was not performing as well as the previous year. When data from October 2018 was compared to October 2017, we saw that there was a deterioration in a number of indicators. This included the time of arrival by ambulance to the initial assessment, which had was slightly worse and increased from seven minutes in September 2017 to nine minutes in September 2018.
- Data for October 2018 showed that 61.2% of patients spent less than four hours in the type one majors' departments in the trust. This was a deterioration from the previous year (81.8%) and much worse than the national comparison of 83.2%.
- Similarly, data showed that 75% of all patients spent less than four hours in any area of the emergency departments in the trust. This was a deterioration from the previous year (81.8%) and much worse than the national comparison of 87.4%. However, data showed that the service performed similar (0.9) to the national comparison (1.0) for the total time all patients spent in the department.
- Data for October 2018, showed that time to treatment was recorded at 61 minutes, which had increased, and was worse than the previous year (49 minutes).
- Trustwide, in October 2018, 45% of admissions waited between four and 12 hours in ED from a decision to admit. This was worse than national average of 12%.

Urgent and emergency services

- There was an increase in the number of patients who reattended the department within seven days. In September 2017, there was 9.6% unplanned reattendances in comparison to 11.6% in September 2018. This was similar to the national comparison.
- There was on onsite GP service which was ran separately from the hospital. However, we were told the service actively assisted wherever possible, by seeing ED walk in patients with minor injuries, or who were more suitable for GP care, rather than emergency care. These patients were streamed from admission.
- **Specialty doctors were unable to respond to all patients in a timely manner.** Records showed that specialty doctors were unable to respond to all patients in a timely manner. Most patients had to wait too long to see a specialist doctor after a referral had been made by ED staff. Of the 23 records reviewed, six patients were reviewed by a specialist doctor. Records showed that the time from referral by the ED doctor to being seen by a specialist doctor was between five minutes to two hours and 23 minutes. The average time of 84 minutes. Four further records showed that patients had been seen by a specialist doctor, however the referral time was not recorded. Notes showed that, these reviews had taken place between one hour and 20 minutes and two hours and forty minutes after the patient was seen by the ED doctor. For example, we saw that one patient was admitted at 9.03pm, seen by the ED doctor at 9.20pm, and reviewed by the specialist doctor at 11.40pm.

Are urgent and emergency services well-led?

As this was a focused inspection, we have not inspected the whole of this key question therefore there is no rating. We found that:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a documented vision for what it wanted to achieve. Plans were being implemented to ease overcrowding in the department were in development with involvement from staff, patients, and key groups representing the local community.
- The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.
- Staff and managers across the service promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.

Leadership

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.** Leadership in medical and nursing staff was clear, positive and collaborative. We saw that they interacted positively with all staff, ensuring that the department was well-managed. It was clear from staff interactions that they had a belief in the leadership of the team. Staff sought their help and opinion when they needed it. Leadership for each clinical area was clearly displayed. Staff were allocated to specific roles within the department, and had armbands denoting what they were responsible for. The nurse in charge of the shift, was kept well informed and had oversight of all activity.
- Senior staff in the department felt very well supported by the trust's executive team and that their concerns were listed to and acted upon.

Vision and strategy for this service

- **The service had a documented vision for what it wanted to achieve. Plans were being implemented to ease overcrowding in the department were in development with involvement from staff, patients, and key groups representing the local community.**
- There was a trust wide plan for improving the flow of patients through the hospital. This included the opening of 14 additional beds for general medicine patients. The beds were planned to open two days after our inspection and were part of a hospital wide reconfiguration. The reconfiguration of services included moving patients that were being cared for in surge areas, to the new beds on Avon 5, this would enable surge areas to function as normal. The trust had worked with the local Healthwatch regarding care for patients in corridor areas in the department.

- The service had started to work on pathways for patients who could be cared for elsewhere. For example, the trust had decided to divert patients with a fractured neck of femur (hip) to the Alexandra Hospital. This process was introduced in December 2018.
- The service leads had a clear vision of what they needed to do to improve flow. This included working on patient pathways in ambulatory care and the provision of assessment trolleys in the medical assessment unit for direct admissions (GP expected). There were also plans to redirect patients from within two postcodes tin the Droitwich area to the Alexandra Hospital. This change was planned for completion at the end of January 2019.
- Senior staff reported effective and positive support from NHS Improvement who had been supported the service with a range of measures to reduce overcrowding in the department.

Governance, risk management and quality measurement

- **The service had a systematic approach to continually monitor the quality of its services. The service monitored activity and performance and used data to identify areas for improvement.**
- Data relating to performance was clearly displayed in the unit. Staff openly discussed performance and what it meant for patients. Staff knew the main risk areas in the department and the actions needed to keep patient safe from avoidable harm
- The service maintained a dashboard of activity which was discussed as part of team and management meetings. Audits of risk assessment in the department were carried out and used to drive improvements.

Culture within the service

- **Staff and managers across the service promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding of the pressures and a common goal.**
- All staff were positive about working in the department. All staff were cheerful, friendly and engaged in conversations with patients, relatives and other staff. Staff demonstrated working to common goals and supported each other. Leaders and staff were committed to driving improvements in the service to keep patients safe from harm and to improve the experience of all patients using the service.
- Doctors told us that there was a strong culture around the importance of formal and informal teaching within the department.
- Nursing staff told us that they were given the opportunity to develop and that they were supported to complete external training. We saw posters and minutes from meetings that confirmed this.
- Interactions between all staff, even when the service was in extremis were positive and respectful. Staff listened to each other, and offered help.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Areas 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 hospital MUST take to improve to:

- The trust must ensure that ambulance handovers are timely and effective. Regulation 12 (2) (a) (b) (i).
- The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments. Regulation 12 (2) (a) (b) (i).
- The trust must ensure that patients receive medical and specialty reviews in a timely manner. Regulation 12 (2) (a) (b) (i).

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve to:

- The trust should fully implement the trust wide actions to reduce overcrowding in the department. Regulation 12 (2) (a) (b).
- The trust should monitor that children using the service are not left unattended for periods of time. Regulation 12 (2) (a) (b).
- The trust should implement additional training of staff who support the ED in times of surges in demand to complete the Global Risk Assessment Tool. Regulation 12 (2) (a) (b).
- Ensure that there is sufficient medical staff to ensure timely assessments and treatment. Regulation 12 (2) (a) (b).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The trust must ensure that ambulance handovers are timely and effective.** **The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.** **The trust must ensure that patients receive medical and specialty reviews in a timely manner.**